STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

SNOW PEAK 1 LIBERTY LAKE REAL ESTATE HOLDING CO LLC
GUARDIAN ANGEL HOMES LIBERTY LAKE
23102 E MISSION AVE
LIBERTY LAKE, WA 99019

RE: GUARDIAN ANGEL HOMES LIBERTY LAKE License # 2035

Dear Administrator:

This letter addresses Compliance Determination(s) 36827 (Completion Date 02/14/2024) and 30613 (Completion Date 12/19/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/14/2024 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-2510, WAC 388-78A-2660-1, WAC 388-78A-2660-2

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

S.J.

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GUARDIAN ANGEL HOMES LIBERTY LAKE
License/Cert.#: 2035
Compliance Determination #: 30613
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 98530
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/06/2023 through 12/19/2023
Complainant Contact Date(s):

Allegation(s):
Physical abuse by staff.

Investigation Methods:

Sample:
Total residents: 75
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Director of Program Development
Executive Director
Alleged Victim
Residents
Agency Caregiver

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Incident investigations
Resident Personalized Expression Plan
Short term monitoring notes
Resident Transfer and Lifting Policy
Mandatory Reporting Policy
RCS Character, Competence, and Suitability Review
Staff background checks
Staff references
Staff orientation documentation
Safety and Security in Memory Care Homes Policy

Prevention of Abuse Policy
Staff Corrective Action form
Staff safety training documentation

Investigation Summary:

The facility investigated the alleged abuse and determined that the Alleged Victim was not provided care consistent with their preferences. Review of staff records showed that the Alleged Perpetrator had not met training requirements prior to caring for residents. Failed facility practice was cited under WAC 388-78A-2510 Specialized training for dementia, and WAC 388-78A-2660 Resident Rights.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 10/06/2023, 10/06/2023 and 10/06/2023 of:

GUARDIAN ANGEL HOMES LIBERTY LAKE
23102 E MISSION AVE
LIBERTY LAKE, WA 99019

This document references the following complaint number(s): 100884, 99357, 98530

The following sample was selected for review during the unannounced on-site visit: 3 of 75 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S.M
Residential Care Services

12/20/2023
Date

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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 10/06/2023, 10/06/2023 and 10/06/2023 of:

GUARDIAN ANGEL HOMES LIBERTY LAKE
23102 E MISSION AVE
LIBERTY LAKE, WA 99019

This document references the following complaint number(s): 100884, 99357, 98530

The following sample was selected for review during the unannounced on-site visit: 3 of 75 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Residential Care Services

Date

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.

Administrator (or Representative)

1/3/2024
Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff completed required specialty training prior to caring for residents with dementia for 1 of 1 staff (Staff B) reviewed for dementia training. This failure placed residents diagnosed with [redacted] at risk for inadequate care by untrained staff.

Findings included...

Review of a facility characteristic roster, dated 10/09/2023, showed that all 13 residents residing in the Bungalow, a memory care house, were diagnosed with [redacted] or [redacted].

In an interview on 10/06/2023 at 10:40 AM, Staff A, Executive Director, stated that Staff B, Caregiver, usually worked in the memory care.

In an interview on 12/15/2023 at 10:52 AM, Staff A stated they were unsure if Staff B completed their specialty dementia training.

In an interview on 12/18/2023 at 1:37 PM, Staff A stated they had no documentation of dementia training for Staff B.

No documentation of specialty dementia training was provided for Staff B.

Plan/Attestation Statement

Administrator (or Representative) Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff completed required specialty training prior to caring for residents with dementia for 1 of 1 staff (Staff B) reviewed for dementia training. This failure placed residents diagnosed with [redacted] at risk for inadequate care by untrained staff.

Findings included…

Review of a facility characteristic roster, dated 10/09/2023, showed that all 13 residents residing in the Bungalow, a memory care house, were diagnosed with [redacted] or [redacted].

In an interview on 10/06/2023 at 10:40 AM, Staff A, Executive Director, stated that Staff B, Caregiver, usually worked in the memory care.

In an interview on 12/15/2023 at 10:52 AM, Staff A stated they were unsure if Staff B completed their specialty dementia training.

In an interview on 12/18/2023 at 1:37 PM, Staff A stated they had no documentation of dementia training for Staff B.

No documentation of specialty dementia training was provided for Staff B.

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, GUARDIAN ANGEL HOMES LIBERTY LAKE is or will be in compliance with this law and / or regulation on (Date) 2/2/2024 .

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

Christian Mann — Administrator (or Representative)

1/3/2024 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff provided care consistent with maintaining resident dignity for 1 of 1 resident (Resident 1). This failure resulted in pain and discomfort for the resident.

Findings included:

A care plan for Resident 1, dated 08/31/2023, showed they preferred that staff allow them to turn themselves when in bed. The care plan stated that it caused Resident 1 pain when staff turned them.

Review of a facility investigation, dated 09/17/2023, showed that during the night shift beginning on 09/16/2023 and ending on 09/17/2023 at 6:10 AM, Staff B, Caregiver, assisted Resident 1 with turning. The investigation showed that Resident 1 complained of pain during the care, asked Staff B to stop, and Staff B did not stop. The investigation showed that a skin assessment revealed two fingertip sized bruises on the top of Resident 1's right thigh. It was documented that Staff C, Licensed Practical Nurse, thought the bruises were likely the result of being turned by Staff B.

In a verbal statement provided by Staff B on 09/18/2023, they stated Resident 1 told them they were hurting them during the care.

In a verbal statement provided by Resident 1 on 09/17/2023, they stated they didn't want Staff B in their room because they were afraid of Staff B.

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, GUARDIAN ANGEL HOMES LIBERTY LAKE is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff provided care consistent with maintaining resident dignity for 1 of 1 resident (Resident 1). This failure resulted in pain and discomfort for the resident.

Findings included:

A care plan for Resident 1, dated 08/31/2023, showed they preferred that staff allow them to turn themselves when in bed. The care plan stated that it caused Resident 1 pain when staff turned them.

Review of a facility investigation, dated 09/17/2023, showed that during the night shift beginning on 09/16/2023 and ending on 09/17/2023 at 6:10 AM, Staff B, Caregiver, assisted Resident 1 with turning. The investigation showed that Resident 1 complained of pain during the care, asked Staff B to stop, and Staff B did not stop. The investigation showed that a skin assessment revealed two fingertip sized bruises on the top of Resident 1's right thigh. It was documented that Staff C, Licensed Practical Nurse, thought the bruises were likely the result of being turned by Staff B.

In a verbal statement provided by Staff B on 09/18/2023, they stated Resident 1 told them they were hurting them during the care.

In a verbal statement provided by Resident 1 on 09/17/2023, they stated they didn't want Staff B in their room because they were afraid of Staff B.

In an interview on 10/06/2023 at 11:59 AM, Resident 1 stated they had not felt safe with Staff B providing their care because Staff B was rough, forceful, and caused them pain and bruising.

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, GUARDIAN ANGEL HOMES LIBERTY LAKE is or will be in compliance with this law and / or regulation on (Date) 2/2/2024.

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

Christopher Mora — Administrator (or Representative)

1/3/2024 — Date

In an interview on 10/06/2023 at 11:59 AM, Resident 1 stated they had not felt safe with Staff B providing their care because Staff B was rough, forceful, and caused them pain and bruising.

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, GUARDIAN ANGEL HOMES LIBERTY LAKE is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date