STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

08/24/2023

Caring Places Management, LLC
Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

RE: Easthaven Villa # 2144

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 28487 (Completion Date 08/24/2023) and 19879 (Completion Date 02/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/24/2023 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630 Reporting abuse and neglect.

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

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(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.

The Department staff who did the Off Site verification:
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,
Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 19879
Intake ID: 65928
Investigator: Celeste Vashey
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 02/14/2023 through 02/22/2023
Complainant Contact Date(s):

Allegation(s):
1) Allegation a male caregiver physically pushed a resident.

Investigation Methods:

Sample:
Total residents: 70
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Resident rooms
Staff to resident interactions

Interviews:
Identified resident
Nursing staff
Family members

Record Reviews:
Medical records
Incident investigation
Facility policies
Staff training records

Investigation Summary:
1) After interview and record review it was determined that the facility will be cited for WAC 388 78A 2630 (1) for not following up with CRU and local law enforcement after an allegation that an agency staff member pushed the resident.

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
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2144	Compliance Determination # 19879
Plan of Correction	Easthaven Villa	Completion Date
Page 1 of 5	Licensee: Caring Places Management, LLC	02/22/2023

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 02/14/2023 and 02/23/2023 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following complaint number(s): 65928, 62472

The following sample was selected for review during the unannounced on-site visit: 3 of 70 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

03/06/2023
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) 03/13/2023 Date

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

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

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(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 facility failed to report to the Compliant Resolution Unit (CRU) and make an immediate report to the local law enforcement agency for 1 of 3 residents (Resident 1). This failure placed residents at risk of abuse and prevented the Department and law enforcement from being able to evaluate systems that were in place to protect residents.

Findings included...

Record review of "Caring Places Management Policies & Procedures Resident Incidents & Investigations", undated, showed, "POLICY: All incidents require a thorough Quality Assurance Investigation to determine what occurred, to determine if any abuse has occurred, and to implement measures, as needed, to prevent recurrence... Prompt reporting to: Supervisor, Nurse, Administrator, Emergency contact(s), Medical professional(s), Abuse Hotline (if abuse is even a remote consideration), Police (if required)...If a criminal act, such as physical or sexual assault is suspected, contact law enforcement immediately and ask for guidance on preservation of evidence."

Record review of R1's face sheet, undated, showed R1 admitted to the facility on [redacted]/2022. R1 had a diagnosis of [redacted].

Record review of an Investigation report for Resident 1 (R1), dated 12/10/2022, documented the incident type as "Altercation with Staff." Under the description of incident, showed, "When caregivers were assisting Resident with [R1's] AM routine, [R1] spoke to them about getting "tossed around" during the night and [R1] was concerned as to what [R1] did wrong. [R1] stated that [R1] was told [R1] "had to stay in bed," and "needed sleep."" Under the "Describe Injury" section showed, "Resident had some complaints of

pain to [R1's] lower right back, but had been complaining of this lower back pain prior to reporting incident." Under the "Notifications Made" section showed, CRU and the police were not notified. Under "Observable symptoms of abuse" section showed, "Resident reports abuse" section marked off as applicable. Under the "Signatures" section showed Staff A's, Resident Care Coordinator (RCC), and Staff E's, Administrator, electronic signatures.

Record review of R1's service agreement and assessment, dated 12/09/2022, under the "Communications" section showed, R1 could communicate their needs but occasionally made statements that did not make sense. Under the "Memory" section showed, R1 showed anxiousness and wandered off without purpose. Under the "Sleeping" section showed, R1 had insomnia and woke up one to two times a night. Under the "Behaviors" section showed, R1 had worsening anxiety and wandering tendencies while sundowning.

Record review of R1's Progress Note, dated 12/10/2022 showed, "Resident reported to caregiver when [R1] woke up that [R1] was tossed around during the night, being made to go to bed. Resident was upset by this and did not know what [R1] did wrong..." Review of R1's Progress Note, dated 12/14/2022, showed R1's spouse reported that three days ago R1 complained of being mistreated by a male caregiver on night shift. The spouse believed that R1's statement was true and was going to follow up with the administration.

In an interview on 01/30/2023 at 10:00 AM, Colleterial Contact 1, (CC1), stated they were concerned that R1 was physically pushed by Staff F, former agency caregiver. CC1 stated that the caregivers within the facility reported Staff F grew frustrated with R1 the night prior. CC1 stated they were informed that R1 wandered the hall in the middle of the night and Staff F instructed R1 to go back to bed. CC1 is under the impression that Staff F pushed R1. CC1 stated they visited R1 the following day of the incident. CC1 confirmed that resident had cognitive impairments that affect R1's memory and ability to communicate. CC1 stated when they arrived to the facility R1 showcased fear and stated do not let the big guy get me. CC1 expressed concern to Staff E, Administrator, that R1 experienced back pain due to the alleged abuse. CC1 is unaware if the authorities were called regarding the incident.

In an interview on 02/14/2023 at 12:00 PM, Staff B, Medication Aid, stated that facility staff members were mandated reporters. If a resident or residents family member expressed concern of physical abuse within the facility that they would make a report to the state hotline. Staff B had knowledge of the allegation of abuse between R1 and Staff F. Staff B stated they did not report the incident to the state hotline because it was already reported. Staff B stated that R1 reported Staff F was rough and that Staff F pushed R1. Staff B stated R1 showcased fear the following day and had increased anxiety. Staff B stated R1 continued to talk about the incident and R1 stated "he pushed me down, he pushed me down."

In an interview on 02/14/2023 at 12:20 PM, Staff A, Resident Care Coordinator, (RCC), stated if the facility received an allegation of abuse, they would report it to CRU. Staff A had knowledge of the incident that took place between R1 and Staff F. Staff A reported resident R1 experienced anxiety after the event. RCC stated CC1 expressed concern that

Staff F pushed R1 due to R1 experiencing back pain. RCC stated R1 having back pain was within their baseline. RCC stated the facility did not contact local law enforcement regarding the incident between Staff F and R1. RCC stated CC1 talked to Staff E, Administrator, about the law enforcement agency being involved.

In an interview on 02/14/2023 at 12:35 PM, Staff C, Certified Nursing Assistant (CNA), stated if a resident or family member expressed concerns of physical abuse the facility would report it to CRU. Staff C stated they were not working when the incident took place between Staff F and R1, but they heard that there was an altercation between the two.

In an interview on 02/21/2023 at 4:20 PM, Staff D, Caregiver, stated if a resident or family member expressed concerns of physical abuse, they would report it to the state. Staff D stated they work evening shift and when they arrived to work the following day, R1 reported that Staff F roughly laid R1 down in bed the night prior. Staff D stated R1 is a memory care resident who continued to report the incident to Staff D and other facility staff members. Staff D stated R1 did not say they were pushed, but they were laid down roughly and told to stay in bed. Staff D stated R1 showcased fear and stated they stayed in bed because they were afraid of Staff F. Staff D stated they did not report the incident to the state and is unsure which facility staff member made the report. Staff D stated they had a conversation about the incident with CC1.

In an interview on 02/22/2023 at 9:20 AM, Staff E, Administrator, stated if a resident or family member expressed concern of physical abuse, they would report it to CRU. Staff E stated the facility would contact local law enforcement if they found findings through their in-house investigation. Staff E stated they completed an investigation but did not find any findings and did not contact local law enforcement. Staff E stated R1 reported back pain but R1 had a history of back pain. Staff E did not report Staff F's license to the Department of Health. Staff E stated the facility reported the incident to CRU. Staff E stated they did not file the report to CRU. Staff E stated Staff A, RCC, filed the report after the investigation was completed.

The allegations were not reported to CRU as of 02/23/2023. The facility was unable to provide any documentation to show they reported the incident to CRU.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 04/07/2023 .

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

Administrator (or Representative) — Date: 03/13/2023

Easthaven Villa
Assisted Living & Memory Care Community
311 Cullens Street NW
Yelm, WA 98597

Plan of Correction

Statement of Deficiencies Report Dated February 22, 2023

Deficiency	Actions	Responsible Person(s)	Due Date	Completed Date
WAC 388-78A-2630 Reporting Abuse and Neglect	Re-train all staff on Mandatory reporting, and when and how to do so. Going forward we will retrain this topic quarterly at staff development meetings. Mandatory reporting training is also part of our orientation process for new staff.	Admins, and Business office manager.	4/7/2023	