STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

RIVERWEST MANOR LLC
RIVERWEST RETIREMENT COMMUNITY
900 N WESTERN AVE
WENATCHEE, WA 98801

RE: RIVERWEST RETIREMENT COMMUNITY License # 1462

Dear Administrator:

This letter addresses Compliance Determination(s) 32016 (Completion Date 11/02/2023) and 26770 (Completion Date 10/03/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/02/2023 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2600-2-a

The Department staff who did the on-site verification:
Nicole Velazquez, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: RIVERWEST RETIREMENT COMMUNITY
Provider Type: Assisted Living Facility
License/Cert.#: 1462
Intake ID: 88236
Compliance Determination #: 26770
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Velazquez
Investigation Date(s): 07/18/2023 through 10/03/2023
Complainant Contact Date(s):

Allegation(s):

1) The named resident had a fall with injuries that were not described adequately described.
2) A named staff member was being investigated for credit card theft and admitted to stealing resident's pills and credit cards.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, Cares, Residents, Staff to resident interactions, Staff availability and response to resident's needs
Interviews:	Residents, Staff and others not associated with the facility
Record Reviews:	Characteristic Roster, Resident records, Facility incident report and investigation, Facility policies, Personnel Records

Investigation Summary:

1) Observations showed that residents were clean and groomed. Staff were observed to be available and responsive to resident's needs. Staff interviews and record review showed that the named resident passed away after the reported fall, facility staff failed to investigate the named resident's fall thoroughly, the facility staff failed to follow their policies related to reporting incidents of significant injury to the department and failed to protect the residents from abuse.
2) Observations showed that residents were clean and groomed. Staff were observed to be available and responsive to resident's needs. Staff to resident interactions were observed to be appropriate and respectful. Interviews and record review showed that there were come missing credit cards that were investigated and reported to the appropriate agencies. A staff member was interviewed and admitted to having take some pills out of a resident's room. They were also identified as the alleged perpetrator during the investigation and was terminated as a part of the investigation.
Deficient practice was identified related to staff abuse, failing to follow facility policy for reporting to the department, failing to investigate an incident. Citations written for WAC 388-78A-2371 and WAC 388-78A-2600. Reference Statement of Deficiencies

dated 10/03/2023.

Conclusion / Action:

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

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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 1462	Compliance Determination # 26770
Plan of Correction	RIVERWEST RETIREMENT COMMUNITY	Completion Date
Page 1 of 5	Licensee: RIVERWEST MANOR LLC	10/03/2023

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 07/18/2023 and 09/07/2023 of:

RIVERWEST RETIREMENT COMMUNITY
900 N WESTERN AVE
WENATCHEE, WA 98801

This document references the following complaint number(s): 88236, 87490

The following sample was selected for review during the unannounced on-site visit: 4 of 49 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher — Residential Care Services

10/16/2023 — 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)

10/16/23
Date

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

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to conduct a thorough investigation to rule out abuse when 1 of 1 resident (Resident 1) sustained injuries from a reported fall. This failure placed Resident 1 and other residents who resided in the ALF at risk of abuse and receiving care from an alleged perpetrator.

Findings included...

Record review of facility policy titled, "Suspected Abuse/Neglect," undated, showed that staff were to complete an incident report to determine the circumstances of the event and to determine the appropriate measures to prevent similar future situations. The policy showed that the facility was to investigate, document their findings, assess the resident and determine what appropriate measures needed to be taken.

Record review showed Resident 1 admitted to the facility on [redacted]/2018 with diagnosis of [redacted] and [redacted] The 03/17/2023 Negotiated Service Agreement showed the resident had difficulty expressing their needs, disruptive behaviors and required assistance with showering, mobility, transfers, positioning and toileting.

Review of facility's Incident Report dated 06/20/2023, completed by Staff B, caregiver, showed that Resident 1 had an unwitnessed fall in their room. Injuries noted at the time of the fall were bruising to both hands, bleeding from both ears and swelling to left side of the face.

An interview with Staff C, Administrator, on 07/18/2023 at 10:24 AM stated that Resident 1's injuries from a fall out of the lowered bed did not make sense. They further stated that they reviewed the investigation and spoke to Staff A, Health Service Coordinator, they had determined that Staff A had not assessed Resident 1 after the 06/20/2023 reported fall

with injuries, nor the changes in behavior, new onset of being fearful of the staff and Resident 1's family. Staff C further stated that they (Staff A) had not completed the investigative tasks of interviewing staff or other residents, and there had been no follow-up on incident to determine the circumstances of the incident to rule out abuse and how to prevent reoccurrence.

On 07/18/2023 at 11:02 AM, Staff D, Resident Care Manager, stated that when they had seen Resident 1 on 06/22/2023, they noted bruising to the forehead, eyes, ears and hands and that staff had stated that Resident 1 had a fall. Staff D stated that the injuries were concerning, and that abuse, and neglect had not been ruled out.

Interview on 07/18/2023 at 1:45 PM, Staff A, Health Services Director stated that they had not done an investigation after Resident 1 had a fall with injury on 06/20/2023. Staff A stated that after there was an abuse allegation made, no investigation was done. Further, Staff A had determined Resident 1's sustained the injuries, they stated that they used the documentation that was on the incident report, and they did not gather any further information. Staff A acknowledged a thorough investigation had not been conducted.

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, RIVERWEST RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 10/16/2023

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

Administrator (or Representative) Date 10/16/23

WAC 388-78A-2600 Policies and procedures.

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

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview, and record review the Assisted Living Facility (ALF) failed to implement the facility's policy for notification to the department and local law enforcement when an allegation of abuse was made for 1 of 1 resident (Resident 1). This failure resulted in

delayed investigation and placed resident 1 at risk of unidentified needs and lack of thorough investigation.

Findings included...

Review of the Department's Assisted Living Facility Guidebook, dated February 2018, showed facility are required to report substantial injuries of an unknown source to Complaint Resolution Unit (CRU).

Record review of facility policy titled, "Suspected Abuse/Neglect," undated, showed that all staff were mandated reporters and must immediately report to report to the department's Aging and Disability Services Administration CRU hotline and appropriate law enforcement agency when there was a reason to suspect that physical assault had occurred.

Incident Report dated 06/20/2023 at 5:45 AM showed Staff E documented Resident 1 fell and was found lying on the floor on their right side and had urinated. The injury portion of the incident report completed by Staff E showed that Resident 1 had sustained injuries of bruising to both hands, bleeding from both ears and swelling to the left side of the face.

On 07/18/2023 at 10:24 AM, Staff B, Administrator, stated that fall incident was reported late to the department and to law enforcement on 07/03/2023 (13 days after the incident) because they (Staff B) were working in the kitchen.

On 07/18/2023 at 1:45 PM, Staff A, Health Services Director, stated that Resident 1 had an unwitnessed fall on 06/20/2023. Resident 1 was not able to verbalize how the fall occurred. Staff A stated that Resident 1 did have injuries to their head and face. They further stated that they had not make a report to CRU and that they did not know why a report was not made.

Interview with Staff D, Resident Care Manager, on 07/18/2023 at 11:02 AM showed that they did not think that Resident 1's 06/20/2023 fall could have caused the significant amount of bruising and injuries to the resident's head and face. They further stated that they did not call CRU, but they recognized that they should have made a report to CRU.

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, RIVERWEST RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 10/16/2023

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

Statement of Deficiencies	License #: 1462	Compliance Determination # 26770
Plan of Correction	RIVERWEST RETIREMENT COMMUNITY	Completion Date
Page 5 of 5	Licensee: RIVERWEST MANOR LLC	10/03/2023

Administrator (or Representative)

10/16/2023
Date

Dear Field Manager Gwin Kearcher, 10/17/2023

We have received your citations on WAC 388-78a-2371 and WAC 388-78A-2600. We have and will continue to protect our residents at all costs. Reporting has been the highlight of staff meetings and will continue to be so. Investigations have been handed over to myself as well as the RCC depending whom is on duty and the other person is always notified in ISP.

WAC 388-78A-2371 (1)(2)(3)(4)

Police department, family, hospice, [redacted], and RCS were notified. Staff member was terminated and turned in to local police on suspected abuse as of 6/26/2023. 6/20/2023 of fall Rn did not complete investigation on her end and was also terminated. Further, We are and will continue to protect our residents at all costs. Investigations have and will continue to be done in completion. All ISP's that are turned in and will continue to do our part in a timely manner with investigations no greater than 24hrs of falls of incidents.

WAC 388-78A-2600 (2) (a)

Staff members have and will continue to be educated on the importance of reporting and following polices. Suspected abuse was reported as soon as it was suspected.

Our community will continue to follow our policies and procedures. They have and will continue to be trained on the importance reporting to the correct officials.

Jennifer S Vance Executive Director

900 N Western Ave

Wenatchee WA 98801

509-662-2797