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

BCD PULLMAN LLC
Regency Pullman
1285 SW Center St
Pullman, WA 99163

RE: Regency Pullman License # 2060

Dear Administrator:

This letter addresses Compliance Determination(s) 40070 (Completion Date 04/19/2024) and 38177 (Completion Date 03/21/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/19/2024 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-2140-1-a-iii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-5

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Regency Pullman
Provider Type: Assisted Living Facility
License/Cert.#: 2060
Compliance Determination #: 38177
Intake ID: 122354
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 03/12/2024 through 03/21/2024
Complainant Contact Date(s):

Allegation(s):
Staff forcefully assisted resident into chair

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents' safety and well-being Any injuries Staff's care and treatment of residents Staff's interactions with residents
Interviews:	One resident, including alleged victim (AV) Three resident representatives, including representative for AV Collateral contact Three facility caregivers Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, and care plans Sample four staff's credentials, including those for alleged perpetrator (AP) Facility investigation documents Facility policy and procedures - Management of Aggression

Investigation Summary:
Staff, including AP, was observed caring for residents in a calm, unhurried manner. Department investigator attempted but was unable to obtain details from AV about the care staff provided to them as the AV had cognitive impairment related to dementia. Resident representatives that were interviewed, including representative for AV, had no concerns about the manner in which staff provided care/assistance to residents. Interviews with staff, and review of sampled residents' Negotiated Service Plans (NSP/care plans) showed the NSP's were not updated to include interventions staff should use to respond to residents' problem behaviors. Failed practice was identified and documented in a Statement of Deficiencies under Washington Administrative Code 388-78a-2140(1)(a)(iii),(2)(a),(5) Negotiated service agreement contents.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Regency Pullman
Provider Type: Assisted Living Facility
License/Cert.#: 2060
Compliance Determination #: 38177
Intake ID: 122638
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 03/12/2024 through 03/21/2024
Complainant Contact Date(s): 03/12/2024, 03/15/2024

Allegation(s):

1 - Staff give residents medications without trying other interventions to manage behavior problems such as anxiety
2 - Facility doesn't resolve grievances related to Issue 1

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents' safety and well-being Any injuries Staff's care and treatment of residents Staff's interactions with residents
Interviews:	One resident Three resident representatives Collateral contact Three facility caregivers Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, and care plans Sample four staff's credentials Facility investigation documents Facility policy and procedures - Management of Aggression

Investigation Summary:

1 - Staff were observed caring for residents in a calm, unhurried manner. They were also observed using non-pharmacological interventions in response to residents' behavioral issues. Resident representatives that were interviewed had no concerns about the manner in which staff provided care/assistance to residents. Staff that were interviewed stated they would use medications as a last resort in response to residents' behavioral issues. Interviews with staff, and review of sampled residents' Negotiated Service Plans (NSP/care plans) showed the NSP's were not updated to include interventions staff should use to respond to residents' problem behaviors. Failed practice was identified and documented in a Statement of Deficiencies under Washington Administrative Code 388-78a-2140(1)(a)(iii),(2)(a),(5) Negotiated service

agreement contents.
2 - Resident representatives that were interviewed had no concerns related to resolution of grievances. Interview with the Administrator showed the facility provided several ways for residents, representatives, and staff to resolve grievances. This included filling out grievance forms; speaking with the staff, facility managers, and Ombudsman; attending resident council meetings; and contacting the corporate and department hotlines. The Administrator was unaware anyone had any concerns related to facility's use of medications to manage residents' behaviors. No failed facility practices were found related to allegation.

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

Statement of Deficiencies	License #: 2060	Compliance Determination # 38177
Plan of Correction	Regency Pullman	Completion Date
Page 1 of 5	Licensee: BCD PULLMAN LLC	03/21/2024

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 03/12/2024, 03/14/2024 and 03/18/2024 of:

Regency Pullman
1285 SW Center St
Pullman, WA 99163

This document references the following complaint number(s): 122354, 122638

The following sample was selected for review during the unannounced on-site visit: 6 of 55 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint 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 — 03/22/2024 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 03/12/2024, 03/14/2024 and 03/18/2024 of:

Regency Pullman
1285 SW Center St
Pullman, WA 99163

This document references the following complaint number(s): 122354, 122638

The following sample was selected for review during the unannounced on-site visit: 6 of 55 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint 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.

Statement of Deficiencies	License #: 2060	Compliance Determination # 38177
Plan of Correction	Regency Pullman	Completion Date
Page 2 of 5	Licensee: BCD PULLMAN LLC	03/21/2024

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure negotiated service agreements included interventions to address problem behaviors for 4 of 6 sampled residents (Residents3, 4, 5, and 6) reviewed for service agreement planning. This failure resulted in caregivers not having ready access to interventions for problem behaviors and placed the residents at risk of harm due to a lack a behavioral interventions.

Findings included...

In an interview on 03/14/2024 at 11:10 AM, Staff D, Caregiver, stated the staff referred to residents' Negotiated Service Plans (NSPs/negotiated service agreements) to find information on how to respond to residents' behavior problems.

In an interview on 03/14/2024 at 11:15 AM, Staff E, Caregiver, stated they recently voiced concerns to the facility management that residents' NSPs were not updated to accurately show the assistance residents needed, such as for management of behavior problems. Staff E stated they were concerned NSPs that were not updated could result in

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure negotiated service agreements included interventions to address problem behaviors for 4 of 6 sampled residents (Residents3, 4, 5, and 6) reviewed for service agreement planning. This failure resulted in caregivers not having ready access to interventions for problem behaviors and placed the residents at risk of harm due to a lack a behavioral interventions.

Findings included…

In an interview on 03/14/2024 at 11:10 AM, Staff D, Caregiver, stated the staff referred to residents' Negotiated Service Plans (NSPs/negotiated service agreements) to find information on how to respond to residents' behavior problems.

In an interview on 03/14/2024 at 11:15 AM, Staff E, Caregiver, stated they recently voiced concerns to the facility management that residents' NSPs were not updated to accurately show the assistance residents needed, such as for management of behavior problems. Staff E stated they were concerned NSPs that were not updated could result in

residents being overcharged for care. Staff E further stated that when they voiced their concern that NSPs were not updated, Staff B, Corporate Nurse, asked them to update the NSPs as Staff E was familiar with the assistance/care residents needed. Staff E stated they were uncomfortable with this request as updating resident NSPs was outside of caregivers' scope of practice.

In an interview on 03/14/2024 at 11:45 AM, Staff F, Caregiver, stated it was appropriate for caregivers to report changes in residents' condition to the medication aides or facility managers, but not to develop or update the NSPs.

In an interview on 03/14/2024 at 12:00 PM, Staff D stated caregivers were responsible for following instructions in the NSPs, but not responsible for developing and updating NSPs.

<Resident 4>

Review of Resident 4's NSP, reviewed on 02/29/2024 by Staff B, showed the resident's behavior issues included refusal of care. The NSP contained instructions for staff to observe for and report the behaviors to the Health and Wellness Director but did not include documented interventions to use to respond to the behavior. Further review of Resident 4's NSP showed the resident displayed poor judgment but did not include specifics regarding the resident's poor judgment or how staff should intervene to address the behavior.

Observation on 03/14/2024 at 10:35 AM, showed Staff A, Administrator, needed to help Resident 4 as they were confused as they propelled their wheelchair in the hallway and needed reassurance and way-finding assistance.

<Resident 5>

Review of Resident 5's NSP, reviewed on 02/14/2024 by Staff B, showed the resident had behavior issues such as grabbing and following others and getting into others' personal space. The NSP did not contain instructions for how staff should intervene for the behaviors.

Observation on 03/14/2024 at 10:30 AM, showed Resident 5 stood very close and tried to touch the department investigator, and repeatedly cried, "Help me". After noticing that Resident 5 continued to display the behaviors after the investigator greeted the resident, Staff E directed Resident 5 to the living room.

In an interview on 03/14/2024 at 10:40 AM, Staff E stated Resident 5 had several behaviors such as repeatedly calling out for help, grabbing others' hands firmly, resisting care, rummaging through other residents' belongings, and wandering. Staff E stated it was difficult to help Resident 5, even with redirection, because of the frequency of the

residents being overcharged for care. Staff E further stated that when they voiced their concern that NSPs were not updated, Staff B, Corporate Nurse, asked them to update the NSPs as Staff E was familiar with the assistance/care residents needed. Staff E stated they were uncomfortable with this request as updating resident NSPs was outside of caregivers' scope of practice.

In an interview on 03/14/2024 at 11:45 AM, Staff F, Caregiver, stated it was appropriate for caregivers to report changes in residents' condition to the medication aides or facility managers, but not to develop or update the NSPs.

In an interview on 03/14/2024 at 12:00 PM, Staff D stated caregivers were responsible for following instructions in the NSPs, but not responsible for developing and updating NSPs.

<Resident 4>

Review of Resident 4's NSP, reviewed on 02/29/2024 by Staff B, showed the resident's behavior issues included refusal of care. The NSP contained instructions for staff to observe for and report the behaviors to the Health and Wellness Director but did not include documented interventions to use to respond to the behavior. Further review of Resident 4's NSP showed the resident displayed poor judgment but did not include specifics regarding the resident's poor judgment or how staff should intervene to address the behavior.

Observation on 03/14/2024 at 10:35 AM, showed Staff A, Administrator, needed to help Resident 4 as they were confused as they propelled their wheelchair in the hallway and needed reassurance and way-finding assistance.

<Resident 5>

Review of Resident 5's NSP, reviewed on 02/14/2024 by Staff B, showed the resident had behavior issues such as grabbing and following others and getting into others' personal space. The NSP did not contain instructions for how staff should intervene for the behaviors.

Observation on 03/14/2024 at 10:30 AM, showed Resident 5 stood very close and tried to touch the department investigator, and repeatedly cried, "Help me". After noticing that Resident 5 continued to display the behaviors after the investigator greeted the resident, Staff E directed Resident 5 to the living room.

In an interview on 03/14/2024 at 10:40 AM, Staff E stated Resident 5 had several behaviors such as repeatedly calling out for help, grabbing others' hands firmly, resisting care, rummaging through other residents' belongings, and wandering. Staff E stated it was difficult to help Resident 5, even with redirection, because of the frequency of the

behaviors.

Observation on 03/14/2024 at 11:00 AM, showed Resident 5 was restless and wandered around in the dining room with wet pants. Further observation showed that Staff E had to coax the resident several times to allow staff to assist with a clothing change.

RESIDENT 6:

Review of Resident 6's NSP, updated by Staff B on 10/10/2023, showed the resident displayed tearfulness and anxiety. Instruction to staff in the NSP included observing and reporting the behaviors but did not include interventions staff should use to address the behaviors.

In an interview on 03/14/2024 at 10:40 AM, Staff E stated Resident 6 got upset and cried often and displayed physical aggression such as holding up their fist as if threatening to hit staff. Staff E further stated Resident 6 often became upset at another resident which would result in aggression between the two residents.

<Resident 3>

Review of Resident 3's face sheet, dated 03/05/2024, showed Resident 3 was diagnosed with [redacted] ([redacted]).

Review of Resident 3's NSP showed that Staff B, Corporate Nurse, reviewed the plan on 01/18/2024 and it showed that the resident displayed verbal and physical aggression, and was at risk for elopement. Further review of the NSP showed it instructed staff to identify triggers for the behaviors and report them to the Health and Wellness Director, but it did not include the interventions staff should use to respond to the behaviors.

In an interview on 03/14/2024 at 3:10 PM, Staff A stated the facility needed to update residents' NSPs to include behavior interventions.

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, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) 4/5/24 .

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

behaviors.

Observation on 03/14/2024 at 11:00 AM, showed Resident 5 was restless and wandered around in the dining room with wet pants. Further observation showed that Staff E had to coax the resident several times to allow staff to assist with a clothing change.

RESIDENT 6:

Review of Resident 6's NSP, updated by Staff B on 10/10/2023, showed the resident displayed tearfulness and anxiety. Instruction to staff in the NSP included observing and reporting the behaviors but did not include interventions staff should use to address the behaviors.

In an interview on 03/14/2024 at 10:40 AM, Staff E stated Resident 6 got upset and cried often and displayed physical aggression such as holding up their fist as if threatening to hit staff. Staff E further stated Resident 6 often became upset at another resident which would result in aggression between the two residents.

<Resident 3>

Review of Resident 3's face sheet, dated 03/05/2024, showed Resident 3 was diagnosed with [redacted] ([redacted]).

Review of Resident 3's NSP showed that Staff B, Corporate Nurse, reviewed the plan on 01/18/2024 and it showed that the resident displayed verbal and physical aggression, and was at risk for elopement. Further review of the NSP showed it instructed staff to identify triggers for the behaviors and report them to the Health and Wellness Director, but it did not include the interventions staff should use to respond to the behaviors.

In an interview on 03/14/2024 at 3:10 PM, Staff A stated the facility needed to update residents' NSPs to include behavior interventions.

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, Regency Pullman 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.

Statement of Deficiencies	License #: 2060	Compliance Determination # 38177
Plan of Correction	Regency Pullman	Completion Date
Page 5 of 5	Licensee: BCD PULLMAN LLC	03/21/2024

Robert Rooper — Administrator (or Representative)

4/1/24 — Date

Administrator (or Representative) Date