STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Legacy1864, LLC
Willow Grove
1620 E Mead St
Spokane, WA 99218

RE: Willow Grove License # 2399

Dear Administrator:

This letter addresses Compliance Determination(s) 36145 (Completion Date 01/31/2024) and 34293 (Completion Date 01/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/31/2024 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-2660-2, WAC 388-78A-2660-4, WAC 388-78A-2660-6, RCW 70.129.100.1

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

S. Jm

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Willow Grove
Provider Type: Assisted Living Facility
License/Cert.#: 2399
Compliance Determination #: 34293
Intake ID: 108904
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/21/2023 through 01/02/2024
Complainant Contact Date(s):

Allegation(s):
1 - Facility staff don't allow resident(s) to have access to their snacks

Investigation Methods:

Sample:	Total residents: 18 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents' well-being Any unmet residents' needs Staff's interactions with residents and response to their needs
Interviews:	Four residents, including alleged victim Four facility caregivers Dietary Supervisor Two Collateral Contacts Director of Care/Administrator Designee
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, and Progress Notes Behavior monitoring sheets for sampled resident House Rules Admission Agreement Staffing schedule Three sampled staff credentials

Investigation Summary:
1 - Snacks purchased by residents, including named resident, were observed stored in a locked room which was also used to store medications and supplies. Alleged victim (AV) stated the staff sometimes did not allow them to have the snacks they bought. Staff interviews and review of Progress Notes pertaining to AV showed staff sometimes did not allow AV to have the snacks they bought because the AV stood in the doorway of the room where medications were stored, or because staff was concerned about the resident eating snacks containing too much sugar. A counselor and the Administrator Designee stated the facility did not allow the AV to keep snacks in their apartment because of sanitation concerns. The facility failed to allow AV's access to snacks they

bought (i.e. their personal property). Failed facility practice was found and documented in a Statement of Deficiencies under Washington Administrative Code 388-78a-2660(1)(2)(4)(6) Resident rights with reference to Revised Code of Washington 70.129.100 Personal property.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2399	Compliance Determination # 34293
Plan of Correction	Willow Grove	Completion Date
Page 1 of **4**	Licensee: Legacy1864, LLC	01/02/2024

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 12/21/2023, 12/21/2023 and 01/02/2024 of:

Willow Grove
1620 E Mead St
Spokane, WA 99218

This document references the following complaint number(s): 108904

The following sample was selected for review during the unannounced on-site visit: 4 of 18 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S M
Residential Care Services

01/11/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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Statement of Deficiencies Plan of Correction Page 2 of 4	License #: 2399 Willow Grove Licensee: Legacy1864, LLC	Compliance Determination # 34293 Completion Date 01/02/2024

Ashley Bennett
Administrator (or Representative)

1/17/2024
Date

RCW 70.129.100 Personal property -- Storage space.

(1) The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

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

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

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

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide a resident with snacks they had purchased for 1 of 4 sampled residents (Resident 3). This failure resulted in a violation of the resident's right to retain their personal property.

Findings included...

Resident 3's Behavior Support Plan (BSP), dated 07/03/2023, showed they experienced anxiety. The BSP further showed Resident 3 made unhealthy food choices, and their issues around eating could trigger constant need for reassurance and problems with aggression.

Review of Resident 3's Progress Note, dated 11/07/2023 at 9:15 PM, showed that Staff B, Caregiver, documented that Resident 3 voiced feeling that staff did not like them because staff did not give them their own snack consisting of "sugary cookies". The note further showed staff explained "we needed to make healthier choices for [Resident 3's] body."

Review of Resident 3's Progress Note, dated 11/14/2023 at 6:30 PM, showed that Staff B documented that Resident 3 yelled at staff members and stated staff did not like [Resident 3] when staff did not give the resident their "personal snack due to the sugars in them". The note further showed staff explained to Resident 3 why the snacks were unhealthy.

Administrator (or Representative) Date

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Review of Resident 3's Progress Note, dated 11/24/2023 at 8:15 PM, showed that Staff D, Caregiver, documented that due to Resident 3's behaviors that day, such as sleeping through an activity, swearing, and yelling, the resident could have the "house snack" instead of their "personal snack".

Review of Resident 3's Progress Note, dated 12/18/2023 at 9:00 PM, Staff C, Caregiver, documented that staff would "hold off" on giving Resident 3 their personal snack and gave the resident the "facility snack" instead because the resident "overstepped a boundary" by being in the medication room. Staff C noted this resulted in the resident getting upset and raising their voice at staff.

In an interview on 12/21/2023 at 11:05 AM, Resident 3 stated they sometimes bought their own snacks which the staff kept locked up. Resident 3 stated staff did not allow them to have the snacks if they were "rude to [staff]" and looked in the medication room. Resident 3 further stated staff limited access to personal snacks because of concern that the resident could become diabetic. Resident 3 stated, "It made me cry" when staff took chocolate away from them.

Observation on 12/21/2023 at 11:35 AM showed snacks, such as boxes of honey-oat bars and juice, were labelled with Resident 3's name and kept locked up in the medication room.

In an interview on 12/21/2023 at 11:35 AM, Staff C stated residents, whose own snacks were kept locked up in the medication room, were not allowed to independently access the snacks there, because of safety concerns since medications and care supplies were also stored in the room.

In an interview on 12/21/2023 at 12:50 PM, Staff C stated they did not allow Resident 3 to have their personal snacks on 12/18/2023, because the resident entered the medication room.

In an interview on 12/20/2023 at 8:30 AM, Collateral Contact 1 stated that snacks purchased by residents were considered the residents' personal property and they were concerned that prohibiting residents' access to their snacks could be a resident rights issue.

In an interview on 12/28/2023 at 1:15 PM, Collateral Contact 2 stated the facility did not negotiate Resident 3's access to the snacks they purchased related to the facility's concerns over the resident's problem behaviors and poor blood sugar control.

In an interview on 01/02/2024 at 11:35 AM, Staff C stated staff limited Resident 3's access to their personal snacks due to concerns of the resident's risk for developing diabetes, and the resident's history of storing food in their apartment in an unsanitary manner. Staff C stated the facility previously allowed Resident 3 access to the snacks they purchased and

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was uncertain when the practice was changed and who initiated limiting the resident's access to their snacks.

In an interview on 01/02/2024 at 11:45 AM, Staff D stated they did not recall Resident 3's physician or counselor providing the facility with specific instructions regarding the resident's access to their personal snacks.

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 01/26/2024.

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

Ashley Bennett 01/17/2024

Administrator (or Representative) Date

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