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

Riverview Lutheran Retirement Community of Spokane
Riverview Terrace
1801 E Upriver Dr
Spokane, WA 99207

RE: Riverview Terrace # 2405

Dear Administrator:

This document references Compliance Determination 49423 (11/04/2024), which included complaint number(s) 151645, 149395.

The Department completed a complaint investigation of your Assisted Living Facility on 11/04/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Amy Wright, NCI Complain Investigator

Consultation:

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:

(5) Appropriate behavioral interventions, if needed;

Review of a facility incident investigation showed that both the Alleged Victim and the Alleged Perpetrator displayed aggression towards the other. Review of the residents' care plans showed that they failed to include interventions to be used by staff when aggression was displayed. No harm identified following altercation. Failed facility

practice identified and consultation provided under WAC 388-78A-2140 Negotiated service agreement contents (5).

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the facility to determine if you have corrected all deficiencies.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Terrace
Provider Type: Assisted Living Facility
License/Cert.#: 2405
Compliance Determination #: 49423
Intake ID: 151645
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/28/2024 through 11/04/2024
Complainant Contact Date(s): 10/31/2024

Allegation(s):
Resident to resident altercation.

Investigation Methods:

Sample:
Total residents: 108
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Alleged Perpetrator
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Administrator
Director of Clinical Wellness
Memory Care Director
Alleged Victim
Alleged Perpetrator
Reporter
Resident Representative

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-Incident investigation
-Aggressive or Assaultive Resident Behavior Policy
-IPC tool
-Illness Prevention and Control Policy
-Progress notes
-COVID Outbreak Requirements
-Handling of Residents' Laundry and Garbage while on

Investigation Summary:

Review of a facility incident investigation showed that both the Alleged Victim and the Alleged Perpetrator displayed aggression towards the other. Review of the residents' care plans showed that they failed to include interventions to be used by staff when aggression was displayed. No harm identified following altercation. Failed facility practice identified and consultation provided under WAC 388-78A-2140 Negotiated service agreement contents (5).

Conclusion / Action:

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