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) 34287 (Completion Date 12/04/2023) and 29823 (Completion Date 10/05/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/04/2023 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-2600-2-j-iii, WAC 388-78A-2600-2-j-ii, WAC 388-78A-2600-2-j-i, WAC 388-78A-2600-2-j, WAC 388-78A-2600-1-a, WAC 388-78A-2660-3, WAC 388-78A-2130-1-c

The Department staff who did the on-site verification:
Antonietta Lettieri-Parkin, Long Term Care Surveyor

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

Sincerely,

S.M

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 #: 29823
Intake ID: 98115
Investigator: Antonietta Lettieri-Parkin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 09/21/2023 through 10/05/2023
Complainant Contact Date(s): 09/21/2023, 09/29/2023

Allegation(s):

1) Resident was restrained for aggressive behavior.
2) The facility refused to take a resident back into the facility without a dictated medication regimen for challenging behavior.

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 3 Closed records sample size: 0
Observations:	Named and sampled residents. Staff and resident interactions. Facility environment.
Interviews:	Named and sampled residents. Facility staff and residents. Two others not associated with the facility.
Record Reviews:	Named and sampled resident files. Ancillary provider medical records for the named resident.

Investigation Summary:

1. The named resident had a recurrent medical condition that caused confusion, behavioral changes and aggression. During two separate episodes of aggression, facility staff documented the resident was restrained on one occasion and verbally stated and documented the resident was restrained on another. Deficient practice identified. The facility was cited for WAC 388-78A-2600 Policies and procedures, SOD dated 09/29/2023.
2. The named resident's assessments identified the medical condition and that it could cause behavior disturbances, including aggression. The facility failed to identify and document care and services necessary in the care plan that had been identified in assessment and failed to implement behavioral interventions for staff to utilize. Deficient practice identified. The facility was cited for WAC 388-78A-2140, Negotiated service agreement contents, SOD dated 09/28/2023.

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

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2399	Compliance Determination # 29823
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Page 1 of 10	Licensee: Legacy1864, LLC	10/05/2023

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 09/21/2023 and 09/21/2023 of:

Willow Grove
1620 E Mead St
Spokane, WA 99218

This document references the following complaint number(s): 98115

The following sample was selected for review during the unannounced on-site visit: 3 of 19 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Antonietta Lettieri-Parkin, Long Term Care Surveyor

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

12/20/2023
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) 10/17/23 Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop, implement policies and provide training on what staff must do to address aggressive behavior related to a medical condition for 1 of 1 resident (Resident 1). These failures contributed to Resident 1 being manually and physically restrained by untrained staff, transferred to the emergency room and placed Resident 1 at risk of physical and psychological harm.

Findings included...

Review of the facility's undated policy "Managing an Assaulting/Aggressive Resident," showed should a resident become hostile or unmanageable in any way that jeopardizes his/her safety or safety of others, staff will immediately move residents away from the scene, attempt to calm the resident, and notify administration of the event for further evaluation and intervention. The policy further showed if the threat of physical harm to another resident or a staff member appears to be imminent, the appropriate law enforcement agency was to be immediately summoned. Review of the policy did not identify staff interventions on how to immediately diffuse an aggressive or assaultive resident while waiting for law enforcement.

Review of Resident 1's Assessment and Preliminary Service Plan, dated 07/18/2023, showed the following:

-Resident had a diagnosis of [redacted].

-Resident had recurrent urinary tract infections (UTIs, a urinary infection that causes sudden confusion in people with dementia, including a sudden change in behavior such as aggression).

-Resident experienced anxiety (nervousness and worry) and agitation.

Review of Resident 1's Observations (the facility's titled progress notes), dated 08/20/2023 through 09/07/2023, showed the following:

-08/21/2023, Fax sent to Resident 1's provider requesting a UA (urine analysis) order to rule out UTI. Resident 1 has had an increase in agitation the past week and a half, incontinence, and frequency with little urine output. No follow up was noted.

-08/30/2023, Resident backed staff into a corner in their room, eloped, pushed, hit, and kicked. "We tried to restrain [Resident 1] and was grabbing and hitting all of us. With all three of us trying to restrain [Resident 1], [Resident 1] was still hitting and kicking us. We wrestled [Resident 1] on to [their] bed, quickly left the room and closed [Resident 1's] door." Staff contacted Resident 1's family member to come to the facility to calm Resident 1 down. Resident 1's family member obtained a UA test for Resident 1 which tested positive for a UTI. Family member obtained antibiotics for treatment.

-09/06/2023, Resident had a behavioral outburst "that exploded into a physical altercation with staff." Resident threw items in their room, rearranged items, jiggled their bathroom doorknob to where others in the facility could hear it. Staff shut the door and backed out. Resident kicked their door; it cracked on the bottom and broke through. A staff member (Staff B, Maintenance) moved a recliner in front of Resident 1's door. When the recliner was moved, Resident 1 exited the room with fist raised. Staff B stepped in front of Resident 1 who started swinging [his fist] and wrestling Staff B. They eventually went down to the ground and Staff B had no other options to hold Resident 1. 911 was called. Law enforcement responded and Resident 1 was taken to a local hospital for an evaluation.

-09/13/2023 IR (facility incident report). Review of an IR dated 09/13/2023 stated staff went into Resident 1's room to clean. The resident exited and re-entered the room, blocked staff into a closet, while holding a side table for 30 seconds. Staff were able to walk out. Resident 1 began charging other staff, pinned them against the wall, causing another staff member to scream. The scream startled Resident 1 who then left the area. Staff called 911 and the resident was taken to a local hospital for an evaluation.

Review of medical records obtained from that local ER, dated 09/13/2023, showed the

following:

-11:48 AM, Resident 1 arrived at the ER for an altered mental status via ambulance.

-3:58 PM, ER received a call from Resident 1's family member who stated Resident 1 recently had a UTI and it took them a long time to recover.

-4:27 PM, Social Work. EMS reported to ER registered nurse that facility reported they had to place Resident 1 in a headlock to subdue them.

History and physical (H&P) summary, dated 09/13/2023, noted "contrary to triage note [Resident 1] is not here for confusion. The patient is here because [they] became aggressive towards 1 other staff member. It sounds like [they] either pushed a staff member had some verbal or physical altercation and paramedics report [Resident 1] was put in a head lock in an attempt to protect some other female staff member."

In an interview on 09/21/2023 at 9:03 AM, Collateral Contact 1 (CC1) stated that when Resident 1 was brought to the emergency room (ER) on 09/13/2023, emergency medical service (EMS) staff stated the facility staff reported that they have had to place Resident 1 in a "headlock" to subdue the resident.

In an interview on 09/26/2023 at 1:30 PM, Staff A was asked about restraining Resident 1 as noted and documented in the resident's observation/progress and specifically about "wrestling" and "restraining" Resident 1. Staff A confirmed Staff B was involved in the hold of Resident 1 on 09/06/2023, stating "it was an impulse." Staff A stated the "hold" during the 09/06/2023 incident included Staff B wrapping their legs around Resident 1's legs and using their arm to hold down Resident 1's upper body. Staff A stated facility staff are not trained specifically on physical de-escalation or re-directive techniques.

In an interview on 10/05/2023 at 2:35 PM, Staff B stated he had not received physical intervention training at the facility but did do martial arts and self-defense classes. Staff B further stated their spouse was a caregiver for individuals with "high behaviors."

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) 11/17/23 .

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

Administrator (or Representative) 10/17/23 Date

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

(3) Not use restraints on any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a resident was not restrained by untrained staff for 1 of 1 resident (Resident 1). These failures contributed to Resident 1 being manually and physically restrained by untrained staff on multiple occasions and needing to be transferred to the emergency room.

Findings included...

Review of the facility's undated policy "Managing an Assaulting/Aggressive Resident," showed should a resident become hostile or unmanageable in any way that jeopardizes his/her safety or safety of others, staff will immediately move residents away from the scene, attempt to calm the resident, and notify administration of the event for further evaluation and intervention. The policy further showed if the threat of physical harm to another resident or a staff member appears to be imminent, the appropriate law enforcement agency was to be immediately summoned. Review of the policy did not identify staff interventions on how to immediately diffuse an aggressive or assaultive resident while waiting for law enforcement.

Review of Resident 1's Assessment and Preliminary Service Plan, dated 07/18/2023, showed the following: The resident had a diagnosis of [redacted].
Resident 1 experienced anxiety (nervousness and worry) and agitation.

Review of Resident 1's Observations (the facility's titled progress notes), dated 08/20/2023 through 09/07/2023, showed the following:

-08/30/2023, Resident backed staff into a corner in their room, eloped, pushed, hit, and kicked. "We tried to restrain [Resident 1] and was grabbing and hitting all of us. With all three of us trying to restrain [Resident 1], [Resident 1] was still hitting and kicking us. We wrestled [Resident 1] on to [their] bed, quickly left the room and closed [Resident 1's] door." Staff contacted Resident 1's family member to come to the facility to calm Resident 1 down.

-09/06/2023, Resident had a behavioral outburst "that exploded into a physical altercation with staff." Resident threw items in their room, rearranged items, jiggled their bathroom doorknob to where others in the facility could hear it. Staff shut the door and backed out. Resident kicked their door; it cracked on the bottom and broke through. A staff member (Staff B, Maintenance) moved a recliner in front of Resident 1's door. When the recliner was moved, Resident 1 exited the room with fist raised. Staff B stepped in front of Resident 1 who started swinging [his fist] and wrestling Staff B. They eventually went down to the ground and Staff B had no other options to hold Resident 1. 911 was called. Law enforcement responded and Resident 1 was taken to a local hospital for an evaluation.

-09/13/2023 IR (facility incident report). Review of an IR dated 09/13/2023 stated staff went into Resident 1's room to clean. The resident exited and re-entered the room, blocked staff into a closet, while holding a side table for 30 seconds. Staff were able to walk out. Resident 1 began charging other staff, pinned them against the wall, causing another staff member to scream. The scream startled Resident 1 who then left the area. Staff called 911 and the resident was taken to a local hospital for an evaluation.

Review of medical records obtained from that local ER, dated 09/13/2023, showed the following:

-4:27 PM, Social Work. EMS reported to ER registered nurse that facility reported they had to place Resident 1 in a headlock to subdue them.

History and physical (H&P) summary, dated 09/13/2023, noted "contrary to triage note [Resident 1] is not here for confusion. The patient is here because [they] became aggressive towards 1 other staff member. It sounds like [they] either pushed a staff member had some verbal or physical altercation and paramedics report [Resident 1] was put in a head lock in an attempt to protect some other female staff member."

In an interview on 09/21/2023 at 9:03 AM, Collateral Contact 1 (CC1) stated that when Resident 1 was brought to the emergency room (ER) on 09/13/2023, emergency medical service (EMS) staff stated the facility staff reported that they have had to place Resident 1 in a "headlock" to subdue the resident.

In an interview on 09/26/2023 at 1:30 PM, Staff A was asked about restraining Resident 1 as noted and documented in the resident's observation/progress and specifically about "wrestling" and "restraining" Resident 1. Staff A confirmed Staff B was involved in the hold of Resident 1 on 09/06/2023, stating "it was an impulse." Staff A stated the "hold" during the 09/06/2023 incident included Staff B wrapping their legs around Resident 1's legs and using their arm to hold down Resident 1's upper body. Staff A stated facility staff are not trained specifically on physical de-escalation or re-directive techniques.

In an interview on 10/05/2023 at 2:35 PM, Staff B stated he had not received physical intervention training at the facility but did do martial arts and self-defense classes. Staff B further stated their spouse was a caregiver for individuals with "high behaviors."

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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) 11/17/23.

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

Administrator (or Representative) — Date: 10/17/23

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor and address a health and safety issue identified in a resident's assessment and documented behavioral interventions in the service agreement (service plan) for 1 of 3 residents (Resident 1). These failed practices resulted in the resident having subsequent encounters with law enforcement requiring emergency department treatment and placed the resident at risk of harm due to a lack of interventions for behaviors and contributed to being restrained.

Findings included...

Review of Resident 1's undated face sheet showed the resident was admitted to the facility on [redacted]/2023.

Review of Resident 1's Assessment and Preliminary Service Plan, dated 07/18/2023, showed the following:

-Resident had a diagnosis of [redacted].

-Resident may become anxious if overstimulated.

-Resident had recurrent urinary tract infections (UTIs, a urinary infection that causes sudden confusion in people with dementia, including a sudden change in behavior such as aggression).

-Resident experienced anxiety and agitation.

-Had a history of wandering and exit seeking.

Residents 1's Preliminary care plan instructions noted in the assessment and service plan included obtaining behavior management training and plan of care (POC) development from mental health and dementia professionals, always intervene with behavior management interventions first and document results, walk and wander with resident as needed, establish secure wandering path out of doors for independence, monitor for symptoms of incontinence, retention, infection, frequency (signs and symptoms of a UTI) and report to provider and family promptly to coordinate medical care. Facility was not able to provide documentation of a behavior management training from a mental health and dementia professional.

Progress notes

Review of Resident 1's Observations (the facility's titled progress notes), dated 08/20/2023 through 09/14/2023, showed the following:

-08/21/2023, Fax sent to Resident 1's provider requesting a UA (urine analysis) order to rule out UTI. Resident 1 has had an increase in agitation the past week and a half, incontinence, and frequency with little urine output. No follow up by facility staff was noted.

-08/22/2023, Attempted to exit through the front door multiple times throughout the shift.

-08/23/2023, Had a BM (bowel movement) on floor. Tried eloping once, urinated on a staff's leg during toileting assistance.

-08/24/2023, Went out front to a visitor's van believing it was their spouse. Got aggressive with staff when trying to assist resident to bed.

-08/25/2023, Making gestures towards their pelvic area when staff assisted with toileting.

-08/30/2023, Resident backed staff into a corner in their room, eloped, pushed, hit, and kicked. Staff contacted Resident 1's family member to come to the facility to calm Resident 1. Resident 1's family member obtained a UA test for Resident 1 that tested positive for a UTI. Family member obtained antibiotics for treatment of Resident 1.

-09/01/2023, Went into Resident 1's room to find "puddles of pee everywhere."

-09/03/2023, Resident 1 was agitated today.

-09/04/2023, Provider decided on Olanzapine (antipsychotic medication) as needed for breakthrough agitation. Medication received by pharmacy.

-09/05/2023, Resident became aggressive during toileting assistance. Was pushing their body into staff and trying to take the toilet paper. Resident charged at both staff who were trying to calm resident down. Staff had to leave the resident and close their door to prevent further escalation.

-09/06/2023, Resident had a behavioral outburst "that exploded into a physical altercation with staff." Resident threw items in their room, rearranged items, and jiggled their bathroom doorknob to where others in the facility could hear it. Staff shut the door and backed out. Resident kicked their door; it cracked on the bottom and broke through. A staff moved a recliner in front of Resident 1's door to clear the area of other residents. When the recliner was moved, Resident 1 exited the room with fist raised, was put in a hold by staff, and 911 was called. Law enforcement responded and Resident 1 was taken to a local hospital for an evaluation.

-09/08/2023, Weekly report: Resident 1 took antibiotics for a UTI and finished those on 09/06/2023. Family member notified us that the resident had adverse reactions when taking Olanzapine. "Behavioral outbursts might have been from that."

-09/12/2023, Weekly report: Resident had been a little aggressive this week with staff and other residents. Had some elopement issues but was easily redirected. Staff have observed that when resident has multiple staff around them at once, the resident feels intimidated. Later that evening, Resident 1 became agitated and acted confused.

-09/13/2023, IR (incident report) made. Please read.

-09/14/2023, Informed emergency room (ER) social worker they would take Resident 1 back into the facility but needed a crisis plan, a care team meeting, and an updated care plan with behavioral support information for the staff.

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Incident reports

Review of an IR, dated 09/06/2023, showed Resident 1 became aggressive, was taken to the ground and placed in a hold until police arrived.

Review of an IR, dated 09/13/2023, showed Resident 1 began "charging" staff. Staff called 911 and the resident was taken to a local hospital.

Review of Resident 1's Negotiated Care Plan (NCP, the facility's titled negotiated service agreement), dated 09/20/2023, showed that Resident 1's neurologist was "trying to find an effective PRN [as needed] to help with breakthrough agitation and aggression. We have learned that if [Resident 1] is left agitated, frustrations increase and lead to a physical altercation between [Resident 1] and staff." The NCP noted staff would monitor for signs of infection that included "pain, rash, irritation, etc.". Further review of the NCP showed care staff would intervene with behavior management interventions but did not state or document and outline what those interventions were. The NCP further showed Resident 1 "has been taken to the hospital 2X, both results from calling 911 when [Resident 1] was physically aggressive with staff. Care staff will report any behavioral outburst and DOC (Director of Care) will follow up with providers to establish the best plan of care."

Review Resident 1's undated facility records showed no health, safety and behavioral interventions based on the resident's assessment.

In an interview on 9-26-23 at 1:30 PM, Staff A was asked about the Negotiated Care Plan and lack of behavioral interventions documented on the plan as required. Staff A stated that behavioral intervention included "redirection, time and space and re-attempting". Staff A stated interventions were noted in the behavior logs in Resident 1's file. No documentation was found.

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

Administrator (or Representative) 10/17/23 Date