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) 39583 (Completion Date 04/10/2024) and 34736 (Completion Date 01/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/10/2024 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-2630-1-a, WAC 388-78A-2160

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2408
Intake ID: 108927
Compliance Determination #: 34736
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 01/03/2024 through 01/11/2024
Complainant Contact Date(s):

Allegation(s):
Quality of care - Named resident fell and sustained a lower back fracture.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 2 Closed records sample size: 2
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Residents, staff members, administrative and members not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An investigation was conducted, and allegation identified in the intake related to fall with fracture, care and services were reviewed. The assisted living facility failed to ensure staff followed the negotiated service plan and check the resident every two hours to prevent falls and failed to ensure staff members report a substantial injury of unknown caused directly to the State Hotline. 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 #:34736
Plan of Correction	Avamere at Port Townsend	Completion Date
Page 1 of 6	Licensee: NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC.	01/11/2024

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 01/03/2024, 01/03/2024 and 01/03/2024 of:

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

This document references the following complaint number(s): 108926, 108927, 108948

The following sample was selected for review during the unannounced on-site visit: 2 of 58 current residents and 2 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 Ste 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

01/22/2024
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

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Residential Care Services

Date

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Peder Berg
Administrator (or Representative)

1/26/24
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 interview and record review, the assisted living facility failed to ensure staff members reported a substantial injury of unknown cause to the department's Aging and Disability Services Administration Complaint Resolution Unit (CRU) hotline consistent with chapter 74.34 RCW in a timely manner as required by mandatory reporters for 1 of 4 sampled residents (Resident 1) reviewed. This failure placed the resident at risk for being abused and neglected.

Findings included...

RCW 74.34.035 "Reports—Mandated and permissive—Contents—Confidentiality.
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department."

Review of The Assisted Living Facility Guidebook, dated February 2018, showed CRU guidelines for reporting substantial injuries of unknown source and fractures. Page 39 stated 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. The appendix F on page 29 stated the assisted living facility was to report suspected abuse and neglect immediately. Substantial injuries were more than superficial and required more than first aid treatments occurred in areas not generally vulnerable to trauma such as the face. Review of Appendix E on page 27 showed, "Notify the Hotline of allegations immediately or as soon as the resident is protected."

Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted]2022 with diagnoses including [redacted].

Review of Resident 1's negotiated service plan, dated 07/28/2023, documented Resident 1

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to ensure staff members reported a substantial injury of unknown cause to the department's Aging and Disability Services Administration Complaint Resolution Unit (CRU) hotline consistent with chapter 74.34 RCW in a timely manner as required by mandatory reporters for 1 of 4 sampled residents (Resident 1) reviewed. This failure placed the resident at risk for being abused and neglected.

Findings included…

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Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted]/2022 with diagnoses including [redacted].

Review of Resident 1's negotiated service plan, dated 07/28/2023, documented Resident 1

was not always oriented to person, place, and/or time. Resident 1 had a history of falls and was at risk for falls.

Review of an incident description report, dated 12/02/2023 at 8:30 AM, showed Staff C, Medication Technician, documented he entered the resident's room and discovered Resident 1 sleeping on the floor in the bathroom. Resident 1 was covered with bowel movement. Resident 1 complained of pain to her back and leg. Resident 1 was unclear how long she had been in the bathroom. Resident 1 was disoriented and not able to give a description how the incident occurred.

Review of a progress note, dated 12/02/2023 at 10:37 AM, showed staff documented Resident 1 was found on the floor in her bathroom. Resident 1 was transported to the hospital and the Executive Director, and the Director of Wellness were notified.

Review of an incident investigation, dated 12/05/2023, showed Staff B, Director of Wellness, documented at approximately 8:30 AM, a Medication Technician found Resident 1 on the floor in her bathroom. Resident 1 was not able to endorse how long she had been on the floor or how she fell. Resident 1 complained of significant pain 10/10 (zero is no pain and 10 is the worst possible pain experienced). Resident 1 was transported to the hospital and diagnosed with a [redacted].

In an interview on 01/03/2024 at 1:43 PM, with Staff A, Executive Director, and Staff B, Director of Wellness, Staff B said when a resident had a fall the medication tech would call and report the incident to Staff A and Staff B. Staff B stated she would review the incident and if abuse and neglect was suspected then she would immediately investigate the incident and make a report to the State. Staff B said incidents that happened on the weekends and when abuse or neglect was not suspected she would investigate and report to State when she returned to work on the following Monday. Staff A said both Staff A and Staff B were responsible for reporting to the State. Staff B said the facility did not have a licensed nurse on site during weekends to complete the investigation and report to State. Staff A stated all staff members were mandated reporters.

In an interview on 01/03/2024 at 2:38 PM, Staff A said he had been instructed by the assisted living facility's company to follow the State reporting guidelines.

In an interview on 01/05/2024 at 2:29 PM, Staff C stated on 12/02/2023 at 8:30 AM he entered Resident 1's room to give the resident medications. Staff C said he found Resident 1 on the floor, called emergency service, and reported to his supervisor and the Director of Wellness.

Review of the Department's reporting record revealed Resident 1 was found on the floor covered in bowel movement on 12/02/2024 at 8:30 AM and the assisted living facility did

was not always oriented to person, place, and/or time. Resident 1 had a history of falls and was at risk for falls.

Review of an incident description report, dated 12/02/2023 at 8:30 AM, showed Staff C, Medication Technician, documented he entered the resident's room and discovered Resident 1 sleeping on the floor in the bathroom. Resident 1 was covered with bowel movement. Resident 1 complained of pain to her back and leg. Resident 1 was unclear how long she had been in the bathroom. Resident 1 was disoriented and not able to give a description how the incident occurred.

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Review of an incident investigation, dated 12/05/2023, showed Staff B, Director of Wellness, documented at approximately 8:30 AM, a Medication Technician found Resident 1 on the floor in her bathroom. Resident 1 was not able to endorse how long she had been on the floor or how she fell. Resident 1 complained of significant pain 10/10 (zero is no pain and 10 is the worst possible pain experienced). Resident 1 was transported to the hospital and diagnosed with a [redacted].

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Review of the Department's reporting record revealed Resident 1 was found on the floor covered in bowel movement on 12/02/2024 at 8:30 AM and the assisted living facility did

not report the incident until 12/04/2024 at 5:36 PM.

This is a recurring deficiency previously cited on 03/08/2023, 12/14/2022 and 10/14/2021.

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) ~~1/11/24~~ 2/24/24 RB.

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

Peder Berg — Administrator (or Representative)

11/26/24 — Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to ensure staff followed the negotiated service plan and check the resident every two hours to prevent falls for 1 of 4 sampled residents (Resident 1) reviewed. This failure contributed to harm to Resident 1 who fell, fractured her lower back, and was hospitalized, and placed the resident at risk for being neglected and services not being met.

Findings included:

Review of Resident 1's (R1) face sheet showed the resident was admitted to the facility on [redacted]2022 with diagnoses including [redacted].

Review of R1's negotiated service plan, dated 07/28/2023, documented the resident was not always oriented to person, place, and/or time. R1 had a history of falls and was at risk for falls. The negotiated service plan had interventions to reduce the number of avoidable falls including every two hours safety checks of R1.

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Review of an incident description report, dated 12/02/2023 at 8:30 AM, showed Staff C, Medication Technician, documented approximately 8:30 AM on 12/02/2024 he entered R1's room and discovered R1 sleeping on the floor in the bathroom. R1 was covered with bowel movement. R1 complained of pain to her back and leg. R1 was unclear how long she had been in the bathroom. R1 was disoriented and not able to give a description of how the incident occurred.

Review of a progress note, dated 12/02/2023 at 10:37 AM, showed staff documented R1 was found on the floor in her bathroom and transported to the hospital.

Review of an incident investigation report, dated 12/05/2023, showed Staff B, Director of Wellness, documented at approximately 8:30 AM, a Medication Technician found R1 on the floor in her bathroom. R1 was not able to endorse how long she had been on the floor or how she fell. R1 complained of significant pain 10/10 (zero is no pain and 10 is the worst possible pain experienced). R1 was transported to the hospital and diagnosed with a [redacted]. R1's last safety check was documented at 05:48 AM on 12/02/2024.

In an interview on 01/05/2024 at 2:29 PM, Staff C stated on 12/02/2023 at approximately 8:30 AM he entered R1's room to give the resident medications and found R1 on the floor. Staff C said the residents' negotiated service plans had the information on the care and services each resident needed. Staff C stated all staff members had access to the residents' negotiated service plans. Staff C said staff members assigned to assist the resident were responsible for reviewing, following the negotiated service plans and document the care and services provided.

In an interview on 01/11/2024 at 1:49 PM, Staff B said R1 was to be checked every two hours related to her fall risk. Staff B stated every two-hour check added to the resident's negotiated service plan was the result of a fall R1 had. Staff B stated when new interventions were updated to the residents' negotiated service plans the information went into the computer communication tab and alerted staff to review. Staff B said staff members were to review and follow the negotiated service plans when assigned to assist the residents. Staff B stated she was available for clarification when staff had questions related to care, services and the negotiated service plans. Staff B said management staff members monitored to ensure residents received the care and reviewed the care staff charting to ensure tasks were being performed.

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Plan/Attestation Statement

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Plan/Attestation Statement

Statement of Deficiencies	License #: 2406	Compliance Determination #: 34736
Plan of Correction	Avamere at Port Townsend	Completion Date
Page 6 of 6	Licensee: NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC	01/11/2024

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IVR Sent In

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Administrator (or Representative)

1/26/24
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