STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

01/10/2024

HIGHGATE BELLINGHAM LP
HIGHGATE SENIOR LIVING
155 E KELLOGG RD
BELLINGHAM, WA 98226

RE: HIGHGATE SENIOR LIVING License # 2097

Dear Administrator:

This letter addresses Compliance Determination(s) 34543 (Completion Date 01/02/2024) and 26903 (Completion Date 09/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/02/2024 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-2371-1, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1

The Department staff who did the on-site verification:
Allison Nunn, Long Term Care Surveyor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: HIGHGATE SENIOR LIVING
License/Cert.#: 2097
Compliance Determination #: 26903
Investigator: Helen Fisher
Investigation Date(s): 07/25/2023 through 09/27/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 89260
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR1) attempted to choke the Named Resident (NR2) while in bed.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 6 Closed records sample size: 0
Observations:	Resident was outside the facility. Facility general cleanliness. Environment.
Interviews:	NR, Health Services Director (HSD), Assistance Health Services, Med Tech, Caregiver.
Record Reviews:	Resident records. Facility records.

Investigation Summary:
The Assisted Living Facility (ALF) staff stated they interfered when the NR1 attempted to choke NR2, they assessed NR2 for injury, notified all parties including the Department. The ALF staff stated that they did an investigation and had reached out to NR1's Primary Care Provider (PCP) for medication evaluation, but PCP refused to do so. The staff stated that the NR1 was involved with another resident when NR1 poured water into their roommate's (NR3) mouth while in bed on 07/24/2023 during the evening shift. Health Service Director (HSD) stated that they were not aware that the NR1 had poured water into the NR3's mouth on 07/24/27. The HSD stated that there was no investigation done and NR3 was left in the room with NR1 the whole night on 07/24/2023. A citation was issued for noncompliance with WAC 388-78A-2371 Investigation.

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: HIGHGATE SENIOR LIVING
License/Cert.#: 2097
Compliance Determination #: 26903
Investigator: Helen Fisher
Investigation Date(s): 07/25/2023 through 09/27/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 91112
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) had multiple physical altercations with other residents and a visitor over a three week period.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 6 Closed records sample size: 0
Observations:	NR and Roommate's appearance and demeanor. Environment
Interviews:	NR, Health Services Director (HSD), Assistance Health Services, Med Tech, Caregiver, Collateral contact
Record Reviews:	NR records. Facility records.

Investigation Summary:
1) The facility staff stated that the NR was not involved in any altercation with another resident resulted to a fall with injury. No records of altercation resulted to a fall with injury found. Unsubstantiated.
2) The staff stated that the NR was upset when a therapy dog on leash was brought in by a visitor. The facility did an investigation when the NR put their hands on a visitor's throat. The facility intervened, called the family and the primary care giver. The visitor was asked not to bring the dog to the facility again. No facility failed practice found.
3) The NR put their hands on another resident's neck. The facility intervened, called 911, notified all parties including the Department, and did an investigation. Plan of care was updated. No facility failed practice.
4) The staff stated that the NR was involved with another resident when NR poured water into roommate mouth while in bed on 07/24/2023 evening shift. Health Service Director (HSD) stated that they were not aware that the NR had poured water poured water into the roommate's mouth on 07/24/27. The NR thought the other residents were dogs. The HSD stated that they did not report to the Department and investigation was not done and the roommate was left in the room with the NR the whole night on 07/24/2023. A citation was issued for noncompliance with WAC 388-

78A-2630 Reporting abuse and neglect and WAC 388-78A-2371 Investigation.

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 #: 2097	Compliance Determination # 26903
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 7	Licensee: HIGHGATE BELLINGHAM LP	09/27/2023

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 07/25/2023, 07/25/2023 and 07/25/2023 of:

HIGHGATE SENIOR LIVING
155 E KELLOGG RD
BELLINGHAM, WA 98226

This document references the following complaint number(s): 89205, 89260, 91112

The following sample was selected for review during the unannounced on-site visit: 6 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

10/22/2023
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.

Administrator (or Representative) 10/18/23 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to investigate a resident-to-resident incident when Resident 1 poured water into their roommate's (Resident 2) mouth while Resident 2 was lying in their bed. This failure resulted in a delay in identifying protective actions and placed Resident 2 at risk for further resident to resident incidents.

Findings Included...

Review of the Assisted Living
Guidebook; Partners in Protection dated 02/2018, Chapter 2 and Appendix F showed State law requires the
assisted living facility to do a thorough investigation when there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. For the facility to provide evidence of the thoroughness of the investigation the information must be documented. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Review of the ALF's Guidelines for Conducting an Internal Investigation showed:
Periodically, you may be confronted with a complaint where situations arise that may require an investigation into alleged misconduct of a team member. Allegations may be received from residents, team members, or other third parties who visit the community. Upon receipt of an allegation, it is important to get as much information as possible from the reporter and then to take appropriate action regarding the team member who engaged in the alleged misconduct. Don't wait for a formal complaint. If you suspect or have informal knowledge of an issue, initiate an investigation.

ALF's Guidelines for conducting an internal investigation does not include a resident-to-resident incidents.

Resident 1
Resident 1 was admitted
in the ALF on [redacted]/2023 with multiple diagnoses including [redacted]

[redacted], and [redacted].

A negotiated service
agreement dated 06/16/2023 showed Resident 1 was independent with mobility and needed redirection for increased in agitation.

Resident 2
Resident 2 was admitted
in the ALF on [redacted]/2022 with multiple diagnoses including [redacted].

A negotiated service
agreement dated 04/05/2023 showed Resident 2 needed total assistance with mobility, transfers, toileting, dressing, and bathing.

In an interview on
07/25/2023 at 2:53 PM, Resident 2 was in bed in the same room with Resident 1 during unannounced onsite visit. Resident 2 stated that Resident 1 poured water in their mouth while in bed. Resident 2 stated that Resident 1 was always angry and yelling. Resident 2 stated that they stayed awake because they were afraid of Resident 1.

In an interview on
07/25/2023 at 2:38 PM, Staff A, Med Tech, stated that they heard Resident 2 yelling for help around 6:00 PM on 07/24/2023 and found Resident 1 pouring water into Resident 2's mouth while Resident 2 was lying in bed. Resident 1 was thinking Resident 2 was Resident 1's dog. Staff A stated that they intervened by redirecting Resident 1. Staff A stated that Resident 2 was scared but was reassured. Staff A stated that Resident 2 remained in the same room with Resident 1. Staff A stated that they filled the "for your information (FYI)" note for the next shift and sent a text message to both Staff B, Health Services Director and Staff E, Clinical Assistant to Staff B. Staff A stated that they were not trained to write in the progress notes or to make a report to the Department.

In an interview on
09/20/2023 at 8:45 AM, Staff C, Resident Care Coordinator, stated that they were trained that the Health Services Director will do an assessment, investigation, and call the Hotline.

In an interview on 07/25/2023 at 3:11 PM, Staff B, Health Services Director, stated that they were not told by the med tech that Resident 1 poured water in Resident 2's mouth while in bed. Staff B stated that an investigation was not done.

On 09/06/2023 at 3:47 PM, Staff B stated that they did not have a written policy and

procedure on how to conduct resident to resident investigations.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 11/24/23 .

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

Administrator (or Representative) 10/17/23 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review,
the Assisted Living Facility (ALF) failed to report to the Department a resident to resident incident when Resident 1 poured water into their roommate's (Resident 2) mouth when lying in bed. This failure resulted in a delay in identifying protective actions, left Resident 2 in an unsafe environment, and placed all memory care residents at risk for abuse.

Findings included...

Review of the ALF's policy "Incident/Accident policy and procedure", dated 08/2016 showed reports are to be completed as soon as possible after the occurrence and kept on file. Any occurrence of an unusual nature is to be reported immediately to a department head or to the Executive Director.

Review of the Assisted Living Guidebook; Partners in Protection, Chapter 1 dated 02/2018 showed pages 5-7.

Facilities are required to report to the Department's 24-hour hotline when there is reasonable cause to believe the act caused a fear of imminent harm; The report should be made immediately by telephone or online.

See Appendix D, Reporting Guidelines for ALF, page 25.
Resident to Resident

a. Mental abuse with psychological harm.

b. Physical abuse / assault with bodily harm.

c. Physical abuse with psychological harm.

Review of "Incident/Accident Reporting Policy" dated 07/2022 showed incident of more serious nature should be reported to the Director of Resident Services and or the Director of Operations and require an investigation at the community level to determine the circumstances of the incident. The incidents need to be reported are:

1) Fracture of the long bone or skull

2) Injuries of unknown source

3) Injuries caused by transfer, or care handling

4) Alleged or suspected abuse

5) Elopement

6) Death not on hospice

Incidents that are reported to the DRS or Director of Operations should still be included in the monthly incident log and clinical reporting and reported to appropriate state agency as required by the specific stated regulations.

Resident 1
Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted], and [redacted].

A negotiated service agreement dated 06/16/2023 showed Resident 1 was independent with mobility and needed redirection for increased in agitation.

Resident 2

Resident 2 was admitted in the ALF on [redacted]/2022 with multiple diagnoses including [redacted].

A negotiated service agreement dated 04/05/2023 showed Resident 2 needed total assistance with mobility, transfers, toileting, dressing, and bathing.

In an interview on 07/25/2023 at 2:38 PM, Staff A, Med Tech, stated that they heard Resident 2 yelling for help around 6:00 PM on 07/24/2023 and found Resident 1 pouring water into Resident 2's mouth while lying bed. Staff A stated that they texted Staff B, Health Services Director and Staff E, Clinical Assistant to Staff B. Staff A stated that they did not report to the Department.

In an interview on 07/25/2023 at 3:11 PM, Staff B, Health Services Director, stated that they were not told by the med tech that Resident 1 poured water in Resident 2's mouth while in bed. Staff B stated that they did not make a report to the Department.

On 09/20/2023 at 8:45 AM, Staff C, Resident Care Coordinator, stated that they were not trained to make a report to the Department's Crisis Response Unit when there's incident/accident happened in the facility.

Review of the Department records
showed no report was made to the Department about the incident with Resident 1 and Resident 2.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 11/24/23 .

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

Administrator (or Representative) — Date: 10/17/23