STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Madrona Assisted Living, LLC

Madrona Assisted Living, LLC
8800 Madison Ave N
Bainbridge Island, WA 98110

RE: Madrona Assisted Living, LLC License # 2210

Dear Administrator:

This letter addresses Compliance Determination(s) 47477 (Completion Date 09/19/2024) and 39323 (Completion Date 06/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/19/2024 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-2630-1-a

The Department staff who did the on-site verification:
Shelley Neeleman, ALF Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Madrona Assisted Living, LLC
Provider Type: Assisted Living Facility
License/Cert.#: 2210
Intake ID: 112493
Compliance Determination #: 39323
Region/Unit #: RCS Region 3 / Unit D
Investigator: Shelley Neeleman
Investigation Date(s): 04/04/2024 through 06/20/2024
Complainant Contact Date(s):

Allegation(s):

Resident Neglect:
1) The AV was injured by a caregiver when the care plan was not followed (the caregiver transferred the AV solo and the AV requires a two person assist).

2) The Director of Nursing conducted an internal investigation and confirmed in writing that this injury was a result of caregiver negligence and error.

3) The Director of Nursing stated that the incident was not going to be called into the state, as the issue was internal and the incident would be put it in her file.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 1 Closed records sample size:
Observations:	General environment Residents Resident rooms Staff Staffing levels Resident to staff interactions
Interviews:	Resident - AV Staff - Executive Director Complainant
Record Reviews:	Resident Characteristic Roster “Coaching and Corrective Action Form”, dated 12/18/2023 “Unusual Incident/Injury Report”, dated 12/17/2023 “Assisted Living Incident Report Form”, dated 12/18/2023 “Physician’s Orders Fax Communication Sheet”, dated 12/17/2023 “Witness Statement Form”, dated 12/17/2023 “Abuse, Neglect, Fraud, and Wrongdoing” policy, dated 07/09/2021 AV’s Service Plan

Investigation Summary:

1, 2, 3) Per interview and record review, the AV was injured while being transferred with the assistance of one caregiver. The AV required emergent medical attention and was sent to the hospital.

Per interview and record review, an investigation was conducted, and a "Corrective Action Form" was written for the staff member. The investigation concluded that the AV’s injury was the result of transferring the AV with a one-person assist, instead of the required two person assist outlined in the AV’s service plan. The Corrective Action Form indicated that this type of incident can be considered negligence of a resident.

Per interview, the incident was considered to be an internal matter, and management staff believed that a report to the Department was unnecessary.

A record review of CRU intakes did not identify any facility reports related to an allegation of neglect.

The facility failed to report an allegation of neglect as outlined in WAC 388.78A.2630 and RCW 74.34.035.

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

PO Box 99250, Lakewood, WA 98496

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 04/04/2024 and 06/12/2024 of:

Madrona Assisted Living, LLC
8800 Madison Ave N
Bainbridge Island, WA 98110

This document references the following complaint number(s): 112493

The following sample was selected for review during the unannounced on-site visit: 1 of 48 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Shelley Neeleman, ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

06/25/2025

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) 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

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to report an allegation of neglect to the Department's Aging and Disability Services Administration Complaint Resolution Unit hotline (CRU) for 1 of 1 sampled resident (Resident 1 [R1]). This failure to notify the Compliant Resolution Unit placed 48 of 48 residents at risk of unreported neglect and prevented the Department from evaluating facility systems in place to protect residents.

Findings included…

RCW 74.32.035 Reports-Mandated and permissive-Contents-Confidentiality.
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Record review of the Department of Social and Health Services book, "Assisted Living Guidebook", dated February 2018, showed that individual mandated reporters must immediately report to the Department's hotline when there is a reasonable cause to believe an incident is abuse, neglect, substantial injuries of unknown source, or personal and/or financial exploitation.

Record review of the facility's "Abuse, Neglect, Fraud, and Wrongdoing" policy, dated 07/09/2021, stated that (1) all staff will receive training on elder abuse incidence, signs and symptoms, and reporting requirements, (2) Residents, their responsible parties, personnel, health professionals and all relevant stakeholders are encouraged to report any suspected incidence of abuse, fraud, or other wrongdoing, (5) if the suspected abuse, fraud, or other wrongdoing is substantiated, a written report is made to the appropriate licensing/regulatory agency, and the responsible party.

Record review of facility's "Coaching and Corrective Action Form", dated 12/18/2023, stated that Staff A, Caregiver, transferred R1 from their bed to a wheelchair without waiting

for the required second person. R1 sustained an injury that required emergency room care.

Record review of facility's "Coaching and Corrective Action Form", dated 12/18/2023, stated that after conducting a full investigation, Staff B, the Director of Nursing, planned to provide a formal "Coaching and a Corrective Action Form" to Staff A as a written warning, due to the severity of the incident and harm caused to R1.

Record review of facility's "Coaching and Corrective Action Form", dated 12/18/2023, stated that Staff A was aware that a second person should have assisted with R1's transfer, and that this type of incident can be considered negligence.

Record review of the CRU intake dated 12/30/2023 indicated that Staff B conducted an internal investigation and confirmed in writing that R1's injury was a result of the caregiver's negligence and error.

Record review of the CRU intake dated 12/30/2023 indicated that Staff B stated the incident was internal and did not need to be reported to the state.

Record review of CRU intakes did not identify any facility reports related to an allegation of neglect.

During an interview on 06/12/2023 at 11:15 a.m., Staff C, the Executive Director (ED) acknowledged that R1's incident was considered to be an internal matter and believed that a report to the Department was unnecessary.

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, Madrona Assisted Living, LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date