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

RP Operations, LLC
Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

RE: Rose Pointe Assisted Living License # 2452

Dear Administrator:

This letter addresses Compliance Determination(s) 33046 (Completion Date 12/05/2023) and 29127 (Completion Date 10/26/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2023 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-2060-4, WAC 388-78A-2060-6, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2660-1, WAC 388-78A-2660-2, RCW 70.129.140.1, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3

The Department staff who did the on-site verification:
Amy Wright, NCI Complain 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: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 95936
Compliance Determination #: 29127
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 09/07/2023 through 10/26/2023
Complainant Contact Date(s):

Allegation(s):

1. Multiple falls with injury.
2. Failure to document every resident fall.
3. Failing to notify family of resident falls.
4. Improper transfers.
5. Insufficient showers.

Investigation Methods:

Sample:
Total residents: 96
Resident sample size: 3
Closed records sample size: 0

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

Interviews:
Executive Director
Wellness Director
Alleged Victim's Family
Residents
Medication Technician

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Fall Protocol Policy
Hospital after-visit summaries
Resident incident reports
Resident assessments
Resident medication administration records
Progress notes

Provider notes
Therapy notes
Hospital discharge summary
Shower documentation
Resident discharge notice

Investigation Summary:

1. The named resident, who had a history of falls, was admitted to the facility without a preadmission assessment. A care plan to alert staff of their fall risk or of interventions to prevent falls had not been established. Review of facility documentation showed that the named resident's incident reports lacked root cause analysis or implementation of measures to prevent reoccurrence. Failed facility practice was cited under WAC 388-78A-2060 Preadmission assessment, WAC 388-78A-2130 Service agreement planning, and WAC 388-78A-2371 Investigations.
2. The named resident had repeated falls at the facility. Review of facility documentation showed that six falls had been documented for the named resident. While interviewing the named resident's representative, they suggested more falls may have occurred, this could not be substantiated. Facility staff were aware that incident reports were to be completed for all resident falls. No failed facility practice.
3. Review of facility documentation showed that the named resident's representative had been notified following each of their falls. In an interview with facility management, they reported that the named resident's representative had been notified of every fall. Staff interviewed were knowledgeable about the required family notification following resident falls. No failed facility practice.
4. Facility documentation showed that the named resident required assistance with transfers. In an interview with facility management, they indicated that the care plan is what staff would have used for guidance in caring for the named resident but had never been developed. Failed facility practice was cited under WAC 388-78A-2130 Service agreement planning.
5. Facility documentation showed that the named resident resided at the facility for 18 days. Review of the resident's shower documentation showed that they received one shower during that time. Failed facility practice was cited under WAC 388-78A-2660 Resident rights.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 95553
Compliance Determination #: 29127
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 09/07/2023 through 10/26/2023
Complainant Contact Date(s):

Allegation(s):

1. Multiple falls.
2. Resident refused readmission to facility.

Investigation Methods:

Sample:	Total residents: 96 Resident sample size: 3 Closed records sample size: 0
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Executive Director Wellness Director Alleged Victim's Family Residents Medication Technician
Record Reviews:	Disclosure of Services Characteristic roster Staff roster Resident face sheets Resident care plans Fall Protocol Policy Hospital after-visit summaries Resident incident reports Resident assessments Resident medication administration records Progress notes Provider notes Therapy notes Hospital discharge summary

Shower documentation
Resident discharge notice

Investigation Summary:

1. The named resident, who had a history of falls, was admitted to the facility without a preadmission assessment. A care plan to alert staff of their fall risk or of interventions to prevent falls had not been established. Review of facility documentation showed that the named resident's fall investigations lacked root cause analysis or implementation of measures to prevent reoccurrence. Failed facility practice was cited under WAC 388-78A-2060 Preadmission assessment, WAC 388-78A-2130 Service agreement planning, and WAC 388-78A-2371 Investigations.
2. Facility management felt they could not meet the needs of the named resident. The named resident's representative was notified of the facility's intent to discharge them. The facility decided to readmit the named resident until alternative placement could be found for them. The named resident was readmitted and was observed present in the facility. No failed facility practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 95173
Compliance Determination #: 29127
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 09/07/2023 through 10/26/2023
Complainant Contact Date(s):

Allegation(s):

1. Inadequate wound care.
2. Inadequate skin care.

Investigation Methods:

Sample:	Total residents: 96 Resident sample size: 3 Closed records sample size: 0
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Executive Director Wellness Director Alleged Victim Resident Medication Technician Family
Record Reviews:	Disclosure of Services Characteristic roster Staff roster Resident face sheets Resident care plans Fall Protocol Policy Hospital after-visit summaries Resident incident reports Resident assessments Resident medication administration records Progress notes Provider notes Therapy notes

Hospital discharge summary
Shower documentation
Resident discharge notice

Investigation Summary:

1. The facility noted the named resident's wound and notified their provider. The provider assessed the wound and provided treatment orders. Facility documentation showed that the treatment orders had been followed. The named resident was sent to the hospital for medical care the same day. Upon their return to the facility the provider assessed the named resident and their wound had resolved. The named resident was observed to have no open wounds. No failed facility practice.
2. The named resident had a medical condition that compromised their lower extremity skin integrity. Review of facility documentation showed there were no treatment orders in place to prevent lower extremity swelling or to improve the integrity of their skin. The named resident was observed to have dry, flaking skin on their lower extremities. Failed facility practice was cited under WAC 388-78A-2130 Service agreement planning.

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 #: 2452	Compliance Determination # 29127
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 1 of 10	Licensee: RP Operations, LLC	10/26/2023

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 09/07/2023, 09/07/2023 and 09/07/2023 of:

Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

This document references the following complaint number(s): 95936, 95553, 95173

The following sample was selected for review during the unannounced on-site visit: 3 of 96 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

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NOV 13 2023
DSHS ALTSA RCS
SPOKANE VALLEY WA

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

11/07/2023

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) — Date: 11-10-23

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(6) Level of personal care needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to conduct a preadmission assessment for 1 of 1 resident (Resident 1) reviewed for preadmission assessments. This failure resulted in the resident being discharged from the facility due to the lack of a preadmission assessment to determine appropriate admittance and potentially contributed to repeated falls with minor injury.

Findings included...

Admission records showed that Resident 1 admitted to the facility on [redacted]/2023 with diagnoses including [redacted], and [redacted].

In an interview on 09/07/2023 at 2:18 PM Collateral Contact 1 (CC1) stated the following:

-The facility had done Resident 1's intake without understanding the level of care they required.

-Resident 1's admission assessment had been very inaccurate, it had not reflected their history of falls, and it wasn't completed until 08/28/2023.

-Resident 1's family had been with Resident 1 the entire day of 08/28/2023 and no assessments were completed with Resident 1.

-They asked Staff A, Executive Director, and Staff D, Marketing and Sales Director, for Resident 1's admission assessment on 08/24/2023 but were told they'd get back to them as Staff B, Wellness Director, had been the only one who had access to it.

Review of Resident 1's facility Care Assessment, dated 08/28/2023, and Wellness Move-In Assessment, dated [redacted]/2023, showed they were incomplete. These assessments did not include Resident 1's history of falls or interventions to prevent falls and had incomplete descriptions of Resident 1's personal care needs.

Review of facility incident reports showed that Resident 1 had six falls during their admission to the facility with one fall on [redacted]/2023 and 08/22/2023, two falls on 08/23/2023, resulting in left hip pain and a laceration to Resident 1's left arm, and two falls on 08/26/2023, resulting in back pain and right shoulder pain.

In an email on 10/19/2023 at 9:17 AM, Staff A, Executive Director, indicated that an elopement assessment and the Care Assessment had been the only two assessments completed for Resident 1 for their admission to the facility.

Review of Resident 1's undated medical file showed no documentation of a preadmission assessment to determine if the resident was appropriate for admittance to the facility.

In an interview on [redacted]/2023 at 2:18 PM, CC1 stated they were moving Resident 1 out of the facility that day as the facility could not provide the level of care the resident required.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 11. 16. 23 .

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

Administrator (or Representative) — Date: 11. 16. 23

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document preventative interventions for resident falls for 2 of 2 residents (Resident 1 and 2) who had repeated falls. These failures resulted in hospitalization for Resident 2 and contributed to multiple falls with injury for Resident 1 and placed the residents at increased risk for future falls with injury due to the lack of interventions to prevent reoccurrence.

Findings included...

Review of the facility's "Fall Protocol Policy," dated 2019, showed it required amendment to the resident's service plan to reflect any changes needed to prevent further falls.

<Resident 1>

Review of an incident report for Resident 1, dated [redacted]/2023, showed the resident had a fall at 2:30 PM that day. Further review of the incident report showed no documented interventions were put in place to prevent falls.

Review of an incident report for Resident 1, dated 08/22/2023, showed the resident had a fall at 3:25 PM that day. Further review of the incident report showed no documented interventions were put in place to prevent falls.

Review of an incident report for Resident 1, dated 08/23/2023, showed the resident was found on the floor at 7:00 AM that day, resulting in left hip pain and a cut to the resident's arm. Further review of the incident report showed no documentation of an investigation to determine the cause of the fall or interventions to prevent falls.

Review of an incident report for Resident 1, dated 08/23/2023, showed the resident had a fall between 8:30 and 9:00 AM that day. Further review of the incident report showed no documented interventions were put in place to prevent falls.

Review of an incident report for Resident 1, dated 08/26/2023, showed the resident had a fall at 7:00 AM that day. Further review of the incident report showed no documentation of an investigation to determine the cause of the fall or interventions to prevent falls.

Review of an incident report for Resident 1, dated 08/26/2023, showed the resident had a

fall at 10:27 PM that day resulting in back and shoulder pain. Further review of the incident report showed no documentation of an investigation to determine the cause of the fall or interventions to prevent falls.

<Resident 2>

Review of an incident reported for Resident 2, dated 08/03/2023, showed the resident had a fall at 9:00 PM that day. Further review of the incident report showed no documented interventions were put in place to prevent fall reoccurrence.

In an interview on 09/07/2023 at 12:44 PM, Staff A, Executive Director, stated that Resident 2 went to the hospital on 08/23/2023 after a fall and increased confusion.

Review of Resident 2's undated medical file showed no documentation of an investigation or interventions to prevent fall reoccurrence for the fall that occurred on 08/23/2023.

Review of Resident 2's NSA, dated 07/17/2023, showed no documentation of the resident's history of falls and there were no interventions to prevent falls.

This is a recurring deficiency previously cited on 12/01/2022.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 11-20-23.

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

Administrator (or Representative) — Date: 11-10-23

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that residents received care and services to maintain personal and environmental cleanliness and comfort for 3 of 3 residents (Resident 1, 2, and 3). This failure placed the residents at risk for decreased quality of life and a diminished sense of dignity.

<Resident 1>

In an interview on 09/07/2023 at 2:18 PM, Collateral Contact 1 (CC1) stated that Resident 1 had been put to bed with their dentures in and had worn the same clothing for two days in a row. CC1 further stated that they found old, green bologna in Resident 1's freezer.

Review of facility documentation showed that Resident 1 received one shower between [redacted]2023 and 09/07/2023.

Observation of Resident 1's apartment on 09/07/2023 at 2:20 PM, showed the trim around their bathroom door was partially detached.

Observation of Resident 1 on [redacted]/202 at 3:20 PM, showed the resident's family moving the resident and their belongings out of the facility due to inadequate care.

<Resident 2>

Review of Resident 2's negotiated service agreement (NSA), dated 07/17/2023, showed that the resident was to be showered weekly.

Review of a provider visit note, dated 08/23/2023, showed that Resident 2 had drainage from a wound on their left calf that was covered with a saturated dressing and their skin was dry and flaky.

Observation of Resident 2 on 09/07/2023 at 1:46 PM, showed that the resident's skin was dry and flaky.

In an interview on 09/07/2023 at 2:01 PM, Staff C, Medication Technician, stated that residents were to receive two showers per week.

Review of facility documentation showed that Resident 2 received 16 showers between 06/12/2023 and 09/04/2023.

<Resident 3>

Review of facility documentation showed that Resident 3 received 10 showers between 06/13/2023 and 09/05/2023.

Observation of Resident 3's apartment on 09/07/2023 at 1:27 PM, showed the room smelled strongly of urine. The carpet appeared unclean with a moderate amount of debris and liquid stains. Observation of Resident 3's hair showed it was unclean and unkept.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 11-10-23 .

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

Administrator (or Representative) — Date: 11-10-23

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:

(b) Identifies the resident's immediate needs; and

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete and update negotiated service agreements for 2 of 2 residents (Resident 1 and 2) with fall risk and changes in condition. This failure potentially contributed to multiple falls with minor injury for Resident 1 and placed the residents at risk for injuries related to falls and health complications.

Findings included...

Review of the facility's "Fall Protocol Policy," dated 2019, showed it required amendment to the resident's service plan to reflect any changes needed to prevent further falls.

<Resident 1>

Admission records showed that Resident 1 admitted to the facility on [redacted]/2023 with diagnoses including [redacted], and [redacted].

In an interview on 09/07/2023 at 12:44 PM, Staff A, Executive Director, stated the following:

-They were aware that Resident 1 was very impulsive, didn't use their call light, and would just get up and go.

-Resident 1's family had been providing the resident 1:1 supervision since 08/27/2023 due to their frequent falls.

In an interview on 09/07/2023 at 12:44 PM, Staff B, Wellness Director, stated that Resident 1 had experienced six or seven falls since moving into the facility.

Review of Resident 1's incident reports showed that the resident had falls on [redacted]/2023 at 2:30 PM, 08/22/2023 at 3:25 PM, 08/23/2023 at 7:00 AM, 08/23/2023 between 8:30 AM and 9:00 AM, 08/26/2023 at 7:00 AM, and 08/26/2023 at 10:27 PM. These falls resulted in back pain, right shoulder pain, left hip pain, and a laceration to the resident's left arm.

In an email dated, 10/29/2023 at 10:06 AM, Staff A stated that a negotiated service agreement had never been initiated for Resident 1.

Review of Resident 1's undated medical file showed no documentation of a negotiated service agreement or any documentation to alert care staff about the resident's risk for falls.

<Resident 2>

Review of Resident 2's incident report, dated 08/03/2023, showed the resident had a fall at 9:00 PM that day.

Review of Resident 2's progress note, dated 08/04/2023 at 10:23 AM, showed Staff A, Executive Director, documented that Resident 2 tripped and fell the night prior.

Review of Resident 2's provider visit note, dated 08/23/2023, showed the resident was diagnosed with [redacted].

In an interview on 09/07/2023 at 12:44 PM, Staff A stated that Resident 2 had gone to the hospital on [redacted]/2023 for increased confusion and a fall. Staff A stated that Resident 2 did not return to the facility until [redacted]/2023. Staff A further stated that Resident 2's skin was to be checked during each shower as it was facility practice for all residents.

In an interview on 09/07/2023 at 12:44 PM, Staff B, Wellness Director, stated that Resident 2's diuretic medication (used to decrease fluid build-up caused by heart failure) had recently been increased due to increased swelling in the resident's legs. Staff B further stated that Resident 2's legs had been weeping (fluid leaking from the skin).

Review of Resident 2's hospital discharge instructions, dated [redacted]/2023, showed that the resident was to be on a low sodium diet and weighed daily.

Review of Resident 2's negotiated service agreement (NSA), dated 07/17/2023, showed no documentation to reflect the resident's change of condition to include skin checks for weeping, daily weight monitoring, fall risk, and low sodium diet. Further review of the NSA showed the following:

- Weight was to be checked monthly.

- Regular diet.

- No history of falls.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10-20-23 .

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

Administrator (or Representative) — Date: 10-10-23