STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Highgate Wenatchee LP
HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

RE: HIGHGATE SENIOR LIVING License # 2225

Dear Administrator:

This letter addresses Compliance Determination(s) 27967 (Completion Date 08/11/2023) and 24298 (Completion Date 06/28/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/11/2023 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-2120-3-b

The Department staff who did the on-site verification:
Nicole Velazquez, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 24298
Investigator: Nicole Velazquez
Investigation Date(s): 05/23/2023 through 06/28/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 80527
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A resident to resident altercation.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 8 Closed records sample size: 0
Observations:	Environment, Cares, Named residents, Residents, Resident to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Facility policy, Facility incident report and investigation, Resident records (Face sheet, Assessment, Care Plan, Progress Notes, Physician orders, FYI Form).

Investigation Summary:
Observations showed that residents were clean and groomed, resident to resident interactions were appropriate and respectful. Staff were observed to be available and responsive to resident's needs. Resident interviews showed that they felt safe and their needs were being met. Staff interviews showed that the residents were separated and assessed. The facility failed to monitor the named residents after the resident to resident altercations. Failed practice identified WAC 388-78A-2120(3)(b).

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 #: 2225	Compliance Determination # 24298
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 3	Licensee: Highgate Wenatchee LP	06/28/2023

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 05/23/2023 and 06/28/2023 of:

HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

This document references the following complaint number(s): 80527

The following sample was selected for review during the unannounced on-site visit: 8 of 54 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit Z
1200 Alder Street
Union Gap, WA 98903

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.

Michelle Closner
Residential Care Services

07/07/2023
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) — Date: 7/7/23

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to monitor residents after an incident for two of two (Resident 1 & 2) residents. This failure placed residents at risk of unmet and unmonitored needs.

Findings included...

Facility policy, titled "Alert Status Documentation Policy," dated 07/2014, showed that the alert charting system was in place to ensure that the needs of residents who need extra attention for some reason. A resident should be on alert charting for about 3 days and that the care partners would check the alert list to know who they were supposed to be monitoring and what they were monitoring the resident for.

Facility incident report dated 04/29/2023 showed that Resident 1 and Resident 2 were involved in a resident-to-resident altercation.

Resident 1

Resident 1's Nursing Assessment dated, 03/16/2023, showed the resident had a diagnosis of [redacted]. Resident 1 was noted to wander with no rational purpose to movement, was oblivious to their safety and have short- and long-term memory deficits.

Record review of 04/29/2023 through 05/03/2023 progress notes, showed that there had not been any documentation of monitoring Resident 1 after the resident-to-resident altercation on 04/29/2023.

Resident 2

Nursing Assessment, dated 04/11/2023, showed that Resident 2 had diagnoses of [redacted]. Resident 2 was noted to be very angry that they were in a memory care setting.

Resident 2's Progress notes reviewed for 04/29/2023 to 5/03/2023, did not show monitoring occurred, after the resident-to-resident altercation on 04/29/2023.

On 05/25/2023 at 1:33 PM, Staff A, Administrator, stated that they were aware that Resident 1 and Resident 2 had a resident-to-resident altercation on 04/29/2023. They stated that they had noted in their review of the two residents' records, that neither Resident 1 nor Resident 2 had documentation of monitoring for changes in condition after the altercation. Staff A further stated that the form for alert charting, "FYI form," was not initiated for either resident related to the altercation, so monitoring was not done.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/28/23 .

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

Administrator (or Representative) — Date: 7/7/23

Plan of Correction

Highgate Senior Living

Complaint Investigation 6/28/23

1) WAC 388-78A-2120
    a. On 7/20/23 at the monthly All Team Meeting the Executive Director will complete a training on Highgate Policy & Procedure for Alert Charting.
    b. Medication Aides and Care Partners who were not able to attend the All Team meeting will meet with ED and/or Resident Care Coordinator to discuss the Alert Charting process and receive a copy of Highgate's policy for future reference.
    c. The Resident Care Coordinator and Clinical Assistant will monitor FYI's for Alert Charting documentation and discuss next steps with ED (end alert charting after 72 hours, notify physician/family with updates, schedule service plan to make appropriate adjustments, update service plans with new behaviors, etc.). When Highgate has an HD in place the RN will be responsible for monitoring FYI's for Alert Charting and determining next steps.
    d. A monthly random audit of Alert Charting will be completed by the Clinical Assistant and RCC to follow up with team members as needed to ensure compliance with Highgate Alert Charting requirements.