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

SESSIONS RESIDENTIAL CARE INC
EVERGREEN RESIDENTIAL CARE
PO BOX 1469
VERADALE, WA 99037

RE: EVERGREEN RESIDENTIAL CARE License # 2138

Dear Administrator:

This letter addresses Compliance Determination(s) 51052 (Completion Date 12/05/2024) and 47917 (Completion Date 10/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2024 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-2240, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

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

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: EVERGREEN RESIDENTIAL CARE
License/Cert.#: 2138
Compliance Determination #: 47917
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 148468
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 09/30/2024 through 10/09/2024
Complainant Contact Date(s): 10/08/2024, 10/10/2024

Allegation(s):

1. Foul odor in facility.
2. Bed collapsed resulting in back pain.
3. Resident sick.
4. Staff overheated hot pack.
5. Resident without ordered medications.
6. Rude staff.

Investigation Methods:

Sample:
Total residents: 45
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Manager
Residents
Alleged Victim

Record Reviews:
-Disclosure of services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-MHP progress notes
-Nursing progress notes
-Appointment summaries
-Facility Rules and Policies
-Resident contract
-Behavioral support plans
-Transference of Care of Discharge Policy
-Medication administration records
-Medication Management Policy

Investigation Summary:

1. Management identified the source of an odor complaint and directed staff to ensure that used briefs were removed from resident rooms and bathrooms as soon as possible after incontinence episodes. No foul odors were noted during the facility tour. The Alleged Victim was interviewed, and they no longer resided at the facility. No harm identified. No failed facility practice.
2. The Alleged Victim's bed collapsed resulting in back pain. No investigation was completed by the facility. Failed facility practice identified and cited under WAC 388-78A-2371 Investigations (1)(2)(3).
3. The Alleged Victim was assessed by a medical provider upon their admission to the facility. Their status was monitored, and the resident was sent out for medical care when their gastrointestinal symptoms worsened. The Alleged Victim was interviewed, and they reported that they received the medical care they needed. Staff were observed available to monitor residents for changes in condition. No failed facility practice.
4. The Alleged Victim was interviewed, and they reported that they assumed the hot pack had been overheated because the gel inside leaked out on their bed. The Alleged Victim denied receiving any burns or injuries from the hot pack or its contents. Staff were observed available to address resident care concerns. No failed facility practice.
5. Record review showed that several of the Alleged Victim's prescribed medications were not obtained for use in a timely manner. Failed facility practice identified and cited under WAC 388-78A-2240 Nonavailability of medications.
6. The Alleged Victim was interviewed, and they reported that staff had been rude by removing items from the resident's walker in preparation for an ambulance trip. Residents were interviewed, and they voiced no concerns about their treatment by staff. Staff were observed to be respectful in their interactions with the residents. No failed facility practice.

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
Plan of Correction

License #: 2138
EVERGREEN RESIDENTIAL CARE
Licensee: SESSIONS RESIDENTIAL CARE INC

Compliance Determination #47917
Completion Date
10/09/2024

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 09/30/2024, 09/30/2024 and 09/30/2024 of:

EVERGREEN RESIDENTIAL CARE
14120 E 3RD
SPOKANE VALLEY, WA 99037

This document references the following complaint number(s): 147639, 148468

The following sample was selected for review during the unannounced on-site visit: 2 of 45 current residents and 1 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

10/17/2024
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.

Administrator (or Representative)

10/28/24
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a resident's prescribed medications in a timely manner for 1 of 1 resident (Resident 1). This failed practice resulted in pain and poor symptom management for Resident 1, multiple trips to the emergency room, and decreased quality of life. Additionally, it placed facility residents at increased risk for unmanaged symptoms, health complications, and decreased quality of life.

Findings included...

Review of an undated negotiated service agreement for Resident 1 showed that the resident required assistance with their medications and that facility staff were to ensure the resident's medications were refilled when necessary.

Review of a progress note for Resident 1, dated 09/16/2024, showed that staff were to remind the resident that all of their medications were to come from the facility's pharmacy.

Review of a progress note for Resident 1, dated 09/18/2024, showed that the resident was complaining of hemorrhoids (swollen and inflamed veins in the rectum and anus that cause discomfort and bleeding) which were painful and needed to be "lanced."

Review of an appointment summary for Resident 1, dated 09/18/2024, showed that the resident was seen by a medical provider that day. The summary showed that the provider prescribed hemorrhoid suppositories daily as needed for Resident 1.

Review of a progress note for Resident 1, dated 09/22/2024, showed that the resident complained of rectal pain and decided to go to the emergency room because the facility did not have their suppositories yet.

Review of a progress note for Resident 1, dated 09/24/2024, showed that Resident 1 reported to staff that a "nodule in [their] rectum" was causing a blockage.

Review of a progress note for Resident 1, dated 09/25/2024, showed that the resident called 911 because they were having back and rectal pain.

Review of a progress note for Resident 1, dated 09/26/2024, showed that the resident's rectal area was raw and red.

Review of a progress note for Resident 1, dated 09/28/2024, showed that the resident was at the emergency department and they were being admitted for observation.

In an interview on 09/30/2024 at 2:47 PM, Staff A, Manager, stated that there were issues with getting some of Resident 1's medications, and that their Estradiol (a medication used to treat symptoms of menopause) and hemorrhoid suppositories took a little longer to get.

Review of a medication administration record (MAR) for Resident 1, dated September of 2024, showed that the resident was prescribed biotin (a B vitamin) on 09/12/2024. The MAR showed that Resident 1 did not start receiving the biotin until 09/24/2024. Review of the MAR showed that Resident 1 was prescribed clobetasol gel (a medication used to treat certain skin conditions) on 09/12/2024, though the resident did not start receiving it until 09/17/2024. Review of the MAR showed that Resident 1 was prescribed estradiol on 09/12/2024, though the resident never received this medication. Review of the MAR showed that hemorrhoidal suppositories were ordered for Resident 1, as needed, on 09/18/2024, though the resident never received the suppositories.

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, EVERGREEN RESIDENTIAL CARE is or will be in compliance with this law and / or regulation on (Date) 11/23/24.

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

IDR

Administrator (or Representative)

12/4/24

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;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document investigative actions following an accident in which a resident's bed collapsed for 1 of 1 resident (Resident 1). This failed practice placed Resident 1 at increased risk for further accidents with potential for injury and placed facility residents at increased risk for accidents with injuries.

Findings included...

Review of a progress note for Resident 1, dated 09/23/2024, showed that the resident reported to staff that their bed broke and their back was hurting.

Review of a progress note for Resident 1, dated 09/24/2024, showed that Resident 1 had disassembled their bed and had placed their mattress on the floor because they were "afraid the bed frame [was] going to collapse again."

Review of a progress note for Resident 1, dated 09/25/2024, showed that Resident 1 called 911 and requested to go to the emergency department for back and rectal pain.

In an interview on 09/30/2024 at 2:47 PM, Staff A, Manager, stated that Resident 1 had been using a facility bed and that the legs at the foot of the bed folded up and the end of the bed fell down. Staff A stated that at first, Resident 1 said they were not sitting on the bed when it fell, then later said they were sitting on the bed when it fell. Staff A stated that Resident 1 complained that their back was "broken." Staff A stated that the bed was fixed though Resident 1 was refusing to sleep on it.

In an interview on 10/08/2024 at 2:28 PM, Resident 1 stated that their bed collapsed while they were sitting on it and that their back was injured. Resident 1 stated that after the bed collapse, they became incontinent of bladder and bowel because of the damage to their pelvic floor. Resident 1 stated that they immediately felt a pinch in their back when the bed collapsed.

In an email communication sent on 10/09/2024 at 12:11 PM, Staff A stated that there was no investigation done for Resident 1's collapsed bed because when the incident occurred, the resident stated that they were not on the bed at the time and claimed no injury.

Statement of Deficiencies	License #: 2138	Compliance Determination # 47917
Plan of Correction	EVERGREEN RESIDENTIAL CARE	Completion Date
Page 5 of 5	Licensee: SESSIONS RESIDENTIAL CARE INC	10/09/2024

Review of facility records showed no investigation for Resident 1's collapsed bed.

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, EVERGREEN RESIDENTIAL CARE is or will be in compliance with this law and / or regulation on (Date) 11/23/24.

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

Administrator (or Representative) — Date: 10/28/24