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

Pine Ridge OpCo LLC
Pine Ridge Alzheimer's Special Care Center
12009 E Mission Ave
Spokane Valley, WA 99206

RE: Pine Ridge Alzheimer's Special Care Center License # 2513

Dear Administrator:

This letter addresses Compliance Determination(s) 26671 (Completion Date 07/14/2023) and 24121 (Completion Date 06/13/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/14/2023 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, WAC 388-78A-2630-1-a, WAC 388-78A-2660-7

The Department staff who did the on-site verification:
Anne Sinclair, NCI Community Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Pine Ridge Alzheimer's Special Care Center
License/Cert.#: 2513
Compliance Determination #: 24121
Investigator: Anne Sinclair
Investigation Date(s): 05/17/2023 through 06/13/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 81005
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1. Staff to resident abuse.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Staff to resident interactions Resident to resident interactions Activities
Interviews:	Business office Manager Regional health support staff Executive Director Family Medtech
Record Reviews:	Sample residents care plan Sample residents face sheet Disclosure of services Characteristic roster Staff roster Facility investigation Staff credential check Resident abuse/neglect policy

Investigation Summary:
1. Agency staff had reported to facility staff a witnessed altercation between another agency staff and two different residents, on consecutive days. The agency staff member failed to report the allegation immediately to facility staff of physical and verbal abuse of a resident. Failed facility practice under WAC 388-78A-2360(1)(a)(b) Reporting Abuse and Neglect, and WAC 388-78A-2660(7) Resident Rights.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2513	Compliance Determination # 24121
Plan of Correction	Pine Ridge Alzheimer's Special Care Center	Completion Date
Page 1 of 5	Licensee: Pine Ridge OpCo LLC	06/13/2023

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 05/17/2023, 05/17/2023 and 05/17/2023 of:

Pine Ridge Alzheimer's Special Care Center
12009 E Mission Ave
Spokane Valley, WA 99206

This document references the following complaint number(s): 81005, 81048, 82613

The following sample was selected for review during the unannounced on-site visit: 4 of 45 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anne Sinclair, NCI Community Complaint Investigator

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JUN 30 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.

Residential Care Services

06/26/2023
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.

Becky Barden
Administrator (or Representative)

6/14/23
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to immediately report allegations of verbal and physical abuse to the Complaint Resolution Unit for 2 of 4 residents (Residents 1 and 2). This failed reporting practice precluded the department from having immediate knowledge to conduct an investigation and placed the resident at risk for abuse.

Findings included...

Record review of the facility's policy titled "Resident Abuse and Neglect", dated effective 11/01/2014, showed that staff who witness or suspect abuse or neglect are to immediately report, by the person who witnessed it, to the supervisor on duty and the appropriate state agency.

Review of a facility incident report, dated 05/03/2023, showed Staff C, Executive Director, had received a verbal report from Staff D, Med Tech, that same morning reporting that Staff A, Caregiver, had reported to Staff D an allegation of observing Staff B, Caregiver, become physically and verbally aggressive with Resident 1 on or around 04/19/2023, and Resident 2 the next day, on or around 04/20/2023.

Review of a facility incident report for Resident 2, dated 05/03/2023, showed that Staff A witnessed Staff B slap and verbally abuse Resident 2 on or around 04/20/2023. The incident report further showed that the incident was not reported to Staff C until 05/03/2023.

In interview on 05/18/2023 at 12:50PM, Staff C stated that Staff A did not report the incidents of alleged abuse involving Staff B and Residents 1 and 2 to facility staff until 05/03/2023, two weeks after the incidents occurred. Staff C further stated that Staff A did not report the incidents to the department.

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In an interview on 06/13/2023 at 9:07AM, Staff A stated they had observed Staff B become physically and verbally aggressive with Resident 1 and 2 on consecutive days on or around 04/19/2023 and 04/20/2023 but did not report it to the department.

Review of the department's reporting data base showed the facility reported the incident on 05/03/2023, fourteen days after the alleged abuse of Resident 1, and fifteen days after the alleged abuse of Resident 2.

This is a recurring deficiency previously cited on 02/23/2023.

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, Pine Ridge Alzheimer's Special Care Center is or will be in compliance with this law and / or regulation on (Date) 6/14/23.

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

Becky Bearden — Administrator (or Representative)

6/14/23 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were free from physical and verbal abuse for 2 of 4 residents (Resident 1 and 2). This failure resulted in Resident 1 and 2 being physically and verbally abused, and placed residents at risk for psychological trauma and decreased quality of life.

Findings included...

Record review of the facility's policy titled "Resident Abuse and Neglect", dated effective 11/1/2014, defined abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult.

<Resident 1>

Review of Resident 1's Individual Service Plan, dated 03/30/2023, showed the resident was diagnosed with [redacted] and required staff assistance with mobility and all manner of activities of daily living (ADLS).

Review of a facility incident report, dated 05/03/2023, showed that on or around 04/19/2023, Staff A, Caregiver, witnessed Staff B, Caregiver, put their hand aggressively behind Resident 1's neck while both staff were assisting the resident. The incident report showed that Staff B pulled Resident 1 up aggressively after Resident 1 began yelling. The incident report further showed that Staff B stated to Resident 1, "You won't talk to me that way, you will not intimidate me," while their hand was on the back of Resident 1's neck.

In an interview on 06/13/2023 at 9:07AM, Staff A stated that Staff B was "very aggressive and forceful" with Resident 1 at time of incident and had stated to Staff A, "I don't tolerate residents being rude to me."

<Resident 2>

Review of Resident 1's Individual Service Plan, dated 03/30/2023, showed the resident had a diagnosis of [redacted], and needed staff assistance with ADLS.

Review of a facility incident report, dated 05/03/2023, showed that on or around 04/20/2023, Staff A witnessed Staff B slap Resident 2 on the face while both staff were assisting Resident 2. The incident report showed that Staff B stated, "That doesn't feel good does it," in response to Resident 2.

In interview on 06/13/2023 at 9:33AM, Staff A stated that Staff B was aggressive with Resident 2 at time of incident.

This is a recurring deficiency previously cited on 02/23/2023.

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, Pine Ridge Alzheimer's Special Care Center is or will be in compliance with this law and / or regulation on (Date) 6/14/23.

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

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Becky Beard
Administrator (or Representative)

6/14/23
Date