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

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

RE: Easthaven Villa License # 2144

Dear Administrator:

This letter addresses Compliance Determination(s) 39849 (Completion Date 04/16/2024) and 26882 (Completion Date 10/12/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/16/2024 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-2160

The Department staff who did the on-site verification:
Maria Salas, ALF Complaint Investigator
Anissa Bearden, 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 #: 26882
Intake ID: 90002
Investigator: Maria Salas
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 07/19/2023 through 10/12/2023
Complainant Contact Date(s):

Allegation(s):
resident choked during meal time resulting in death

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Dining
Interviews:	Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:
Based on record review and interview the Negotiated Service Agreement was not followed contributing to a residents death. Failed practice identified.

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 #: 2144	Compliance Determination # 26882
Plan of Correction	Easthaven Villa	Completion Date
Page 1 of 3	Licensee: Caring Places Management, LLC	10/12/2023

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 07/19/2023 and 07/25/2023 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following complaint number(s): 90002

The following sample was selected for review during the unannounced on-site visit: 3 of 77 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 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.

Jody Just Region 3 Field Serices Administrator — 10/25/2023
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) 11/3/23 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement the Negotiated Service Plan for 1 of 3 reviewed residents (Resident 1 [R1]). This failure resulted in harm when R1 choked and died.

Findings included...

Record review of R1's Face Sheet, undated, showed R1 admitted on [redacted]2022, with a history of Alzheimer's disease (a loss of cognitive function thinking, remembering, and reasoning).

Record review of R1's Negotiated Service Plan, dated 05/01/2023, showed R1's diet was regular textured foods cut up and thin liquids (thin liquids are most often used if you do not have a swallowing problem with liquids. Water, milk, tea, coffee, and juice are all examples of the thin liquids.). R1 was able to feed himself. R1 was known to eat too fast and pocket food in his cheeks. Staff interventions showed for every meal staff were to observe R1 for pocketing of foods. Staff were to cue R1 to swallow and drink fluids as needed. Staff were to cue R1 to eat slowly. Staff were to cue R1 to take sips of fluids between every three to four bites of food.

Record review of an Incident Report, dated [redacted]2023, showed that R1's table was one of the first tables served at dinner. As the staff were serving meal plates, Staff A, Caregiver, noticed R1 eating quickly and encouraged him to slow down and take a drink of water. Staff A then continued to walk around and help serve dinner plates. While staff were serving plates to the other side of the dining room, Staff B, Caregiver, heard residents yelling out for help. Staff B went over to where R1 was seated and observed him to be in distress and what *appeared* to be him choking. Abdominal thrusts were attempted without success. R1 then became pale in color and Staff E, Assistant Administrator, instructed for CPR (Cardiopulmonary Resuscitation) to be started when no pulse was felt for R1. R1 was declared deceased at the local Emergency Department.

In an interview on 07/19/2023 at 12:15pm, Staff C, Caregiver, stated that a copy of the

Statement of Deficiencies	License #: 2144	Compliance Determination # 26882
Plan of Correction	Easthaven Villa	Completion Date
Page 3 of 3	Licensee: Caring Places Management, LLC	10/12/2023

care plans for each resident living in the Memory Care Unit were kept in the breakroom. Staff were required to review and sign care plans when initial care plans were started or any updates with changes to the care plan had happened. Staff C stated that there was always at least one staff person in the dining room during meals. Staff C stated that staff walk around circling between each area of the dining room, so they could monitor residents for safety.

In an interview on 08/29/2023 at 12:35pm, Staff A stated that R1 had a modified diet. Staff A stated they had noticed R1 eating unusually fast that day and shoveling food into his mouth. Staff A stated she had cued R1 to slow down and had observed him take food out of his mouth and put in on the plate. Then she had returned to the kitchen to grab more plates to pass out to other residents. Staff A stated that she was the only staff person monitoring the side of the dining room R1 was sitting in. Staff A stated that R1 did not require a staff person to be with him at all times while eating meals. Staff A stated that she was unable to recall what R1's care planned interventions were related to eating. Staff A stated she was aware that R1 needed close observation. When asked how she would know when R1 took every three to four bites of food so he could be cued to take a drink of fluids, Staff A stated that a staff person was always in the dining room observing the residents.

In an interview on 07/19/2023, Staff E, Assistant Administrator, stated that they did not do one to one observation for R1 during meals. When asked how the staff were to know many bites R1 had taken to implement interventions stated in Service Plan, Staff E stated that there was always at least one person in the dining room.

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) 11/25/23 .

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

Lori Wills

Administrator (or Representative)

11/2/23

Date

Easthaven Villa

Plan of Correction

Statement of Deficiencies Report Dated 10/12/23

Deficiency	Actions	Responsible Person(s)	Due Date	Completed Date
WAC388-78A-2160 Implementation of Negotiated Service Agreement: Failed to implement the NSA for 1 of 3 Residents. Failure resulted in harm when Resident choked and died.	Education with Kitchen staff and Caregiving staff on how the swallow works, specialized diets, importance of knowing who has swallowing concerns or are on special textured diets	LPN	11-25-23	
	Binder made for kitchen to show in writing specialized diets, likes and *dislikes, choking history and* interventions to prevent choking.	Nurse, RCC, Admin	11-25-23	
	Staff educated by reading and initialing NSA on all resident dietary information and interventions for swallowing.	Nurse, RCC, Admin	11-25-23	
	Staff will be able to state which Residents have specialized diets, which require supervision from a far, and interventions for each Resident.	Nurse, RCC, Admin, Caregivers	11-25-23	

Easthaven Villa

	Weekly Checks with caregivers to check for knowledge of specialized diets and those Residents that need supervision, cues or reminders while eating. Daily checks on diets served by staff ,to check for appropriate textures served. Alert dietary staff if changes need to be made.	RCC, Nurse, Admin, Caregiver Caregiver, RCC, Nurse, Admin	11-25-23 11-25-23	
	Review abdominal thrusts procedure and when to start CPR with all staff. Define Supervision in dining room duties. Caregivers and Med Aide to communicate when leaving dining room, helping others etc. so one staff in dining room throughout meal.	Nurse, Admin Nurse, Admin, RCC	11-25-23 11-25-23	

Easthaven Villa

	Re-educate importance of supervising Resident, not to leave resident if observe issues with chewing or swallowing. Random spot checks on knowledge and appropriate diets served to Resident.	Nurse, RCC, Admin RCC, Nurse, Admin	11-25-23 11-25-23	