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) 35157 (Completion Date 01/12/2024) and 30660 (Completion Date 12/04/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/12/2024 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-2120-1, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-4

The Department staff who did the on-site verification:
Felicia Cantu, 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: The Orchards at Grandview **Provider Type:** Assisted Living Facility

License/Cert.#: 2503
Intake ID: 100727
Compliance Determination #: 30660
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 10/06/2023 through 12/04/2023
Complainant Contact Date(s):

Allegation(s):
A named resident has a significant wound and was not being treated.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Wound care
Interviews:	Identified resident Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Resident records(face sheet, care plans, assessments, chart notes, doctor orders)

Investigation Summary:
Observations showed that the named resident had a significant pressure injury. Interviews and record review showed that the facility failed to place named resident on alert charting, and take appropriate actions to prevent worsening pressure injury. Failed practice identified. WAC 388-78A-2120 reference statement of deficiencies dated 12/04/2023.

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

License/Cert.#: 2503
Intake ID: 100799
Compliance Determination #: 30660
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 10/06/2023 through 12/04/2023
Complainant Contact Date(s): 11/17/2023

Allegation(s):

1) A named resident passed away because of an an infection the facility did not know about.
2) A named resident was not showered regularly and cared for properly.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Facility environment Staff to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster House policies Hospital records Resident records (face sheet, care plan, assessments, chart notes, doctor orders)

Investigation Summary:

Interviews and record review showed that the named resident was hospitalized and passed away due to [redacted]. The facility failed to monitor, follow the negotiated service agreement (NSA), and take appropriate actions to identify a wound infection to resident's heel. Failed practice identified. WAC 388-78A-2120 reference statement of deficiencies dated 12/04/2023.

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: 101123
Compliance Determination #: 30660
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 10/06/2023 through 12/04/2023
Complainant Contact Date(s):

Allegation(s):
A named resident has significant wound and there are no wound care orders.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Wound care
Interviews:	Identified resident Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Resident records(face sheet, care plans, assessments, chart notes, doctor orders)

Investigation Summary:
Observations showed that the named resident had a significant pressure injury. Interviews and record review showed that the facility failed to monitor, place named resident on alert charting, and take appropriate actions to prevent worsening pressure injury. Failed practice identified. WAC 388-78A-2120, reference statement of deficiencies dated 12/04/2023.

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
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License # 2503	Compliance Determination # 30660
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Page 1 of 6	Licensee: Grandview WA Management LLC	12/04/2023

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 10/06/2023 and 10/06/2023 of:

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

This document references the following complaint number(s): 99563, 100727, 100799, 100917, 101123

The following sample was selected for review during the unannounced on-site visit: 4 of 37 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, 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

12/13/2023
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.

Statement of Deficiencies	License #: 2503	Compliance Determination # 30660
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Administrator (or Representative) 12/18/23 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to monitor, evaluate and take action for residents assessed needs related to skin concerns for 2 of 2 residents (Residents 1 and 2). These failures resulted in harm due to an emergent hospitalization for Resident 1 and a delay in medical treatment for Resident 2's pressure injury (wound that occurs from prolonged pressure on skin).

Findings included...

Record review of the ALF's policy titled "Change of Condition" undated, showed that the facility acknowledges changes of condition that includes skin conditions, increased confusion, a change of Activities of Daily Living changes (ADL's) and an incident that has adversely affected the resident's wellbeing. The facility will place resident on "alert charting" [when there is a change in condition a resident will be monitored on alert charting for at least 72 hours and care staff would chart on the selected resident every shift on their facility progress notes.]

Review of the ALF's policy "Medical Incident Policy" dated 05/01/2019 showed that the ALF is to provide a safe environment for all residents. The staff will respond with appropriate procedures when a minor or major emergency occurs to provide the best care for residents. The facility will take appropriate action to resolve the possibility of future occurrences. A minor or major incident could include skin tears, scrapes, or abrasions.

Upon discovery of a minor or major incident the facility will immediately assess, decide what action to take which would include what treatment plan. Then staff would notify the facility nurse and doctor, then documentation will take place in resident chart notes and an incident report will be completed and Negotiated Service Agreement (NSA) will be implemented.

Resident 1

Review of Resident 1's facility records showed that Resident 1 was admitted to the ALF on [redacted] 2023 and had a diagnosis of [redacted], and [redacted].

Review of Resident 1's updated NSA dated 09/07/2023 showed that staff were to assist Resident 1 with showers and provide foot care at least one time a week.

Review of Resident 1's assessment dated 09/7/2023 did not show documentation of a wound to the left heel or buttocks.

Resident 1's chart notes on [redacted] 2023 showed they were sent to local hospital for altered mental status and weakness.

Per hospital records on [redacted] 2023, Resident 1 was seen due to multiple falls and altered mental status. On arrival Resident 1 was hypotensive (dangerously low blood pressure). Resident 1 had significant fungal infection on chest, groin creases, inner thighs, and rectal area. An abscess (confined pocket of pus) to left foot was discovered by hospital staff. A wound culture (test to detect bacteria) showed that the left heel was positive for infection called Staphylococcus aureus (can cause serious infection that can travel to the blood stream). Resident 1 also had severe wound excoriations and cellulitis(infection) to lower legs and a stage 2 pressure sore (partial thickness loss of skin that appears red or pick) to buttocks. Resident 1 was diagnosed with [redacted] Other diagnosis included [redacted].

Review of Resident 1's facility records from 09/07/2023 to 09/25/2023 showed no documentation of Resident 1's pressure area/wound to the left heel and buttocks.

Review of Resident 1's death certificate showed that Resident 1 died on [redacted] 2023 at 6:35 PM caused by [redacted].

On 10/05/2023 at 12:30 PM, Collateral Contact 1 (CC1), Resident's Representative, stated that Resident 1 passed away in the hospital on [redacted] 2023 from a diagnosis of [redacted]. CC1 stated that they

were shocked in the condition that Resident 1 was when they arrived at the hospital. CC1 expressed that they observed that Resident 1 had open sores to top of feet and had sores all over their body. It was discovered that that Resident 1 also had a necrotic wound (dead tissue) heel. "I had no clue [Resident 1] had a wound to their heel, the heel had a black spot on it this could have been prevented." CC1 also expressed that they thought that the facility staff were not following the Negotiated Service Agreement (NSA). CC1 stated that they did not observe staff provide foot and nail care for Resident 1.

On 10/06/2023 at 10:45 AM Staff A, Registered Nurse, Health Wellness Director, stated that Resident 1 died due to other health conditions and they had no knowledge of a wound to Resident 1's heel.

On 10/06/2023 at 11:37 AM Staff B, Caregiver stated she was a lead caregiver and cared for Resident 1 when Resident 1 was still living in the facility. Staff B stated that they were not aware of any significant wounds to feet.

On 10/30/2023 at 4:05 PM Staff C, Shower Aide stated they did not observe Resident 1's feet.

On 11/6/2023 at 10:30 AM Staff E, Administrator acknowledged care staff should have noticed a significant wound to Resident 1's foot.

Resident 2

Review of Resident 2's initial move in assessment dated 01/10/2020 showed that their skin was clean, dry, and intact.

Review of Resident 2's NSA dated 07/31/2023 showed that Resident 2 had a fall on 7/23/2023 and 07/31/2023. Resident 2 required total assist with getting up out of bed, getting dressed, hygiene, and needed to be toileted every two hours.

Review of Resident 2's updated NSA dated 08/14/2023 showed that Resident 2 had a "spot" that was red and swollen. Resident 1 was dependent upon staff, Licensed Nurse, and an outside agency was to take care of skin issues. Staff was to reposition Resident 2 every two hours, encourage resident to change positions throughout the day, help prevent skin breakdown while in bed, and always keep skin clean and dry.

Per Resident 2's record, there was no alert charting documentation regarding resident's skin concerns from end of July 2023 to 08/14/2023 and then from 08/14/2023 to 10/06/2023.

On 10/06/2023 at 11:31 AM, during an observation with Staff A and Staff H, Resident Care

Coordinator's (RCC), Resident 2 was observed in their bed. Resident 2 had a pressure sore to their hip. The wound had full thickness of tissue loss in which the wound base was covered by slough (thick dark yellow moist material) with possible tunneling (wound that has progressed to an opening underneath the surface of the skin), and the depth unknown. The surrounding of the wound base was red.

On 10/06/2023 at 11:37 AM, Staff B stated that she remembered that Resident 2 had "redness" to hip in July 2023 after their falls then became bed bound. Care staff "tried" to reposition Resident 2 but did not think they had a process to document that they repositioned Resident 2 every two hours. Staff B expressed that the dressing to wound was often left off.

Review of Resident 2's record showed on 10/24/2023, the facility sent a referral to Collateral Contact 2 (CC2), Home Health Agency requesting nursing services for wound care for Resident 2's worsening pressure sore (two months after the red and swollen spot on the hip was identified).

On 10/30/2023 at 5:00 PM, Staff D, Caregiver stated that the last week of July 2023 she notified Staff H that Resident 2 had "redness" to their hip and that it felt very warm. Staff H stated that she would notify Staff A. Staff D stated that three weeks later she noticed that the wound had blistered and had opened. Staff D expressed concern that the appropriate wound care orders were not received timely and believed the significance of skin injury (sore) could have been prevented.

On 11/03/2023 at 3:13 PM Staff F, Caregiver, stated that they were not instructed to complete alert charting to monitor Resident 2's wound. Staff F also stated that the dressing to wound was left off often and the wound would get soiled frequently due to Resident 2's incontinence (unable to control urination).

On 11/15/2023 at 10:57 AM Staff A, stated that they charted by exception and had not placed Resident 2 on alert charting yet. Staff A also stated there was referral to wound care/home health but had still not been approved yet.

On 11/27/2023 at 1:15 PM, CC2 stated that on 10/26/2023 they sent a notification to the ALF facility that the referral for Resident 2, regarding wound care needed to be revised in order to proceed. CC2 stated they had not received any phone calls or follow-up regarding the referral, as requested.

On 11/30/2023 at 2:32 PM Staff E, Administrator stated that Resident 2 had passed away on [redacted] 2023 due to [redacted].

On 12/04/2023 at 10:58 AM Staff H, RCC, stated that their usually process for "alert charting" was that a resident who needed to be placed on "alert charting" would be on for at least 72 hours and care staff would chart on the selected resident every shift on their

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facility progress notes.

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) 12/19/23.

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

Janet Wall

Administrator (or Representative)

12/18/23

Date