



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

Grandview WA Management LLC
The Orchards at Grandview
2001 W 5th St
Grandview, WA 98930

RE: The Orchards at Grandview License # 2503

Dear Administrator:

This letter addresses Compliance Determination(s) 29031 (Completion Date 09/06/2023) and 24832 (Completion Date 07/06/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/06/2023 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, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2371

The Department staff who did the on-site verification:

Elaine Lopez, Licensors

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

Sincerely,

A handwritten signature in cursive script that reads "Gwin Kaercher".

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



Residential Care Services Investigation Summary Report

Provider/Facility: The Orchards at Grandview **Provider Type:** Assisted Living Facility

License/Cert.#: 2503

Intake ID: 83687

Compliance Determination #: 24832

Region/Unit #: RCS Region 1 / Unit G

Investigator: Gwin Kaercher

Investigation Date(s): 06/05/2023 through 07/06/2023

Complainant Contact Date(s):

Allegation(s):

The medication technician failed to recognize pain and provide adequate pain medication for a named resident.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 6 Closed records sample size: 2
Observations:	The facility's common areas, resident to staff, resident to resident interactions, facility laundry room, and a morning meal serve out were observed.
Interviews:	Sampled residents, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (Negotiated Service Agreement (NSA), NSA updates, progress notes, Medication Administration Records (MAR), incident investigations, facility policies, activity calendar, staff roster, staff work schedules, facility training booklet for behaviors, and resident medical supply invoices.

Investigation Summary:

Record review showed that the May 2023 MAR had seven doses of a pain medication that was not initialed as given to the named resident. Interview with the facility nurse stated that they did not notify the doctor and probably had notified the hospice staff who were in the facility on that date.

Technical assistance provided regarding requirement to notify the doctor if a medication was not given.

Failed practice identified WAC 388-78A-2371 and WAC 388-78A-2630 reference Statement of Deficiencies dated 07/12/2023.

Conclusion / Action:

☒ 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: The Orchards at Grandview **Provider Type:** Assisted Living Facility

License/Cert.#: 2503

Intake ID: 83944

Compliance Determination #: 24832

Region/Unit #: RCS Region 1 / Unit G

Investigator: Gwin Kaercher

Investigation Date(s): 06/05/2023 through 07/06/2023

Complainant Contact Date(s):

Allegation(s):

1. Residents who need assistance with eating were not getting help, they were left in soiled brief for hours, beds were not being made, linens were dirty and soiled.
2. Staff were not repositioning residents like they were supposed to.
3. When the reporter went to check and change residents, they were not cleaned properly and would have feces stuck on them.
4. Medications were not given properly.
5. Staff were not certified to do medication pass, the nurse was not there most of the time, and the facility allows the staff to do the medication pass.
6. Non-certified staff administering medications without training and or medication delegation.
7. A staff member smokes dabs (Marijuana).
8. The staff member who smoked went into resident rooms to smoke, does their Tik-Tok videos, and residents were left alone.
9. A couple of months ago, the reporter walked into a resident's room and found three staff members holding the named resident down, pretty aggressively.
10. Reporter felt they were harassed, traumatized, and blamed for something every day by the administrator and human resources.
11. The named resident was hospice and their pain medication was not given and staff said to give the named resident Motrin for pain because family did not want the Morphine given.
12. The named resident was screaming in pain for awhile that day.
13. There was not communication from the nurse to the night shift staff.
14. Facility staff hide things, pretend like no one knows anything , and do not take responsibility for anything.
15. Some staff make fun of residents, do not know how to care for dementia residents, yell and bully residents when they get frustrated.
16. Residents complain about the food and sometimes get diarrhea after eating.

Investigation Methods:

Sample: Total residents: 40
Resident sample size: 6
Closed records sample size: 2

Observations: The facility's common areas, resident to staff, resident to resident interactions, facility laundry room, and a morning meal serve out were observed.

Interviews:	Sampled residents, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (Negotiated Service Agreement (NSA), NSA updates, progress notes, Medication Administration Records (MAR), incident investigations, facility policies, activity calendar, staff roster, staff work schedule, facility training booklet for behaviors, and resident medical supply invoices.

Investigation Summary:

1. 2. 3. Observations on 06/05, 06/07, 06/20 and 06/27/2023 showed residents in clean clothes, no odors in sampled resident rooms or common areas. Observations on 06/20/2023 showed three facility staff provided resident checks between 5 AM to 6:30 AM. Two of the three staff removed dirty linen from the resident rooms in hall 2 and 3. Two of three staff changed resident undergarments for residents on hall 2 and 3. The staff member on hall 1 changed 2 resident's briefs. Observations on 06/20 and 06/27/2023 showed staff assisting residents with eating. Interview with the facility administrator stated that staff had to walk by their office in order to take out the bags of soiled garbage. In addition, the facility had placed a camera in the laundry room to ensure staff were doing laundry. Interview with the facility administrator stated that staff were to do resident checks every two hours.
4. Review of sampled resident MARs showed medications given as prescribed. Interview with the facility nurse stated that an investigation was completed, and the MT was terminated.
5. 6. Staff record review showed staff who were Medication Technicians (MT) were nurse delegated and had the required training. Observations on 06/05, 06/07, 06/20, and 06/27/2023 showed the facility nurse to be in the facility.
7. 8. Interviews with facility staff showed that there was a staff member who smoked in the break room and blew the smoke out the exterior door. Staff interviewed denied smoking dabs (Marijuana). Staff denied smoking in resident rooms, doing Tik-Tok videos, or leaving resident's unattended.
9. Staff interviewed denied knowing about an incident where a resident was held down by staff. Record review showed that the facility had not investigated incidents or reported to the State hotline. Failed practice identified in reporting and investigations.
10. Interview with the facility administrator showed that if staff had concerns they would talk to the Resident Care Coordinator (RCC) and or the nurse to discuss the concern. The administrator also stated that most staff get along and do their job.
11. 12. Record review showed that family requested that the narcotic pain medication not be given to the named resident. Review of the MAR showed that the named resident had other pain medication prescribed and given that was not a narcotic. Interview with the resident's representative stated that they did not want the narcotic given.
13. Interview with the facility nurse and facility administrator showed that there was shift to shift communication and that the shift coming on arrived and walked the hall with the outgoing shift staff member. Interview with the facility nurse showed that an NSA update form would be completed for all shift communications.
14. Onsite observations and interviews showed staff to be approachable and answered questions the licensors had. Record review did find the facility was not doing investigations or reporting to the State hotline. Facility failed practice identified for investigations and reporting.
15. Observations showed staff to resident interactions were respectful. Interview with the facility administrator denied knowing or witnessing staff making fun of residents, not caring for residents, or yelling/bullying residents. The administrator stated they would not tolerate that and staff would be fired if that happened. The administrator

also stated a recent training for all staff on how to care for resident's with dementia and behaviors.

16.Observations on 06/05, 06/07, 06/20, and 06/27/2023 showed residents eating their meals, no reported complaints about the food. Interview with the facility administrator and facility nurse denied having resident's complain or have diarrhea after eating at the facility.

Failed practice identified WAC 388-78A-2371, WAC 388-78A-2630 and 388-78A- 2660, reference Statement of Deficiencies dated 07/12/2023.

Conclusion / Action:

- ☒ 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: The Orchards at Grandview **Provider Type:** Assisted Living Facility

License/Cert.#: 2503

Intake ID: 85401

Compliance Determination #: 24832

Region/Unit #: RCS Region 1 / Unit G

Investigator: Gwin Kaercher

Investigation Date(s): 06/05/2023 through 07/06/2023

Complainant Contact Date(s):

Allegation(s):

1. A named resident prior to their death, was bleeding from their eyes and suffocating.
 2. Residents were neglected due to no communication between staff.
 3. Another named resident had wounds on their legs, no treatment occurred, and we were told to leave it alone.
 4. A Medication Technician (MT) during the night shift was not changing their residents, smoked in the laundry room or outside, slept on shift, and sometimes slept in resident rooms or the living room.
 5. Another named resident had fallen, had a gash on their leg, wounds were not reported even though the MT was aware of the wounds.
 6. Residents complained of not getting enough food.
 7. Residents were over medicated.
-

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 6 Closed records sample size: 2
Observations:	The facility's common areas, resident to staff, resident to resident interactions, facility laundry room, and a morning meal serve out were observed.
Interviews:	Sampled resident, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (Negotiated Service Agreement (NSA), NSA updates, progress notes, Medication Administration Records (MAR), incident investigations, facility policies, activity calendar, staff roster, staff work schedule, facility training booklet for behaviors, and resident medical supply invoices.

Investigation Summary:

1. Record review showed that the named resident had chronic obstructive pulmonary disease (lung disease), refused treatment for the disease, and refused to be taken to the hospital or to have end of life services. Review of the progress notes showed

facility communication with the named resident's family which respected the named resident's wishes.

2. Interview with the facility nurse and facility administrator showed that there was shift to shift communication and that the shift coming on arrived and walked the hall with the outgoing shift staff member. Interview with the facility nurse showed that an NSA update form would be completed for all shift communication.

3. Interview with the facility administrator and Registered Nurse showed that the named resident with wounds died more than one year ago.

4. Observations and interviews on 06/20/2023 showed three staff that appeared to be laying/sitting on the couch/chair with blankets. The three staff appeared to have face skin indents where they had been laying down. Staff interviews showed that one night shift staff member did work and would smoke and exhale the smoke out the break room door to the outdoors. Facility failed practice identified for resident rights.

5. Record review showed that the facility completed an incident investigation and notified the doctor. Records also showed the doctor assessed and treated the named resident's skin tear/rug burn at the facility.

6. Observations on 06/05, 06/07, 06/20, and 06/27/2023 showed residents eating their meals, residents who required assistance were being assisted by staff, and no reported complaints about the food. Interview with the administrator stated that residents are given the option for second and third helpings. Additional interviews with the facility administrator and facility nurse denied having resident's complain or having diarrhea after eating at the facility.

7. Observations on 06/05, 06/07, 06/20, and 06/27/2023 showed hallways to be bare, urine on the floor in multiple hallways on different days and times, and the television was on a screen saver with instrumental music. Observations on 06/20/2023 showed the television having the Roku home screen displayed from 4:30 AM to 8:30 AM. No television programs were displayed. Observations showed sampled residents were awake and sat in couches/chairs in the common living room facing the television. Failed practice identified at 388-78A-2660, reference Statement of Deficiencies dated 07/12/2023.

Conclusion / Action:

- ☐ 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: The Orchards at Grandview **Provider Type:** Assisted Living Facility

License/Cert.#: 2503

Intake ID: 86491

Compliance Determination #: 24832

Region/Unit #: RCS Region 1 / Unit G

Investigator: Gwin Kaercher

Investigation Date(s): 06/05/2023 through 07/06/2023

Complainant Contact Date(s):

Allegation(s):

There was a sexual encounter between two male residents in a resident's room.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 6 Closed records sample size: 2
Observations:	The facility's common areas, resident to staff, resident to resident interactions, facility laundry room, and a morning meal serve out were observed.
Interviews:	Sampled resident, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (Negotiated Service Agreement (NSA), NSA updates, progress notes, Medication Administration Records (MAR), incident investigations, facility policies, activity calendar, staff roster, staff work schedule, facility training booklet for behaviors, and resident medical supply invoices.

Investigation Summary:

Facility staff reported the sexual incident between two residents with [REDACTED] diagnoses to the nurse and administrator. Further interviews with the facility administrator and the Registered Nurse (RN), stated they had not known about the details of the incident. Interviews with the facility administrator and facility nurse showed that they did not complete an investigation, call local law enforcement, and did not report the sexual incident to the State hotline. Failed practice identified at 388-78A-2371 and WAC 388-78A-2630, reference Statement of Deficiencies dated, 07/12/2023.

Conclusion / Action:

☒ 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
1200 Alder Street, Union Gap, WA 98903



Statement of Deficiencies	License #: 2503	Compliance Determination # 24832
Plan of Correction	The Orchards at Grandview	Completion Date
Page 1 of 7	Licensee: Grandview WA Management LLC	07/06/2023

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 06/05/2023, 06/07/2023, 06/20/2023, 06/27/2023 and 07/06/2023 of:

The Orchards at Grandview
2001 W 5th St
Grandview, WA 98930

This document references the following complaint number(s): 83687, 83944, 85401, 86491

The following sample was selected for review during the unannounced on-site visit: 6 of 40 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Elaine Lopez, Licensor

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.

Staci Riley

IDR PM for Reg 1G

Residential Care Services

August 23, 2023

Date

This document was prepared by Residential Care Services for the Locator website.

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

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to report to the department's Aging and Disability Services Administration Complaint Resolution Unit Hotline when staff persons had reasonable cause to believe that abuse of a resident had occurred. Additionally, the ALF did not make an immediate report to the appropriate law enforcement agency and the department for 2 of 2 Residents (3, 8) who had incidents of suspected sexual and physical abuse, and 1 of 1 Resident (1), who had two incidents with significant injury. These failures placed the residents at risk of abuse.

Findings included...

Review of the facility policy titled, "State Occurrence Reporting" dated 05/2019, showed when a reportable incident occurred, staff were to notify the appropriate state agencies per state regulation. The policy also stated that the facility developed multiple occurrence reports for multiple incidents which can consist of (but not limited to):

- Death of a Resident
- Brain Injury
- Burns
- Missing Resident
- Physical Abuse
- Sexual Abuse
- Verbal Abuse
- Neglect
- Misappropriate of Property

The policy showed if one of the above incidents occurred requiring the administrator to report the incident to a state agency, the following would occur: The administrator would initiate and answer all of the questions on the occurrence report, fax the occurrence report to the appropriate state agency, print a fax report to verify the report was sent/received, and file the occurrence report with the corresponding Incident Report per state regulations.

Review of the facility's "Navigating Through Challenging Behaviors" dated January 2012, included, "Handling sexual behaviors" on page 19 of the booklet. Page 19 of the booklet stated, "Sexual assault of any kind towards a vulnerable adult (see page 25 of the Learner's Guide) is abuse and needs to be reported to DSHS and law enforcement."

Resident 1

On 06/15/2023 at 1:48 PM, Collateral Contact 1 (CC1) Resident Representative, stated that when the resident had fallen, they were sent to the hospital, and the hospital found that they had a broken nose.

Resident 1's record showed they moved into the facility on [REDACTED]/2023. A Negotiated Service Agreement (NSA) updated on 03/03/2023 showed Resident 1 had been admitted onto Hospice services. Resident 1's diagnoses included [REDACTED], and [REDACTED].

Record review showed an NSA Update form dated 02/21/2023 showed that Resident 1 had gotten up from their chair and fell, causing facial bruising, cuts, and a sprained arm.

A progress note dated 02/21/2023 at 8:00 AM written by Staff B, Registered Nurse, showed that Resident 1 was found on the floor in their apartment. Resident 1's eyebrow and nose were bleeding and was sent to the hospital. Diagnosis from the hospital visit was [REDACTED], and [REDACTED] for Resident 1.

On 06/20/2023 at 8:15 AM, Staff B was asked if the fall with an arm injury and fractured nose, had been reported to the State hotline. Staff A (Administrator) and Staff B stated probably not, because everyone was aware of it. Staff A also confirmed that Resident 1 had a broken nose.

Another progress note dated 04/06/2023 at 3:30 PM written by Staff B showed that Resident 1 had an unwitnessed fall in their room, hitting the back of their head.

An NSA Update form dated 04/06/2023 showed that Resident 1 had tried to transfer

themselves and fell hitting their head.

On 06/20/2023 at 8:15 AM, Staff B was asked if the fall when Resident 1 hit their head had been reported to the State hotline. Staff B, stated, "No, Emergency Medical Services (EMS) were in the building." Staff B added that the resident had moved into the facility because of falls at their home, so it was a given that the resident was going to have falls.

Resident 3

On 06/20/2023 at 6:26 AM Staff G, Caregiver, stated that Resident 3 went into their apartment and hit their roommate, Resident 4, twice in the face. Staff G stated that they had informed Staff A, of the incident.

On 06/20/2023 at 8:15 AM Staff B and Staff A were asked if Resident 3's resident to resident, physical altercation incident had been reported to the State hotline or if local law enforcement (LLE) had been called. Staff B stated that the incident was not called into the state or to the LLE, because the two residents were equally demented, and no physical injuries occurred.

Review of Resident 3's 05/15/2023 NSA included diagnosis of [REDACTED], and [REDACTED]. The NSA showed under Cognitive/Behavior Status, on page, that for assistance the resident was total assist due to being disoriented, required constant supervision for safety, was verbally and physically aggressive, and was a potential threat to safety of self and others.

Resident 8

On 06/20/2023 at 6:26 AM, Staff G, Caregiver, stated that on 06/11/2023 during night shift, Resident 8 wandered into Resident 4's apartment. Facility staff found Resident 8 in bed with Resident 4, engaged in an act of sexual intimacy.

On 06/20/2023 at 8:15 AM, Staff A and Staff B were asked if the resident-to-resident sexual intimacy incident between Resident 3 and Resident 4 had been investigated and reported to the State hotline. Staff A stated that the incident was not reported to the hotline because both residents were equally demented.

On 06/21/2023 at 11:55 AM, Staff A stated that according to their dementia book/training, if residents are equally demented and because they all have sexual desires that it was okay for residents with dementia to be sexually active.

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, The Orchards at Grandview is or will be in compliance with this law and / or regulation on (Date) 7/18/23.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. Safety plan created, implemented, approved and copy attached.

Janet Walling
Administrator (or Representative)

8/25/23
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 investigate and document incidents when 2 of 2 Residents (3, 8) were found to have had a sexual encounter, and 1 of 1 Resident (4) had a resident-to-resident physical altercation. This failed practice placed residents in the home at risk of abuse and did not place interventions to reduce the risk of further incidents.

Resident 3

On 06/20/2023 at 6:26 AM Staff G, Caregiver, stated that Resident 3 went into their apartment, which they shared with Resident 4. Resident 3 hit their roommate, Resident 4, twice on the face. Staff G stated the incident was reported to Staff A, Administrator, when it occurred.

On 06/20/2023 at 8:15 AM, Staff B, Registered Nurse, and Staff A, were asked if an incident investigation had been completed for Resident 3 and Resident 4's physical altercation incident. Staff A and Staff B stated that they had not completed an incident report.

Review of an admission note dated [REDACTED]/2023 showed that Resident 3 moved into the facility due to progressed dementia. The admission note showed that Resident 3 was

inappropriately urinating, defecating (having a bowel movement), exit seeking, drinking/eating inedible objects, throwing himself down, inconsolable crying, verbally and physically aggressive.

Review of Resident 3's 05/15/2023 Negotiated Service Agreement (NSA) included diagnosis of [REDACTED], and [REDACTED]. The NSA showed on page 8 under Cognitive/Behavior Status that for assistance the resident was, "Total: Resident is always disoriented and requires constant supervision for safety. Resident is verbally and physically aggressive. Resident is potential threat to safety of self or others. Resident is resistive to redirection."

In addition, below the cognitive behavioral status showed a list frequent behaviors and interventions. The facility wrote in, "Physically resistive to care and physically aggressive spits everywhere." The facility did not document interventions for staff to provide on Resident 3's behaviors.

Resident 8

On 06/20/2023 at 6:26 AM, Staff G stated that during the night shift on 06/11/2023 Resident 8 had wandered into Resident 4's apartment. Facility staff found Resident 8 in Resident 4's bed. Resident 4 was performing an intimate act on Resident 8.

Review of Resident 8's 04/05/2023 NSA showed diagnoses that included [REDACTED] and [REDACTED]. The NSA showed on page 8 under Cognitive/Behavior Status that for assistance the resident was, "Total: Resident is always disoriented and requires constant supervision for safety. Resident is verbally and physically aggressive. Resident is potential threat to safety of self or others. Resident is resistive to redirection." The NSA also showed under the tab of Interventions were the options of mentally clear, slightly confused, moderately confused and total confusion. Facility marked that Resident 8 was, "Total Confusion."

Review of Resident 4's NSA dated 01/05/2023 showed diagnoses that included [REDACTED] and [REDACTED]. The NSA showed that the resident required total assistance for their activities of daily living. The NSA also showed that the resident received support services from a local [REDACTED].

On 06/20/2023 at 8:15 AM, Staff B and Staff A were asked if an incident investigation had been completed and if local law enforcement had been notified for Resident 4 and Resident 8's nonconsensual (both residents 8 and 4 had diagnoses of [REDACTED]) sexual incident. Staff A and Staff B stated that an incident report had not been completed and local law enforcement were not notified.

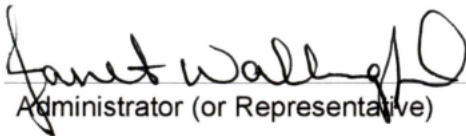
On 06/21/2023 at 11:55 AM Staff A stated that according to their dementia book/training, if residents are equally demented and because they all have sexual desires that it was okay for residents with dementia to be sexually active.

On 07/06/2023 at 11:00 AM Staff A stated that family of Resident 8 and Resident 4 were not notified at the time of the sexual incident.

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, The Orchards at Grandview is or will be in compliance with this law and / or regulation on (Date) 7/18/23.

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


Administrator (or Representative)

8/25/23
Date



The
ORCHARDS
at Grandview



Safety Plan

All resident safety

Staff training was provided in writing the following:

- When Behavior Becomes Challenging- Steps to Navigating Challenging Behaviors
- Prevent or minimize challenging behaviors
- Looking At Specific Behaviors
 - Handling a Client's Anger
 - When anger turns to possible violence
 - Pushing, pinching, slapping, kicking, biting
 - Handling sexual behaviors
 - Disrespectful behaviors
 - Anxiety

Floor supervisor, or med aide in their absence will:

- Report all incidents to ED and RN via phone or in-person. Ensuring Incident Reports are completed accurately.
- All lights are on
- TV is on dementia specific programming
- Furniture is in place
- Walk the floor to ensure it is clean, mop where necessary
- Carry and answer the house phone
- Check the common bathrooms- clean when necessary
- Direct care staff
- Spot check resident rooms
- Ensure residents are appropriately dressed
- Provide relief to care staff when on breaks
- Laundry is running

****Facility employee supervision will ultimately be provided by ED, RN, and RCC. This will include non-scheduled visits during NOC shift and weekends. Facility RN will provide oversight ED with support from Consulting RN when necessary.**

Specific Resident Safety Plan

1. [REDACTED]: Relocated to a private room. Notified POA/Son, and case worker. NSA created and implemented for staff to keep [REDACTED] and [REDACTED] separated in common areas- including but not limited to sitting in the dining room.
2. [REDACTED]: Notified POA/daughter, and case worker. NSA created and implemented for staff to keep [REDACTED] and [REDACTED] separated in common areas- including but not limited to sitting in the dining room.
3. [REDACTED]: Notified POA. Door locks changed to prevent [REDACTED] from entering other resident's room. A key will be required to open ALL facility doors.
4. [REDACTED]: Continue current care plan which includes:
 - Encourage [REDACTED] to use her call-light buttons
 - Staff will make sure call-light button is within reach.
 - Staff will do 15-minute safety checks when not in common areas during wake hours
 - Staff will place a pillow or doll on her lap to discourage standing.

Staff Reporting in compliance to WAC 388-78A-2371

An **Incident** is defined as any happening that is **not** consistent with the routine operation of the facility **or** the routine care of a particular resident.

All incidents and/or accidents occurring on the premises, grounds, and/or on facility sponsored outings must be reported immediately and an incident report must be filled out. Reporting will be done via phone or in-person to all parties listed on Incident Report.

Safety Measures

In accordance with WAC 388-78A-2371, 388-78A-2630 and in complying with the requirements of the State Vulnerable Adult Act, Chapter 74.34 RCW, and the Elder Justice Act of 2009, Section 1150B of the Social Security Act, The Orchards at Grandview will investigate actions and findings for any alleged or suspected neglect, abuse, or exploitation that jeopardizes or affects a resident's health or life.

1ST PRIORITY: Protect the victim(s)/resident(s) from further harm.

2ND PRIORITY: Perform a thorough investigation, and report to the Department and law enforcement as required.

The facility must:

1. Determine what occurred and document circumstances of event with use of the appropriate occurrence report. This thorough investigation will systematically collect and

review evidence/information that describes and explains an event or a series of events. It seeks to determine if abandonment, abuse, neglect, or misappropriation of resident property occurred, and how to make necessary changes to the provision of care and series to prevent reoccurrence.

2. When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident substantiated; and protect other residents during the investigation. This may require moving residents to another room.

Reporting

In the event that reporting is questionable, the facility will contact the DSHS Complaint Investigator. The facility will report as followed:

To the Department:

- When there is reasonable cause to believe violations have occurred involving abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation;
- Any reasonable suspicion of a crime, including physical or sexual assault, has been committed against a resident;
- Any act, when there is reasonable cause to believe the act caused a fear of imminent harm;
- Substantial injuries of unknown source not related to suspected abuse or neglect (because under some circumstances the failure to take preventive measures may constitute abuse or neglect).

To Law Enforcement:

- When there is a reason to suspect that sexual assault or physical assault against a resident has occurred (*except* under circumstances described below), or:
- When there is reasonable cause to believe that an act has caused fear of imminent harm.
- Limited Exception: An incident of physical assault between residents always has to be reported to the Department, but does not have to be reported to Law Enforcement, *unless*

(a) it caused more than minor bodily injury *and*

- required more than basic first aid, *or*
- if the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same residents or involving the same residents; or there is an attempt to choke a resident, *or*

(b) the injured resident or his or her legal representative or family member asks that a report be made.

All-staff meeting on 6/22/23 to review all previous information listed and staff expectations:

- Keeping residents safe by monitoring residents in common areas and using tools provided in the “Navigating Through Challenging Behaviors” and their ECS Care Plans where appropriate.
- Sleeping at work.
- Running laundry.

Janet Wallingford, ED: _____ Date: _____

Stephanie Gibbons, RN: _____ Date: _____