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

Victoria Aid Opco LLC
Victoria Place
491 Discovery Rd
Port Townsend, WA 98368

RE: Victoria Place License # 2185

Dear Administrator:

This letter addresses Compliance Determination(s) 48569 (Completion Date 10/10/2024) and 36013 (Completion Date 01/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/10/2024 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-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-2-a

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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: Victoria Place
Provider Type: Assisted Living Facility
License/Cert.#: 2185
Compliance Determination #: 36013
Intake ID: 112855
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/30/2024 through 01/31/2024
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident-to-resident altercation in the community.

Investigation Methods:

Sample:
Total residents: 34
Resident sample size: 2
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Management

Record Reviews:
Medical records
Progress Notes
Care Plans
Incident Reports
Incident investigation
State reporting log
Facility policies

Investigation Summary:
Quality of Care/Treatment: Facility investigated incident, and monitored residents. Facility made notifications to family, and provider, however failed to report the physical resident-to-resident altercation immediately to the Department per policy. 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 #: 2185	Compliance Determination # 36013
Plan of Correction	Victoria Place	Completion Date
Page 1 of 4	Licensee: Victoria Aid Opco LLC	01/31/2024

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 01/30/2024 and 01/31/2024 of:

Victoria Place
491 Discovery Rd
Port Townsend, WA 98368

This document references the following complaint number(s): 112855

The following sample was selected for review during the unannounced on-site visit: 2 of 34 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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.

Cory Cisneros
Residential Care Services

02/07/2024
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)

2/13/2024
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to implement the facility policy to notify the Department's Complaint Resolution Unit hotline immediately when they became aware of a resident-to-resident altercation that occurred in the facility, for 1 of 1 incident reviewed. This failure placed Resident 1 (R1), Resident 2 (R2), and all other residents who experience similar incidents at the facility at risk for further harm due to the department's inability to investigate the incident.

Findings included...

Review of the facility policy titled, "Incident Reports," last reviewed 12/01/2023, it stated, "All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman, state licensing agency, and in the case of any assault to local law enforcement. Refer to the Abuse, Neglect, and Exploitation Policy."

Review of the facility policy titled, "Abuse, Neglect and Exploitation," last reviewed 12/01/2023, it stated, "Resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy." Under the "Procedure" section, it stated, "Any community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Resident Care Director, and Executive Director. In all cases the Executive Director will be informed as soon as possible... Staff will immediately make a report to the Department's Aging and Disability Administration Complaint Resolution Unit Hotline -- 1-800-562-6078, or online."

Review of the facility Incident Log from 12/17/2023 to 01/19/2024, showed two entries for a Resident-to Resident altercation between R1 and R2 dated for 12/31/2023 at 7:30AM.

Administrator (or Representative) _____ Date _____

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Review of the facility Incident Log from 12/17/2023 to 01/19/2024, showed two entries for a Resident-to Resident altercation between R1 and R2 dated for 12/31/2023 at 7:30AM.

Review of R1's Face Sheet showed that R1 was admitted to the facility on [redacted] 2022.

Review of R1's Incident Report stated, "[R1] was asked what [R2] was doing in [their] apartment, to which [they] replied that [R2] slapped [them] because [they] asked [R2] to leave [their] apartment." "[A staff member] was on [their] way to another resident room when [they] saw [R2] walking out of [R1's] apartment." Under the "Notifications" section of the incident report, it showed that the Department was notified via online report on 01/03/2024 at 12:00PM.

Review of R2's Face Sheet showed that R2 was admitted to the facility on [redacted] 2023.

Review of R2's Incident Report stated "[A staff member] was on [their] way to get another resident ready when [they] heard arguing. [They] observed [R2] walking out of] R1's] apartment." Under the "Notifications" section of the incident report, it showed that the Department was notified via online report on 01/03/2024 at 12:00PM.

During an interview with Staff B, The Resident Care Coordinator, on 01/21/2023 at 11:53AM, when asked within what time frame state would be notified of resident-to-resident altercations, Staff B stated, "We would notify them right then and there that day, or as soon as we become aware."

During an interview with Staff A, The Executive Director on 01/21/2023 at 12:10PM, Staff A was asked who at the facility was responsible for making the Department notification. Staff A stated "Usually myself or the nurse would make the state report." Staff A was asked why this incident was not reported until 3 days later. Staff A stated, "It was reported to us late." Asked Staff A to clarify if they meant that the incident was reported to management late by staff. Staff A stated "Yes." Staff A was asked within what time frame the Department should be notified. "Normally, it would be done immediately. They failed to contact me or the on-call on the weekend... That failed that weekend."

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date) 2/13/2024.

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

Administrator (or Representative) — 2/13/2024 Date

Review of R1's Face Sheet showed that R1 was admitted to the facility on [redacted]/2022.

Review of R1's Incident Report stated, "[R1] was asked what [R2] was doing in [their] apartment, to which [they] replied that [R2] slapped [them] because [they] asked [R2] to leave [their] apartment." "[A staff member] was on [their] way to another resident room when [they] saw [R2] walking out of [R1's] apartment." Under the "Notifications" section of the incident report, it showed that the Department was notified via online report on 01/03/2024 at 12:00PM.

Review of R2's Face Sheet showed that R2 was admitted to the facility on [redacted]/2023.

Review of R2's Incident Report stated "[A staff member] was on [their] way to get another resident ready when [they] heard arguing. [They] observed [R2] walking out of] R1's] apartment." Under the "Notifications" section of the incident report, it showed that the Department was notified via online report on 01/03/2024 at 12:00PM.

During an interview with Staff B, The Resident Care Coordinator, on 01/21/2023 at 11:53AM, when asked within what time frame state would be notified of resident-to-resident altercations, Staff B stated, "We would notify them right then and there that day, or as soon as we become aware."

During an interview with Staff A, The Executive Director on 01/21/2023 at 12:10PM, Staff A was asked who at the facility was responsible for making the Department notification. Staff A stated "Usually myself or the nurse would make the state report." Staff A was asked why this incident was not reported until 3 days later. Staff A stated, "It was reported to us late." Asked Staff A to clarify if they meant that the incident was reported to management late by staff. Staff A stated "Yes." Staff A was asked within what time frame the Department should be notified. "Normally, it would be done immediately. They failed to contact me or the on-call on the weekend... That failed that weekend."

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Administrator (or Representative) Date