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

Caring Places Management, LLC
Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

RE: Riverside Place License # 2363

Dear Administrator:

This letter addresses Compliance Determination(s) 25065 (Completion Date 06/07/2023) and 22067 (Completion Date 03/28/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/07/2023 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-2160

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

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverside Place
Provider Type: Assisted Living Facility
License/Cert.#: 2363
Compliance Determination #: 22067
Intake ID: 74498
Investigator: Phan Pham
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/28/2023 through 03/28/2023
Complainant Contact Date(s):

Allegation(s):

1) Quality of care - Residents were not being assisted with incontinent care and soaked in urine.
2) Resident rights - Residents were being neglected.

Investigation Methods:

Sample:	Total residents: 28 Resident sample size: 5 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, and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An investigation was conducted, and allegation identified in the intake related to1) Quality of care and services and 2) Resident rights were reviewed. The facility failed to ensure staff members provided incontinent care as agreed upon the service agreement. 2) Resident rights were reviewed and there was insufficient evidence to support failed facility practice. Additional residents reviewed for care, services and resident rights 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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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2363	Compliance Determination # 22067
Plan of Correction	Riverside Place	Completion Date
Page 1 of 4	Licensee: Caring Places Management, LLC	03/28/2023

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 03/28/2023, 03/28/2023 and 03/28/2023 of:

Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

This document references the following complaint number(s): 74498

The following sample was selected for review during the unannounced on-site visit: 5 of 28 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, Suite 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

04/06/2023
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)

4.14.23
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff members provided incontinent care as agreed upon in the Negotiated Service Agreement for three of five sampled residents (Resident 1, Resident 2 and Resident 3) reviewed. This failure placed the residents at risk for sustaining skin break down and a decreased quality of life.

Findings included...

Review of a 24-hour staff communication form, dated 03/14/2023, showed Staff C, Caregiver, documented it was in the residents' care plans that staff "Need to be changing every incontinent resident. No reason they should be sleeping in a soaked bed." The form was read and signed by Staff G, Activity Director.

In an interview on 03/28/2023 at 11:20 AM, Staff G said she read and signed the 24-hour communication form dated 03/14/2023. Staff G stated she did not do anything with the information.

Resident 1 (R1)

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2022 with diagnoses including [redacted]. Review of Resident 1's resident service agreement, dated 03/21/2023, documented Resident 1 required staff assistance with her activities of daily living, toileting and changing her incontinent products at night.

On 03/28/2023 at 11:15 AM, R1 was observed sitting in the dining room and neatly groomed. During an interview the resident said she needed staff assistance with toileting and was wet at night. The resident was not able to provide additional details of the incidents.

In the interviews on 03/28/2023 at 8:41 AM and 11:26 AM, Staff C, stated on 03/21/2023 and 03/23/2023 around 7:15 AM Staff C assisted R1 to get up in the morning and she observed urine had completely soaked through the resident's incontinent products and the chuck pad. Staff C said R1 had urine up to her shoulder and her beddings were wet. Staff C stated she had witnessed residents being soaked in urine when she started her shift in the morning for the past two to three months and had informed management staff members.

Resident 2 (R2)

Review of Resident 2's face sheet showed the resident admitted to the facility on [redacted]/2021 with diagnoses including [redacted]. Review of R2's resident service agreement, dated 09/16/2022, documented R2 required staff assistance with his activities of daily living. On 02/13/2023 R2's service agreement was updated to include when checking for the resident's safety from 10:00 PM to 6:00 AM, staff were to check R2 for toileting needs.

On 03/28/2023 at 8:40 AM, Resident 2 was observed in bed and covered with blankets. The resident was not able to provide information related to the care and services received.

In an interview on 03/28/2023 at 8:57 AM, Staff F, Caregiver, stated on 03/27/2023 about 7:30 AM she assisted R2 and observed the resident had urine up to his back and R2's incontinent products, chuck pad, clothes and beddings were soaked in urine. Staff F said she had witnessed R2 being soaked in urine couple times a week for the last couple months. Staff F stated she had notified the previous shift caregivers and management staff members.

In an interview on 03/28/2023 at 9:21 AM, Staff D, Caregiver, said early morning on 03/22/2023 she assisted R1 and R2, and witnessed the residents' incontinent products, clothes, their backs and beddings were soaked with urine. Staff D stated she had observed residents being soaked in urine for the last couple months. Staff D said she had notified management staff members. Staff D stated R1 and R2 needed assistance with toileting and staff members were responsible to check and change every two hours.

Resident 3 (R3)

Review of Resident 3's face sheet showed the resident admitted to the facility on [redacted]/2019 with diagnoses including [redacted]. Review of R3's resident service agreement, dated 01/11/2023 documented R3 was incontinent of urine and required assistance with toileting, monitoring for dryness and changing of her incontinent products. Staff members were to check R3 and make sure the resident's incontinent products were clean and dry.

On 03/28/2023 at 11:05 AM, Resident 3 was observed in the dining room and neatly groomed. R3 said she needed assistance to toileting and was not able to provide information related to the care and services received.

In an interview on 03/28/2023 at 8:28 AM, Staff E, Caregiver, said early morning two weeks prior, for two days, she assisted R3 and witnessed the resident's incontinent products, clothes, and beddings were soaked with urine. Staff E stated she reported to management staff members. Staff E said R1, R2, and R3 needed assistance with toileting and incontinent care. Staff E stated residents' negotiated service agreement had the information on the care and services each resident needed. Staff E said caregivers were supposed to assist residents with incontinent care and were to follow the negotiated service agreements when assisting residents.

In an interview on 03/28/2023 at 11:26 AM, Staff C, said on 03/20/2023 and 03/21/2023 around 7:30 AM Staff C assisted R3 and observed urine had soaked through the resident's incontinent products and the chuck pad. Staff C said R3 had urine up to her back and R3's beddings were wet. Staff C stated caregivers were responsible for assisting residents with

incontinent care and keeping the residents dry. Staff C said the resident's negotiated service agreement had information on the care and services each resident needed, and staff members were supposed to read and follow the services agreement. Staff C stated management staff verbally informed caregivers in standup meetings when updates were being made to the residents' service agreements.

In an interview on 03/28/2023 at 11:38 AM, Staff B, Resident Care Coordinator, said staff members had not brought to her attention that residents were soaked in urine. Staff B stated the residents required staff members assistance with toileting and incontinent care. Staff B said residents were on a two-hour check and change program and care staff members were responsible for assisting the residents. Staff B stated care staff members had been trained to review and follow the residents' negotiated service agreements when assisting residents. Staff B said she routinely communicated with staff members and observed residents to ensure services were being provided. Staff B stated Staff G should have communicated with her when asked about the 24-hour communication form dated 03/14/2023.

In an interview at 11:58 AM, Staff A, Executive Director, said staff members had been reporting residents were being found soaked in urine and she had spoken to the alleged staff members.

This is a recurring deficiency previously cited on 03/10/2021.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) May 10th 2023

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

Administrator (or Representative) — Date: 4.14.23

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