STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Santé Shoreline ALF Op Co LLC
Laurel Cove Community
17201 15th Ave NE
Shoreline, WA 98155

RE: Laurel Cove Community License # 2389

Dear Administrator:

This letter addresses Compliance Determination(s) 45153 (Completion Date 08/05/2024) and 40587 (Completion Date 06/13/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/05/2024 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-2660-1, WAC 388-78A-2660-4, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-5

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Laurel Cove Community
Provider Type: Assisted Living Facility
License/Cert.#: 2389
Compliance Determination #: 40587
Intake ID: 128134
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 04/30/2024 through 06/13/2024
Complainant Contact Date(s):

Allegation(s):

1. Named Resident 1 (NR1) was found in Named Resident (NR2) ‘s bed with them, indecently exposed.

Investigation Methods:

Sample:	Total residents: 65 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Incident investigation State reporting log Resident Records

Investigation Summary:

1. In an interview, NR1 nor NR2 recalled the events surrounding the incident. The ALF completed an investigation. NR1 and NR2's family representatives reported not being notified by the ALF staff about the incident. Record review showed the ALF failed to assess and care plan for NR1's sexual behaviors placing the resident and other memory care residents at risk for sexual assault. Failed practice identified. See Statement of Deficiency dated 06/13/2024.

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: Laurel Cove Community
Provider Type: Assisted Living Facility
License/Cert.#: 2389
Compliance Determination #: 40587
Intake ID: 126614
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 04/30/2024 through 06/13/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) was startled by staff, slipped and fell back, resulting in injuries .

Investigation Methods:

Sample:
Total residents: 65
Resident sample size: 4
Closed records sample size: 1

Observations:
Residents
Resident to resident interactions
Staff to resident interactions

Interviews:
Nursing staff
Family members
Social services staff

Record Reviews:
State reporting log
Incident investigation
Resident Records

Investigation Summary:

1. Interview and record review showed the NR had no initial injuries. Later in the same morning the NR began to experience pain, the ALF called 911 and the resident was transported to the emergency department. The NR was hospitalized for fractures. The ALF discharged the NR, while hospitalized, due to the physical aggression on the memory care unit. The ALF failed to ensure a written discharge notice was given to the resident or resident representative explaining the reason for discharge and the location where the resident would move. This caused the NR to be displaced and remain in the hospital for additional days due to being discharged from the ALF. Failed practice identified. See Statement of Deficiency dated 06/13/2024.

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2389	Compliance Determination # 40587
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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 04/30/2024, 04/30/2024, 05/16/2024 and 05/16/2024 of:

Laurel Cove Community
17201 15th Ave NE
Shoreline, WA 98155

This document references the following complaint number(s): 128134, 127588, 127463, 126701, 125557, 126614

The following sample was selected for review during the unannounced on-site visit: 4 of 65 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

6/18/2024
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.

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Administrator (or Representative) Chelsea Seu

Date 6-25-2024

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) violated 1 of 1 resident's (Resident 3) rights when they discharged him without documented cause or a written notice. This failure caused Resident 3 to be unable to return to his home, remain hospitalized for an extended period of time, and violated his rights.

Findings included...

NOTE: Revised Code of Washington 70.129.110 - Disclosure, transfer, and discharge requirements. (3) Before a long-term care facility transfers or discharges a resident, the facility must: (a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident; (b) Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; (c) Record the reasons in the resident's record; and (d) Include in the notice the items described in subsection (5) of this section. (4)(a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged. (b) Notice may be made as soon as practicable before transfer or discharge when: (i) The safety of individuals in the facility would be endangered; (ii) The health of individuals in the facility would be endangered; (iii) An immediate transfer or discharge is required by the resident's urgent medical needs; or (iv) A resident has not resided in the facility for thirty days. (5) The written notice specified in subsection (3) of this section must include the following: (a) The reason for transfer or discharge; (b) The effective date of transfer or discharge; (c) The location to which the resident is transferred or discharged; (d) The name, address, and telephone number of the state long-term care ombuds.

Record review of an undated Face Sheet, showed the ALF admitted Resident 3 on [redacted]/2024 with multiple medical diagnoses including [redacted]. Review of an Assessment, dated 03/01/2024, showed Resident 3 had behaviors that placed himself or others at risk but did not list what behaviors they were. Review of an Individual Service Care Plan (equivalent to Negotiated Service Agreement ((NSA)), undated, showed no listed behavioral disturbances that required interventions or would be a risk to himself or other residents. The

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Assessment and NSA showed Resident 3 was independent or minimum assist with all activities of daily living.

Record review of an Incident Report and Investigation, dated [redacted]/2024, showed that Resident 3 had a fall, resulting in increased pain later in the day. The ALF staff called 911 and Resident 3 was transported to the emergency department. Resident 3 was admitted to the hospital and diagnosed with [redacted].

In an interview, on 05/23/2024 at 1:41 PM, Collateral Contact 1 (CC1 – Hospital Social Worker) stated that Resident 3 was scheduled to return to the ALF on [redacted]2024 and was at baseline functioning and care level. CC1 stated she had not spoken to anyone at the ALF and that no one from the ALF came to assess Resident 3 for discharge. CC1 stated Resident 3's Family Representative informed her, on [redacted]/2024, that the ALF would not allow the resident to return and the family would need to find placement. CC1 reported that the ALF did not send a discharge notice to Resident 3 while in the hospital. CC1 stated that because the ALF would not let him return, he remained medically stable in the hospital for an additional five days. CC1 stated Resident 3 was not experiencing behavior issues and was easily re-directable at the time of his hospital discharge. CC1 stated Resident 3 was not aggressive and was safe to return to the ALF.

In an interview, on 05/21/2024 at 10:30 AM, Collateral Contact 2 (CC2- Resident 3's Family Representative) stated that the ALF told the family on 04/16/2024 that Resident 3 could return. CC2 stated that she was notified by the ALF, on [redacted]/2024, that Resident 3 could not return because he was aggressive without one-to-one care. CC2 stated that Resident 3 lived at the ALF for less than a month and they had not been notified about aggressive behaviors before his hospitalization. CC2 stated that she had not received a written discharge/transfer notice that Resident 3 could not return.

Review of Resident 3's ALF records showed no documentation, progress notes, incident reports, care plans, etc., that showed combative or aggressive behaviors. Review of Resident 3's Bedside Individual Care Service Plan (a condensed version equivalent to the Negotiated Service Agreement-NSA), dated from 03/21/2024, showed no documentation of any behavior issues that would place himself or other residents at risk or require one on one care. There was no other documentation that showed the safety of the individuals in the ALF were at risk. The records showed the ALF made no attempts to reasonably accommodate, if Resident 3 was having combative and aggressive behaviors, to avoid discharge such as communication with physician, behavioral health, or other non-pharmaceutical re-direction. There was no discharge/transfer letter for Resident 3, detailing the reason for the ALF not allowing Resident 3 to return in his records.

In an interview, on 05/22/2024 at 10:50 AM, Staff B (Director of Nurses) stated that Resident 3 could not return to facility because he was combative and aggressive towards other residents. Staff B confirmed she had not re-assessed or visited Resident 3 at the hospital. When asked if there was any documentation regarding Resident 3's behaviors. Staff B referred only to the Bedside Individualized Service Plan which did not have any information or details showing Resident 3 had behavior issues. Staff B stated a discharge notice had not been issued to Resident 3 or their representative.

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In an interview, on 05/22/2024 at 2:36 PM, Staff D (Business Office Manager) stated that Resident 3 did not have discharge notice in their file.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 7/2/2024 .

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

Administrator (or Representative) — Date: 6/21/2024

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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

(ii) 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 interview and record review, the Assisted Living Facility (ALF) failed to complete an Assessment that identified behavior issues, when a sampled resident (Resident 1) exhibited inappropriate sexual behaviors towards other residents. This failure placed Resident 1 at risk of not receiving care specific to behavioral needs and placed 7 of 7 male residents at risk of sexual assault.

Findings included...

Note:
Washington Administrative Code 388-78A-2090 Full assessment topics. (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (a) History of substance abuse; (b) History of harming self, others, or property; or (c) Other conditions that may require

behavioral intervention strategies.

Record review of an Event Report,
dated 05/02/2024, showed Resident 1 was found by the ALF staff indecently exposed in bed with another resident. The Event Report showed that the staff reported Resident 1 had a pattern of continued inappropriate sexual behaviors with a history of making sexual advances toward other male residents in the Memory Care Unit (MCU). Resident 1's Individualize Care Service Plan (equivalent to a Negotiated Service Agreement), undated, did not show documentation or interventions for Resident 1's inappropriate sexual behaviors.

Record review of an undated Face Sheet, showed the ALF admitted Resident 1 to the MCU on [redacted]/2023 with multiple medical diagnoses including [redacted]. Record review of an Assessment under Behavior Intervention Record, dated 04/23/2024, showed Resident 1 had two episodes of wandering into other resident's rooms. The Assessment showed Resident 1 required monitoring for aggressive or abusive behavior towards other residents or self. Individual
Care Service Plan, undated, showed no listed behavioral disturbances that required interventions or would be a risk to Resident 1 or other residents.

Record review of an Event Report, dated 05/02/2024,
showed Resident 1 was found on 04/22/2024, by the ALF staff indecently exposed, undressed from the waist up, in bed with Resident 2. The Event Report showed that the staff reported to ALF management that Resident 1 had continued to exhibit inappropriate sexual behaviors and made sexual advances towards other male residents in the MCU.

In an interview, on
05/21/2024 at 9:54 AM, Collateral Contact 3 (CC3 – Resident 1's Family Representative) stated that he had not been notified by the ALF that Resident 1 was found in Resident 2's bed indecently exposed on 04/22/2024. However, CC3 stated that this was not the first time Resident 1 had exhibited sexual behaviors toward other male residents in the unit. CC3 stated the ALF had ensured him that interventions were in place to prevent Resident 1's sexual behaviors from happening, however it continues to be a problem.

Record review showed the
Assessment did not identify problem behaviors. Review of the NSA showed it no longer addressed the resident's current needs regarding sexual behaviors therefore requiring a new assessment.

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In an interview, 06/07/2024
at 11:31 AM, Staff A
(Executive Director) stated that it was previously reported that Resident 1 had made sexual advances towards other residents. Staff A confirmed Resident 1's Assessment was not updated to reflect identified behaviors.

This deficiency was previously cited on
02/01/2023.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 7/2/2024 .

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

Chelsea Sue — Administrator (or Representative)

6/25/2024 — Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement included a plan to monitor and address interventions for identified behavior issues, when a sampled resident (Resident 1) exhibited inappropriate sexual behaviors towards Resident 2. This failure placed Resident 1 at risk of not receiving

care specific to behavioral needs and placed 7 of 7 male residents at risk of sexual abuse.

Findings Included...

Record review of an undated Face Sheet, showed the ALF admitted Resident 1 to the MCU on [redacted]/2023 with multiple medical diagnoses including [redacted].

Record review of an Event Report, dated 05/02/2024, showed Resident 1 was found on 04/23/2024, by the ALF staff indecently exposed, undressed from the waist up, in bed with Resident 2. The Event Report showed that the staff reported to ALF management that Resident 1 had continued to exhibit inappropriate sexual behaviors and made sexual advances towards other male residents in the MCU.

In an interview, on 05/21/2024 at 9:54 AM, Collateral Contact 3 (CC3 – Resident 1's Family Representative) stated that he had not been notified by the ALF that Resident 1 was found in Resident 2's bed indecently exposed on 04/22/2024. However, CC3 stated that this was not the first time Resident 1 had exhibited sexual behaviors toward other male residents on the unit. CC3 stated the ALF had ensured him that interventions were in place to prevent Resident 1's sexual behaviors from happening, however it continues to be a problem.

In an interview, 06/07/2024 at 11:31 AM, Staff A (Executive Director) stated that it was previously reported that Resident 1 had made sexual advances towards other residents.

Resident 1's Individualize Service Care Plan (equivalent to a Negotiated Service Agreement), undated, did not include any information regarding Resident 1's pattern of inappropriate sexual behaviors. The Care plan did not include how to monitor, address or interventions related to inappropriate sexual behaviors.

This deficiency was previously cited on 02/01/2023.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 7-2-2024.

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

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Chelsea Sun — Administrator (or Representative)

6/25/2024 — Date