STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Park View Villas, LLC
Park View Villas
2020 A St Se Ste 101
Auburn, WA 98002

RE: Park View Villas License # 2332

Dear Administrator:

This letter addresses Compliance Determination(s) 30121 (Completion Date 09/25/2023) and 26946 (Completion Date 07/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/25/2023 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-2630-1-a

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Park View Villas
Provider Type: Assisted Living Facility
License/Cert.#: 2332
Compliance Determination #: 26946
Intake ID: 88734
Investigator: Phan Pham
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 07/18/2023 through 07/20/2023
Complainant Contact Date(s):

Allegation(s):

1) Resident rights - A staff member allegedly pulled Named resident.
2) Quality of care - Named resident was found with an injury to her arm.

Investigation Methods:

Sample:	Total residents: 30 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.
Interviews:	Named resident, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An on-site investigation was conducted, and the concerns related to 1) resident rights and 2) quality of care and treatments were reviewed. 1) The resident's care plan had interventions to ensure necessary care and services were being met. There were insufficient evidence to support resident's rights were being violated. 2) The facility failed to ensure staff members report injury of unknown source to the Department. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

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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 07/18/2023, 07/18/2023 and 07/18/2023 of:

Park View Villas
1430 Park View Lane
Port Angeles, WA 98363

This document references the following complaint number(s): 88734

The following sample was selected for review during the unannounced on-site visit: 4 of 30 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

07/26/2023
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) 8/1/23 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 observation, interview and record review, the assisted living facility failed to ensure staff members reported an injury of unknown origin directly to the Department's Complaint Resolution Unit (CRU) hotline for 1 of 4 residents (Resident 1) reviewed. This failure placed the resident at risk of abuse.

Findings included...

Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted] 2017 with diagnoses including [redacted].

Review of Resident 1's negotiated service plan, dated 03/03/2023, documented Resident 1 had memory problems and was able to make herself understood. Resident 1 required staff members assistance with transfers, toileting and bathing.

On 07/18/2023 at 11:40 AM, Resident 1 was observed in her room and neatly groomed. Resident 1 stated she had an injury to her arm, and it had been resolved. Resident 1 said she was not able to recall how the injury occurred.

Review of an incident investigation report, dated 07/04/2023 at 3:10 PM, documented Resident 1 stated she had obtained a bruise when a staff member assisted the resident out of the shower on the morning of 07/04/2023. The Registered Nurse observed the injury and documented Resident 1 had a reddish/purple bruise, four inches in width, extending the circumference of Resident 1's left upper arm. Staff members allegedly involved reported the injury had been there for over a week.

In an interview on 07/20/2023 at 10:53 AM, Staff A, Resident Care Director, stated on 07/04/2023 she was notified Resident 1 had an injury to her left arm. Staff A said she observed the resident's arm and noticed the resident had a reddish/purple skin discoloration approximately four to five inches in length covered the circumference of her upper left arm. Staff A stated she had spoken with the alleged staff members, and they reported the injury had been there for more than a week. Staff A said the characteristic of the injury showed that the injury was not new. Staff A stated staff members had been instructed to report injuries to Staff A when the injuries were discovered and to report to

the state CRU hotline.

In an interview on 07/20/2023 at 3:48 PM, Staff B, Caregiver, stated she assisted Resident 1 with a shower on 06/29/2023, noticed the injury on her left arm and reported to the Registered Nurse. Staff B said she observed the residents' skin when assisting residents and reported injuries to the Registered Nurse. Staff B stated she had not been trained to report injury of unknown source to the state CRU hotline.

In an interview on 07/20/2023 at 4:06 PM, Staff C, Medication Tech, stated she assisted Resident 1 in June 2023 and noticed the resident had a bruise around her upper left arm. Staff C said she asked Resident 1 about the injury and the resident was not able to articulate how the injury occurred. Staff C stated she reported the resident's injury to the Registered Nurse. Staff C said she had been instructed to report injuries of unknown source to the Registered Nurse and/or the Executive Director.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) 8/31/23 .

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

Administrator (or Representative) — Date: 8/1/23