STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

06/21/2024

SCRIBER GARDENS LLC

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

RE: SCRIBER GARDENS LLC License # 2203

Dear Administrator:

This letter addresses Compliance Determination(s) 42446 (Completion Date 06/14/2024) and 37676 (Completion Date 04/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/14/2024 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-2930-1-b-i

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (360)651-6971.

Sincerely,

Jayne Hill

Jayne Hill, Field Manager
Region 2, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: SCRIBER GARDENS LLC **Provider Type:** Assisted Living Facility
License/Cert.#: 2203
Compliance Determination #: 37676 **Intake ID:** 119658
Investigator: Wesler Dumecquias **Region/Unit #:** RCS Region 2 / Unit A
Investigation Date(s): 03/04/2024 through 04/11/2024
Complainant Contact Date(s): 03/04/2024

Allegation(s):

1. Named residents (NR1 and NR2) had long call wait times, resulting in NR1 falling 2x and being sent to the emergency room, as well as a delay in NR2's brief being changed.
2. The Assisted Living Facility (ALF) was short staffed and had only one caregiver overnight.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified residents Activities Dining Resident rooms Resident care equipment Resident to resident interactions Staff to resident interactions
Interviews:	Identified residents Nursing staff Residents Family members
Record Reviews:	Incident investigation Facility policies Care plans Home health and PT notes Toileting records.

Investigation Summary:

1. The Assisted Living Facility (ALF) had issues with their call pendants not functioning. Three of the three sampled residents stated they had to wait longer for staff to come and help them when they called. Two of the three sampled residents had intermittently nonfunctioning call pendants. Observation showed that 2 of the call pendants were not transmitting an alert on the ALF staff's pagers when tested. A failed practice was

identified. A citation was issued for noncompliance with WAC 388-78A-2930(1) (b) (i)—communication system.
2. The ALF was continuously hiring for staff. Interviews with sampled residents showed they were not concerned with the staffing but stated they had issues with long waits sometimes with staff responding and pendants not always working. A failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2930(1) (b) (i)—communication system.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 03/04/2024 and 03/04/2024 of:

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

This document references the following complaint number(s): 119658, 118655, 120142

The following sample was selected for review during the unannounced on-site visit: 3 of 43 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit Z
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Jayne Hill
Residential Care Services

04/17/2024
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.

Betty Rankin
Administrator (or Representative)

4-22-24
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure 3 of 3 residents (Residents 1, 2, and 3) received reliable, working pendants. This failure placed Residents 1, 2 and 3 at risk of unmet care needs and potential injury when unable to call for assistance.

Findings included...

Resident 1
During an interview on 03/04/2024 at 4:03 PM, Staff C, Med tech, stated that Resident 1's pendant did not always work. Staff C stated that the pendants were unreliable because the call would not register on the staff pagers even when residents pressed the pendant button. Staff C stated that at 4:23 PM when they pressed Resident 1's pendant to test it, Staff C confirmed that the call from the pendant did not alert Staff C's pager.

During an interview on 03/04/2024 at 4:23 PM, Resident 1 stated that their pendant functioned sometimes. Resident 1 stated that this resulted in a longer wait for the care staff to arrive.

Observation on 03/04/2024 at 4:27 PM showed when Resident 1 pressed their pendant, it did not work. Observation showed that the call did not register into Staff C's pager.

Resident 2
Observation in Resident 2's apartment on 03/04/2024 at 4:35 PM, showed that Resident 2 did not have a pendant. Observation showed a pull cord laid on Resident 2's table.

During an interview on 03/04/2024 at 4:35 PM, Resident 2 stated that they did not have a

pendant. Resident 2 stated that the pendant the facility provided did not work. Resident 2 stated that they waited for 45 minutes, or even longer, for staff to respond. Resident 2 stated that when they pressed the pull cord, staff did not come to help them. Resident 2 stated that it was disgusting for them to sit in their "crap". Resident 2 stated that they needed to scream to ask for help.

Observation from the hallway on 03/04/2024 at 4:40 PM showed that while in their apartment room, Resident 2 yelled for help .

During an interview on 03/04/2024 at 4:03 PM, Staff C stated that Resident 2's pendant did not work. Staff C stated that the pendant had not worked for a while.

Resident 3
On 03/04/2024 at 4:03 PM, Staff C stated that Resident 3's pendant had an issue. Staff C stated that the pendant had not worked for a while. Staff C stated that there was an issue resetting Resident 3's call button which resulted in the calls not showing on the pagers. Staff C stated that they relied on residents' calling out for help. Staff C stated that they would know if a resident needed help when staff completed their safety checks.

During an interview on 03/04/2024 at 4:40 PM, Staff C stated that when Resident 3 pressed the button, it failed to send an alert to Staff C's pager.

Observation on 03/04/2024 at 4:41 PM, when Resident 3 pressed their pendant, it did not work. Observation showed that the call did not register into Staff C's pager.

During an interview on 03/04/2024 at 4:42 PM, Resident 3 stated that when they pressed their call button to ask for help, they were unsure how long it took before staff arrived. Resident 3 stated that staff came after "some time". Resident 3 stated that they needed to scream before staff would come and help them.

On 03/04/2024 at 1:58 PM, Staff A, Executive Director, stated that there was no policy for operating, maintaining, and monitoring the ALF's pendant call system. Staff A stated that the ALF's pendant call system did not support registering and printing the call logs.

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) 5/26/24 .

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

Statement of Deficiencies	License #: 2203	Compliance Determination # 37676
Plan of Correction	SCRIBER GARDENS LLC	Completion Date
Page 4 of 4	Licensee: SCRIBER GARDENS LLC	04/11/2024

Betsy Tuttle 4-22-24

Administrator (or Representative) Date