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) 33015 (Completion Date 11/27/2023) and 29361 (Completion Date 10/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/27/2023 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-2640-1-a, WAC 388-78A-2100-2-b

The Department staff who did the on-site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 29361
Investigator: Brittney Shull
Provider Type: Assisted Living Facility
Intake ID: 96516
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/12/2023 through 10/17/2023
Complainant Contact Date(s): 09/07/2023, 10/12/2023

Allegation(s):

1) The named resident has a pressure injury that has worsened.
2) The named resident's wound assessment documentation may have been falsified or the staff may not have been monitoring the wound.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 5 Closed records sample size: 0
Observations:	Environment, Residents, Staff to Resident interaction, Staff presence and availability, The Named Resident's wound.
Interviews:	Staff, Residents, Others not associated with the facility.
Record Reviews:	Resident records, Hospital records, Personnel records.

Investigation Summary:

1, 2) Interview and record review showed that the named resident had a wound that the facility was monitoring. The facility failed to complete an assessment for the wound or to notify the resident's representative upon discovering the wound. Failed practice identified, reference WAC 388-78A-2100, WAC 388-78A-2640 reference Statement of Deficiencies dated 10/10/2023.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 29361
Investigator: Brittney Shull
Provider Type: Assisted Living Facility
Intake ID: 96703
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/12/2023 through 10/17/2023
Complainant Contact Date(s): 09/19/2023, 10/12/2023

Allegation(s):
The named resident had bed sores requiring urgent care and the named representative was unaware of them.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 5 Closed records sample size: 0
Observations:	Environment, Residents, Staff to Resident interaction, Staff presence and availability, The Named Resident's wound.
Interviews:	Staff, Residents, Others not associated with the facility.
Record Reviews:	Resident records, Hospital records.

Investigation Summary:
Interview and record review showed that the named resident had a wound that worsened. The facility failed to complete an assessment for the wound or to notify the resident's representative upon discovering the wound. Failed practice identified, reference WAC 388-78A-2100, WAC 388-78A-2640 reference Statement of Deficiencies dated 10/10/2023.

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
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2225	Compliance Determination # 29361
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 6	Licensee: Highgate Wenatchee LP	10/17/2023

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 09/12/2023 and 09/12/2023 of:

HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

This document references the following complaint number(s): 95677, 96516, 96887, 97318, 97996, 96703

The following sample was selected for review during the unannounced on-site visit: 5 of 48 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
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.

Gwin Kaercher — Residential Care Services

10/20/2023 — 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: 10/27/23

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview, and record review the Assisted Living Facility (ALF) failed to notify the resident's representative or their physician of a wound which worsened for 1 of 1 resident (Resident 1). This failure disallowed the resident's representative and their physician input and involvement in the resident's course of treatment and placed the resident at risk of further injury.

Findings included...

388-78A-2020 Definitions.

"Significant change" means a change in the resident's physical, mental, or psychosocial status that causes either life-threatening conditions or clinical complications.

A record review of Resident 1's progress notes by Staff A, Clinical Assistant, showed that:

- On 08/11/2023, Resident 1 had a wound believed to be a pressure injury to the right inner ankle and the care team was placing a pillow between the legs to relieve pressure.
- On 08/16/2023, Resident 1 did not report pain to the right ankle and it was without redness, discharge, or heat to the touch.
- On 08/23/2023, Resident 1 continued to have no pain, no drainage of the right ankle, and no signs of infection. It further showed that the wound appeared to be a smaller size. It lastly showed that the care team was putting tall socks on Resident 1 to help prevent them from hitting the ankle on things and the right ankle dressing was changed this day.
- On 08/30/2023 Resident 1's ankle was scabbed and area surrounding it was red, without heat or pain to the touch.
- In an interview on 09/07/2023 at 3:40 PM Staff E, Life Enhancement Specialist, stated that Resident 1 began having a pressure sore at the end of July 2023 and it was only a little red. They further stated that the wound was covered with tall socks to make sure Resident 1 didn't hit it on things. They stated that by August 2023, it was worse, and Resident 1 was

no longer able to walk and had to use a wheelchair.

In an interview on 09/12/2023 at 1:41 PM Staff C, Medication Aide, stated that on 08/16/2023 Resident 1's leg was red, scaly and had a scab. Staff C also stated that they were supposed to report to Staff A because they did not have a nurse in the facility. Staff C stated that they told Staff A on 08/16/2023 that they should call Resident 1's physician to ask for wound care because it looked red and infected, but Staff A told them it was not necessary, and the plan was to keep socks covering the wound and it was getting better. Staff C stated that it got way worse when they saw it on 09/01/2023 which was the day Resident 1 went to the emergency room.

A review of Resident 1's record from 07/01/2023 through 09/01/2023 did not show a notification to Resident 1's Representative or their physician.

A record review of Resident 1's hospital records on 09/01/2023 showed that Resident 1 had an infected sore to the right ankle with eschar (black tissue scab from dead skin) and surrounding cellulitis (skin infection that is red and painful). It further showed that the wound had progressed over the last month.

A record review of Resident 1's wound care visit dated 09/11/2023 showed that Collateral Contact 1 (CC1), Resident1's Representative, was unaware of the wound until the facility called on 09/01/2023 that they were taking Resident 1 to the emergency room.

In an interview on 09/12/2023 at 11:34 AM, Staff D, Executive Director, stated that they did not know Resident 1 had an ankle wound until they sent Resident 1 to the emergency room.

In an interview on 09/19/2023 at 10:15 AM, CC1 stated that the ALF called to notify them that Resident 1 needed to be seen by a physician right away for an ankle wound. They further stated that they had attended a wound care appointment with Resident 1 and the clinician was concerned the wound may never heal.

In an interview on 10/10/2023 at 2:06 PM, Collateral Contact 2 (CC2), Resident 1's Physician Office Staff, stated that the ALF had not notified Resident 1's primary care physician regarding the right ankle wound. They further stated that they were first alerted to the right ankle wound on 09/11/2023 when they received a request for additional studies from a wound care consultation.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2225	Compliance Determination # 29361
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 4 of 6	Licensee: Highgate Wenatchee LP	10/17/2023

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) November 1, 2023.

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

Administrator (or Representative) — Date: 10/27/21

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to identify, evaluate, and take appropriate action to complete or obtain an assessment for 1 of 1 resident (Resident 1) who had a change in condition. This failure placed Resident 1 and other residents at risk for unevaluated, unmet, and unmonitored needs.

Findings included...

A record review of a facility document titled, "Assessment Standards," dated September, 2018, showed that each time a change occurs in a resident's condition, residents should be assessed.

Resident 1

Resident 1's facility record showed that Resident 1 was admitted to the facility on [redacted]/2021 with a diagnosis of [redacted] Resident 1's assessment, dated 04/21/2023 showed that they did not have any skin problems and that they did not use an assistive device to walk.

A record review of a facility document titled, "Service Plan," dated 04/21/2023 showed that Resident 1 could walk without assistance and that staff should report to the nurse when Resident 1 could not bear weight or had any pain and discomfort. The service plan did not show any skin concerns and did not show that Resident 1 required a wheelchair for mobility.

A record review of Resident 1's progress notes by Staff A, Clinical Assistant, showed that on 08/11/2023, Resident 1 had a pressure injury wound to the right inner ankle and the care team was placing a pillow between the legs to relieve pressure.

A record review of Resident 1's hospital records on 09/01/2023 showed that Resident 1 had an infected sore to the right ankle with eschar (black tissue scab from dead skin) and surrounding cellulitis (skin infection that is red and painful). It further showed that the wound had progressed over the last month.
In an interview on 09/07/2023 at 3:40PM Staff E, Care Partner, stated that Resident 1 began having a little pressure sore at the end of July. They stated that by August, it was progressively worse, and Resident 1 was no longer able to walk and had to use a wheelchair.

A record review of a progress note dated 09/01/2023 showed that Resident 1 began an antibiotic.

A record review of a document titled, "Wound Care Outpatient Initial Evaluation," dated 09/11/2023 showed that Resident 1 had a non-pressure chronic ulcer of the right ankle with fat layer exposed. It further showed that Resident 1 was ambulatory until recently but now using a wheelchair due to foot pain. It further showed that ALF staff had been applying antibiotic ointment and gauze dressings.

In an interview on 09/12/2023 at 11:34 AM, Staff D, Executive Director, stated that they did not know Resident 1 had an ankle wound until they sent Resident 1 to the emergency room on 09/01/2023. They further stated that no one was monitoring Staff A's work because they did not have a nurse until they 09/05/2023.

During an observation on 09/12/2023 at 2:08PM, Resident 1 was observed to be in a wheelchair with a bandage taped to their right ankle.

In an interview on 09/12/2023 at 2:52PM, Staff G, Resident Care Coordinator (RCC), stated that Resident 1's assessment or care plan had not been updated to reflect Resident 1's changes in the worsening ankle wound or ambulatory status.

In an interview on 10/02/2023 at 2:23 PM, Staff H, Care Partner, stated that prior to 08/23/2023, Resident 1's ankle had only been a little swollen, without an open wound or pain and Resident 1 could ambulate independently, without assistance or use of any assistive device. They further stated that on 08/23/2023 Resident 1 had blood and pus (thick yellowish-white fluid formed from inflammatory response typically associated with an infection) on their ankle wound and was using a wheelchair, but they were not told why. They lastly stated that staff had recently been trying to encourage Resident 1 to use a walker for ambulation but Resident 1 had become deconditioned and would give up after attempting only a couple steps.

Statement of Deficiencies	License #: 2225	Compliance Determination # 29361
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 6 of 6	Licensee: Highgate Wenatchee LP	10/17/2023

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) November 1, 2023.

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

Jen T. Long — Administrator (or Representative)

10/27/23 — Date

Plan of Correction

Highgate Senior Living

SOD Date: 10/17/23

WAC 388-78A-2640 Reporting significant change in resident's condition.

a. Highgate Senior Living hired RN/Healthcare Director Marla Starcevich on 9/5/2023. Marla Starcevich will be responsible for monitoring that the physician and resident responsible party are contacted when a resident has a significant change of condition.
b. The RN/Healthcare Director may designate a Medication Aide to assist with communicate to physician and resident's responsible party. The residents clinical record will be updated specifying the date and name of the physician or resident responsible party contacted.
c. The RN/Healthcare Director will complete a nursing assessment, work with the Resident Care Coordinator to update the Service Plan, and set-up a meeting with the resident's responsible party to review any changes to the residents care needs.
d. The ED will review documentation monthly for any resident identified as having a significant change of condition. If any concerns noted by ED will be reported to RN/Healthcare Director so that corrective steps can be taken immediatley.

Plan of Correction

Highgate Senior Living

SOD Date: 10/17/23

WAC 388-78A-2100 On-going assessment

a. Highgate Care Center policy and procedure for Assessment Standards were reviewed with RN/Healthcare Director on 10/3/2023.
b. Any residents who have a significant change in condition will be assessed by the RN/Healthcare and an updated nursing assessment will be completed. The RN/Healthcare Director will coordinate with the Resident Care Coordinator to update the Service Plan. A Service Plan meeting will be held with the resident responsible party to review identified changes to care.
c. The ED will complete a monthly audit for any residents with a significant change of condition and notify RN/Healthcare Director of any concerns so that corrective steps can be taken immediately.