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

05/15/2024

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

RE: HIGHGATE SENIOR LIVING # 2225

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 41316 (Completion Date 05/15/2024) and 37600 (Completion Date 03/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/15/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

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

(a) The changes identified in the resident per subsection (2) of this section; and

(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.

(4) Take appropriate action in response to each resident's changing needs.

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 #: 37600
Investigator: Felicia Cantu
Investigation Date(s): 02/29/2024 through 03/28/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 119191
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
1,2) A named resident was in pain and was not evaluated by staff timely.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Staff list Outside agency records Resident records(face sheets, progress notes, care plans, assessments, doctor orders).

Investigation Summary:
1,2) Interviews and record review showed that the named resident was in pain and was emergently transferred to the hospital prior to pain medication was given. Failed practice identified. WAC 388-78A-2120, reference statement of deficiencies date 03/28/2024.

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 #: 37600
Investigator: Felicia Cantu
Investigation Date(s): 02/29/2024 through 03/28/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 120880
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Facility staff is not checking on and assessing the residents in the facility.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Facility environment Resident to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Staff list Hospital records Resident records (face sheets, care plan, assessments, chart notes, and doctor orders).

Investigation Summary:
Interviews and record review showed that a named resident was emergently transferred to the hospital. Failed practice identified. WAC 388-78A-2120 reference statement of deficiencies dated 03/28/2024.

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 #: 37600
Investigator: Felicia Cantu
Investigation Date(s): 02/29/2024 through 03/28/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 120897
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named staff member is not checking on resident's health concerns.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Staff list Hospital records Resident records (face sheet, care plan, assessment, chart notes, and doctor orders).

Investigation Summary:
Interviews and record review showed that a named resident was emergently transferred to the hospital. Failed practice identified. WAC 388-78A-2120 reference statement of deficiencies dated 03/28/2024.

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 # 37600
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 5	Licensee: Highgate Wenatchee LP	03/28/2024

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 02/29/2024 and 02/29/2024 of:

HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

This document references the following complaint number(s): 119191, 120880, 120897

The following sample was selected for review during the unannounced on-site visit: 4 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, 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

04/05/2024
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.

Statement of Deficiencies	License #: 2225	Compliance Determination # 37600
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 2 of 5	Licensee: Highgate Wenatchee LP	03/28/2024

Administrator (or Representative) 4/14/24 Date

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

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

(a) The changes identified in the resident per subsection (2) of this section; and

(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.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interviews and record review the Assisted Living Facility (ALF) failed to identify and take appropriate action timely when 1 of 2 Residents (Resident 1) had an onset of decline in medical condition. This contributed to an emergent hospitalization for Resident 1.

Findings included...

Review of the ALF's policy titled "Alert Status Documentation Policy" updated 09/01/2023 showed that "Alert Charting" means that a nurse, coordinator, or clinical assistant will write a progress note at least once per day, and the care partners will address the alert issue with an FYI (four your information) form once per shift. The progress notes should address the specific reason the resident requires alert documentation. All nurses will check the alert status list at beginning of every shift, so they know the current issues on their shifts, so they know who needs vitals, if someone has new pain, or if someone is ill. Care partners will check the alert list at the beginning of their shifts. If there are alarming, new, or worsening findings, then the care partners should inform the nurse right away and not wait till end of their shift. Any member of the Care Team may place a resident on alert charting when they think a resident needs extra monitoring.

Review of the ALF's policy titled "Assessment Standards" dated 09/01/2018 showed that the Healthcare Director and Resident Care Coordinator both attend the initial assessment, change of condition assessment, and any ongoing assessment to ensure the most accurate and complete information is gathered. The objective in completing assessments is to determine the individual care needs and special attention for each Resident's service plan

Administrator (or Representative) _____ Date _____

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Residents should be assessed at least each time a change occurs in a resident's condition (change of condition assessment).

On 03/13/2024 at 11:20 AM Staff B, Administrator stated that when a resident needs to be monitored, care staff document (handwrite) on alert task sheets (FYI forms) and then they give the sheets to nursing staff. Nursing staff would make a note in their progress notes electronically. Staff F explained that care staff do not have access to document in progress notes electronically.

Resident 1

Review of Resident 1's face sheet showed they were admitted to the ALF on [redacted]/2022 with a diagnosis of [redacted] ([redacted]).

Review of Resident 1's most updated Service Plan dated 09/11/2023 showed that symptoms of fever, changes in appetite, and uncontrolled movements should be reported to the nurse.

Review of Resident 1's FYI forms (filled out by care staff) dated 02/03/2024 showed that Resident 1 was having fever of 100.4-102.3 (normal range 97.9- 98.6) throughout the evening shift, was unstable, had complaints of stomach pain, was extremely lethargic, and shaky.

Review of Progress notes documented by Staff A, Health and Wellness Director showed the following:

- On 02/03/2024 a caregiver reported to Staff A that Resident 1 was having symptoms of diarrhea, abdominal pain, and fever of 101.0. Tylenol was advised to give to Resident 1.
- On 02/04/2024 Resident 1 was tired.
- On [redacted]/2024 Resident 1 had pain and fever 0f 101.2. Resident 1 was sent to the hospital.

Review of Resident 1's medication administration record showed that there was an order to give Tylenol (medication to decrease fever) every 4 hours as needed for fever or pain.

On 02/29/2024 at 11:21 AM Staff D, Caregiver stated that she worked on [redacted]/2024 from 6:00 AM to 8:00 AM. Staff D expressed that Resident 1 could not sit up on their own, had complaints of back pain, and their lips were blue. Staff A was notified via radio and was told by Staff A that she would check on Resident 1, "I feel that [Resident 1] should have been assessed immediately."

On 03/13/2024 at 4:30 PM Staff C, Caregiver stated that she noticed that Resident 1

started to look "sick" and they stated that their "tummy hurt" on 02/02/2024, and verbally notified Staff A on 02/02/2024. On [redacted]/2024 at the beginning of her morning shift (arrived at 11:00 AM), she noticed Resident 1 was pale, lips were blue, complained of back pain, and was screaming. 911 was called by staff after lunch time.

On 03/25/2024 during a second interview at 4:15 PM Staff C stated that she also worked on 02/02/2024 and recalled that Resident 1 was at their usual baseline and went about their usual morning routine on 02/02/2024. Resident 1 was usually one of the first residents to get up out of bed in the mornings and ambulate with their walker to get coffee before breakfast.

Review of Resident 1's hospital record showed that Resident 1 arrived at the hospital on [redacted]/2024 at 1:07 PM and expired at 6:40 PM.

On 03/13/2024 at 1:04 PM Collateral Contact 1(CC1) stated that Resident 1 passed away on [redacted], at 6:40 PM. CC1 stated that the death certificate showed that Resident 1 passed away due to [redacted] ([redacted]), [redacted] ([redacted]), [redacted], and [redacted].

On 03/22/2024 at 1:30 PM Staff A stated that she was notified of Resident 1's condition on the morning of [redacted]/2024 via the FYI forms that the care staff filled out during their shifts over the weekend. Staff A explained that the FYI forms that are filled out by care staff are reviewed by nursing staff at beginning of each shift. If care staff feel that there is an immediate issue, they should be aware to call her directly. Staff A stated she was home on Saturday 02/03/2024 and Sunday 02/04/2024 and did not receive a call from any care staff. Resident 1's health care provider had not been notified regarding new onset of fever days prior. Staff A also stated that they did not have a process to initiate a Temporary Service Plan to specify what specifics for care staff to monitor. Staff used their "alert charting" FYI forms to communicate with staff to monitor the residents who need monitoring.

On 03/22/2024 at 1:30 PM Staff A stated that she was unaware that Resident 1 had not received Tylenol (medication to decease fever) on 02/03/2024 despite the documentation that showed Tylenol was advised for fever on 02/03/2024. Staff A expressed she assumed that the Med-tech on shift gave Tylenol for fever on 02/03/2024.

On 03/22/2024 at 4:02 PM Staff E, Caregiver stated that she worked on 02/03/2024 and filled out an "FYI form" that resident had fever, was very unstable, had complaints of stomach pain, and was extremely lethargic but did not call or speak to Staff A until [redacted]/2024.

This is a recurring deficiency previously cited on 06/28/2023.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2225	Compliance Determination # 37600
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 5 of 5	Licensee: Highgate Wenatchee LP	03/28/2024

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) 4/25/24 .

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

Administrator (or Representative) — Date: 4/19/24

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A Monitoring Resident's Well-Being

a. On 4/17/24 at the monthly Care Partner and Medication Aide meeting the Health Care Director will review Highgate policy and procedure for monitoring resident well-being including when to call the HD due to a significant change in condition. Team Member C, D, and E will attend this training.
b. Care Partners and Medication Aides who were not able to attend the meeting on 4/17/24 will meet with Health Care Director and/or Resident Care Coordinator to review Highgate policy and procedure for monitoring resident well-being including when to call HD due to a residents significant change in condition.
c. On 4/18/24 at the monthly All Team Meeting Executive Director will review the importance of informing Health Care Director immediately should a resident exhibit a significant change of condition. Symptoms to report to Health Care Director include fever, diarrhea, extreme pain, change in appetite, fatigue and lethargy.
d. Health Care Director and Resident Care Coordinator will review all current residents to verify that a change of condition assessment is not needed.
e. Each month the HD and RCC will audit current residents to verify they do not need be assessed for a change of condition. ED will be notified of audit outcome and corrective steps taken if required.