STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Pacwest Kennewick, LLC
Parkview Estates
7820 W 6th Ave
Kennewick, WA 99336

RE: Parkview Estates License # 2025

Dear Administrator:

This letter addresses Compliance Determination(s) 28857 (Completion Date 09/04/2023) and 25034 (Completion Date 07/05/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/04/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2160

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Parkview Estates
Provider Type: Assisted Living Facility
License/Cert.#: 2025
Compliance Determination #: 25034
Intake ID: 83025
Investigator: Melissa Milanez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 06/08/2023 through 07/05/2023
Complainant Contact Date(s): 07/04/2023

Allegation(s):

1) The named resident was never checked on by the nurse after returning from the hospital.
2) The named resident lost 50 lbs. in the last six months.
3) The named resident had three falls in the last three months and were not reported to the POA.
4) The named resident had four hospital visits that were not reported to the POA.
5) Physical therapy was not started for the resident.
6) The named resident was denied ten baths and did not receive a bath for at least two and half months.
7) The named resident was left in their wheelchair, fell, and was never checked on by the nurse.
8) The named resident went months where the facility did not order their incontinent supplies.
9) The named resident had money missing from their locked drawer.

Investigation Methods:

Sample:	Total residents: 107 Resident sample size: 3 Closed records sample size: 1
Observations:	Environment, cares, residents, resident rooms, staff to resident interactions, resident to resident interactions, facility common areas, staff availability and response to resident's needs, med pass.
Interviews:	Facility staff, Residents, and others not associated with the facility.
Record Reviews:	Characteristic roster, facility policies, resident records (face sheet, assessments, care plan, progress notes, physician orders), facility incident report and investigations, shower schedule, weight monitoring schedule, staff phone list.

Investigation Summary:

1) Identified resident no longer lived at the facility. The identified resident's representative stated that they moved the resident due to the resident not having

proper care and services. Interviews and record review showed that the named resident was assessed and placed on alert charting. Record review showed that a change in condition care plan was completed, and resident was put on a two-hour safety check. No deficient practice rising to the level of citation was identified.
2) Interview and record review showed that the named resident had a weight loss of forty pounds in the last six months. The facility was unable to provide documentation of weights for the last 6 months. Deficient practice was identified related to failure to follow the NSA and weigh resident monthly per policy, please see the statement of deficiency for WAC 388-78A-2160 dated 07/05/2023.
3,4) Interviews with facility staff confirmed the resident had one fall at the facility since admission, and three hospital visits, with the last visit, resident not retuning back to the facility. Record review showed the named resident was assessed after the fall and sent to the ER for further evaluation. Interview and record review showed that the facility followed their policy, and all notifications were made, no deficient practice rising to the level of citation was identified.
5) Interviews and record reviewed showed that the resident received physical therapy services upon receiving the primary care provider referral. Record reviewed showed documentation of all physical therapy visits by an outside agency. No deficient practice rising to the level of citation was identified.
6) The facility staff confirmed that the resident refused a shower several times but were unable to confirm when the resident last had a shower. There were facility records noting that the resident did not receive a shower in the last two months. Deficient practice identified, see the statement of deficiency for failure to follow the negotiated care plan, WAC 388-78A-2160 dated 07/05/2023.
7) Interviews and record reviewed showed that the named resident was placed on frequent safety checks and was last checked on one hour prior to the fall. Fall precautions were in place prior to the fall, facility staff followed their policy, sent the resident to the ER, and made all notifications. No failed practice found.
8) Interviews and record review showed that there was a delay in ordering incontinent supplies for the named resident due to waiting on a provider’s signature, but facility staff provided supplies to the resident as needed. No deficient practice rising to the level of citation was identified.
9) Observations showed the named resident had a lock box available. Interviews and record review showed that the resident's representative reported the missing money to the facility. Facility staff responded immediately, initiated an investigation, but were unable to find the missing money. The staff made all notifications and reimbursed the named resident's representative for the missing money. The facility’s response and investigation into the missing money met minimum regulatory standards. No deficient practice rising to the level of citation was identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Statement of Deficiencies	License #: 2025	Compliance Determination # 25034
Plan of Correction	Parkview Estates	Completion Date
Page 1 of 3	Licensee: Pacwest Kennewick, LLC	07/05/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 06/08/2023 and 06/08/2023 of:

Parkview Estates
7820 W 6th Ave
Kennewick, WA 99336

This document references the following complaint number(s): 83025, 85355

The following sample was selected for review during the unannounced on-site visit: 3 of 107 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator
Elaine Lopez, Licensor
Anna Cairns, ALF Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jovin Kaercher
Residential Care Services

07/11/2023
Date

Statement of Deficiencies	License #: 2025	Compliance Determination # 25034
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I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Sonya Y. Arnold
Administrator (or Representative)

7.11.2023
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement the Negotiated Service Agreement (NSA) that directed facility staff to ensure 1 of 3 sampled residents (Resident 1) had monthly weight monitoring and scheduled showering assistance. This failure placed the resident at risk for unmet needs and decline in their condition.

Findings included...

Record review of facility's policy titled, "Weight and Vital Monitoring Policy", revised August 2018, showed that residents weights and vital signs were to be obtained at least monthly in order to ensure that each resident maintains or enhances their health status.

On 06/06/2023 at 10:23 AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 had a significant weight loss that was not reported to them. CC1 stated that the last documented weight was in October of 2022, Resident 1 weighed 198 pounds. CC1 stated they were made aware of Resident 1's current weight of 152 pounds from the rehab facility were Resident 1 was currently residing. CC1 stated that Resident 1 was supposed to be weighed monthly, but the last documented weight was 10/26/2022.

On 07/03/2023 at 4:43 PM, CC1 stated that the facility informed her that Resident 1 was scheduled for a shower twice a week. CC1 stated Resident 1 went without a bath for at least two and half months. CC1 also stated they were never made aware of Resident 1's weight loss.

Review of Resident 1's NSA, revised on 02/28/2023 showed that the Resident needed physical assistance with showers twice weekly on Monday's and Thursdays. The NSA also showed that staff were to notify the Registered Nurse (RN)/Residential Care Coordinator (RCC), and daughter of all refusals. Additionally, the NSA also showed that Resident 1

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required weight monitoring monthly, and the Licensed Nurse was to monitor and assess as needed.

Review of Resident 1's Assessment dated 02/27/2023 showed that Resident 1 did not always display safe judgement or sound decision making and had mild deficits with moderate memory loss. The assessment also showed that Resident 1 required physical assistance with showers twice weekly on Mondays and Thursdays, and weight monitoring monthly.

Review of Resident 1's record showed from October 2022 through April 2023 one documented weight was obtained on 10/26/2022. The record showed no other weights were obtained after October 2022 (six months).

Review of Resident 1's shower schedule from 02/27/2023 thru 04/17/2023 showed facility staff documented five "resident refusals", three "resident not available", and three "no shower given."

On 06/08/2023 at 10:22 AM, Staff B, Regional Nurse, stated that their process for weighing residents were that weights were to be divided up by all caregiving staff. Weights were then to be documented and followed up by the RCC and the Nurse. Staff B stated that that per their policy, weights are to be done monthly. If the resident had a significant weight loss, facility staff were to re-weigh the resident, notify the nurse and the physician. Staff B also stated that the last documented weight for Resident 1 was in October 2022 and that Resident 1 had a recent significant change in condition.

On 06/08/2023 at 12:32 PM, Staff Member B, Regional Nurse, stated that the facility dropped the ball. Staff B acknowledged that Resident 1 was impacted by the facility's failure to provide showers and obtain monthly weights.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Parkview Estates is or will be in compliance with this law and / or regulation on (Date) August 25, 2023.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Sonya Y. Arnold — Administrator (or Representative)

7. 11. 2023 — Date