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

NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC
Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

RE: Avamere at Port Townsend License # 2408

Dear Administrator:

This letter addresses Compliance Determination(s) 25061 (Completion Date 06/05/2023) and 20270 (Completion Date 03/08/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/05/2023 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-2630-1-a

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

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

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 follow-up on 02/21/2023, 02/21/2023, and 02/23/2023 of:
Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

This document references the following SOD dated: 03/08/2023

The following sample was selected for review during the unannounced on-site visit: 3 of 58 current residents and 0 former residents.

The department staff that inspected 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

03/15/2023
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) 3/24/23 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to report an injury of unknown origin directly to the Department's Complaint Resolution Unit hotline for 1 of 3 residents (Resident 1) reviewed. This failure placed the resident at risk of abuse.

Findings included...

Review of the Assisted Living Facility (ALF) Guidebook, dated February 2018, showed CRU guidelines for reporting substantial injuries of unknown source on page 39. It showed substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect must be reported to the Department, because the injuries may have resulted from the failure to take preventive measures. Substantial injuries are more than superficial and required more than first aid treatments occurred in areas not generally vulnerable to trauma such as the face.

Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted]2022 with diagnoses including [redacted] and [redacted]. The resident negotiated service plan, dated 12/27/2022, documented the resident had memory impairment and was not always oriented to person, place, and/or time. The resident was independent with communication, speech, and hearing. The resident ambulated independently and was at risk for falls.

On 02/21/2023 at 3:53 PM, Resident 1 was observed sitting on a chair in the hallway and was neatly groomed. The resident stated she had several falls and pointed to the area above her left eye. The area above the resident's left eyebrow had a dime size bump and bluish skin color discoloration on her left cheek. The resident was not able to provide additional details how the injury occurred.

Review of an incident investigation report, dated 01/29/2023 at 7:30 AM, documented at 7:00 AM care staff entered the Resident 1's room to assist the resident with dressing and the resident was sitting on her couch fully dressed. The care staff noticed Resident 1 had a

large purple bruise around her left eye and the white part of the resident's eye appeared completely red. The resident was not able to give a description or able to recall what had happened. The investigation showed the resident was disoriented, confused, and denied she had fallen. The resident was transported to the hospital for evaluation.

Review of Resident 1's progress notes, dated 01/29/2023 at 10:01 AM, documented a caregiver found a large bruise around the resident's left eye and the inside of her left eye was completely red. The resident denied she had fallen and was not able to recall what had happened.

Review of Resident 1's progress note, dated 01/30/2023 at 11:09 AM, documented Resident 1 had a large left periorbital ecchymosis (bruising or discoloration around the eyes as result of a head injury) as well as a subconjunctival hemorrhage (skin discoloration surrounding her left eye and bleeding in the white area of the eye) and was tender to touch around her left eye. The resident was not able to recall how the injury occurred.

Review of Resident 1's progress notes, dated 02/02/2023 at 4:17 PM, documented Resident 1's left eye still appeared to be a dark purple.

Review of Resident 1's progress notes, dated 02/05/2023 at 8:05 PM, documented Resident 1 still had bruising and swelling around the left eye.

In an interview on 02/21/2023 at 6:28 PM, Staff B, Medication Tech, stated that for injuries of unknown origin she had been trained to assess the resident's injuries, call 911 if necessary, complete an incident report and report to the Licensed Nurse and the Executive Director.

In an interview on 02/21/2023 at 6:34 PM, Staff C, Caregiver, stated that for injuries of unknown origin, her responsibilities were to call the Medication Tech, stay with the resident and report the incident to her supervisors.

In an interview on 02/21/2023 at 6:39 PM, Staff A, Executive Director, stated he recalled Resident 1 had an injury of unknown origin to her left eye and the resident was not able to articulate what had happened. Staff A said staff members had been trained to report injury of unknown origin to the Department within 24 hours or sooner. Staff A said he reviewed the incident, believed it was reasonably related to her memory loss and did not report to the Department.

Review of an email received by Staff A, dated 03/08/2023 at 4:14 PM, showed Staff A stated the facility utilized the DSHS (ALF) guidebook when conducting all investigations.

This was an uncorrected deficiency previously cited 12/14/2022.

Plan/Attestation Statement

Statement of Deficiencies	License # 2408	Compliance Determination # 20270
Plan of Correction	Avamere at Port Townsend	Completion Date
Page 4 of 4	Licensee: NorthWest HC Seaport Landing (WA) Operator NT HCI LLC	03/08/2023

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 4/20/23

IDR Request sent 3/24/23

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

Peder Berg — Administrator (or Representative)

3/24/23 — Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at Port Townsend **Provider Type:** Assisted Living Facility

License/Cert.#: 2408
Compliance Determination #: 17666
Investigator: Phan Pham
Investigation Date(s): 12/14/2022 through 12/14/2022
Complainant Contact Date(s):

Intake ID: 58775
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
1. Accidents - Named resident had bruises to his body.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.
Interviews:	Residents and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
1. An investigation was conducted, and allegation identified in the intake related to accidents, injuries, care and services were reviewed. The resident care plan had measures to keep the resident safe and was being followed at the time of the incident. The facility failed to ensure staff members reported when a resident went missing and a COVID - 19 case to the complaint resolution unit. Additional residents reviewed for care, services and safety 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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Statement of Deficiencies	License #: 2408	Compliance Determination # 17666
Plan of Correction	Avamere at Port Townsend	Completion Date
Page 1 of 4	Licensee: NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC	12/14/2022

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 12/14/2022, 12/14/2022 and 12/14/2022 of:

Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

This document references the following complaint number(s): 58775

The following sample was selected for review during the unannounced on-site visit: 3 of 58 current residents and 1 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

12/22/2022
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)

11/6/2023
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members report when a resident went missing directly to the Department's Aging and Disability Services Administration Complaint Resolution Unit (CRU) hotline consistent with chapter 74.34 RCW as required by mandatory reporters for 1 of 3 current sampled residents (Resident 1) reviewed. This failure placed the resident at risk for harm and/or neglect.

Findings included...

Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted]2022 with diagnoses including [redacted]. The resident negotiated service plan, dated 08/31/2022, documented the resident had memory problems, was independent with ambulation, and was dependent on staff for providing cueing and general directions.

On 12/14/2022 at 10:20 AM, Resident 1 was observed ambulating in her room and was neatly groomed. The resident stated she went for a walk and was not able to find her way back to the facility. The resident was not able to provide additional information related to the incident.

Review of a facility incident investigation report, dated 10/31/2022, documented at 6:00 PM the assisted living facility staff received a phone call from a local law enforcement officer. The officer reported Resident 1 was found in the neighborhood, confused and they had the resident at the police station.

On 12/14/2022 at 12:17 PM, during an interview, Staff B, Medication Tech, said she had been trained to immediately report when a resident went missing to the Executive Director, call local law enforcement for assistance and report to the State CRU hotline.

At 12:31 PM, during an interview, Staff A, Executive Director, stated the resident went out of the assisted living facility and had gotten lost. Staff A said the incident was reported by the interim Licensed Nurse on 10/31/2022. Staff A was not able to provide additional information to support the incident was reported.

On 12/14/2022 review of the Department's reporting record showed the assisted living facility did not report the incident to the Complaint Resolution Unit.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date)_____

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

IDR Requested. letter mailed

Administrator (or Representative)

11/6/2023
Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to report a confirmed case of COVID-19 (Corona Virus Disease 2019- a respiratory illness) to the local health jurisdiction, the Washington State Department of Health and the Complaint Hotline Unit as required for one of one sampled resident (Resident 2) reviewed. This failure placed the residents at risk for contracting the disease.

Findings included...

Review of the assisted living facility Resident Characteristic Roster showed Resident 2 admitted to the facility on [redacted] 2020. The roster showed the resident was dependent on staff members for assistance with activities of daily living and medication services.

On 12/14/2022 at 9:36 AM, a cart of personal protective equipment was observed in the hallway in front of the Resident 2's door. The resident was not available for interview during onsite visit.

At 9:49 AM, Staff C, Housekeeper, said Resident 2 had COVID-19.

At 9:52 AM, Staff A, Executive Director, stated Resident 2 had tested positive for COVID-19.

On 12/14/2022 at 12:11 PM, Staff A said he would be the person to report positive COVID-19 cases and did not make the report. Staff A stated he did not recall that the assisted living facility needed to report to the local health jurisdiction, the Washington State Department of Health and the Complaint Hotline Unit for one positive COVID-19 case.

At 12:17 PM, during an interview, Staff B, Medication Tech, stated the assisted living facility had one resident that tested positive for COVID-19. Staff B reviewed Resident 2's record and said a person not associated with the facility had provided care for the resident and had tested positive for COVID-19. Staff B stated she was asked to test Resident 2 for COVID-19 on 12/06/2022 and the resident was positive. Staff B said she reported to the Licensed Nurse and the Executive Director.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 1/6/2023.

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

Peder Berg — Administrator (or Representative)

1/6/2023 — Date