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

Summer Wood OpCo LLC
Summer Wood Alzheimer's Special Care Center
830 NW Sunburst Ct
Moses Lake, WA 98837

RE: Summer Wood Alzheimer's Special Care Center License # 2514

Dear Administrator:

This letter addresses Compliance Determination(s) 30721 (Completion Date 10/06/2023) and 27736 (Completion Date 08/18/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/06/2023 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-2160

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

If you have any questions, please contact me at (509)514-3899.

Sincerely,

Lori Redford

Lori Redford, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Summer Wood Alzheimer's Special Care Center
License/Cert.#: 2514
Compliance Determination #: 27736
Investigator: Sylvia Shauvin
Investigation Date(s): 08/07/2023 through 08/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 91555
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1 - Facility served peanut butter to resident that had peanut allergy

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents' safety and well-being Meal and snacks Kitchen, including tray line and Dietary supervisor's office
Interviews:	Ten residents Resident representative Four caregivers Health Services Director/Facility licensed nurse Cook Dietary Supervisor Business Office Manager Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, behavior tracking, and Progress Notes Facility investigation documents Dietary posting - special diets and preferences Named resident's allergy form Policy and procedures - Emergencies Sample two staff's credentials

Investigation Summary:
1 - Named resident was observed dependent on staff for meals and snacks. In an interview with named resident, they stated they were allergic to peanuts, and the facility served them peanut butter. Interviews with dietary staff and caregivers showed the resident was allergic to peanuts and, the facility served the resident a peanut butter cookie, resulting in unresponsiveness which required intervention by emergency personnel. Failed facility practice was found. The deficiency was documented in a

Statement of Deficiencies under Washington Administrative Code 388-78a-2160
Implementation of Negotiated Service Agreement.

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: Summer Wood Alzheimer's Special Care Center
License/Cert.#: 2514
Compliance Determination #: 27736
Investigator: Sylvia Shauvin
Investigation Date(s): 08/07/2023 through 08/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 91804
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1 - Resident left the building

Investigation Methods:

Sample:
Total residents: 48
Resident sample size: 9
Closed records sample size: 0

Observations:
Residents' safety and well-being
Any resident injuries
Environmental safety e.g. alarm system, areas of possible egress
Supervision/monitoring of residents

Interviews:
Ten residents
Resident representative
Four caregivers
Health Services Director/Facility licensed nurse
Business Office Manager
State Fire Marshall
Maintenance staff
Administrator

Record Reviews:
Sample residents' Face Sheets, assessments, care plans, behavior tracking, and Progress Notes
Communication with prescribers
Facility investigation documents
Staffing schedule - June through August 2023
Activity schedule - Aug 2023
Sample two staff's credentials
Facility policies - Management of behaviors (e.g. wandering, elopement, agitation)

Investigation Summary:
1 - Named resident was observed in the facility without signs of harm. Breakaway stops were observed on windows which maintenance staff stated was in response to

named resident's recent, unsupervised exit from facility. Facility investigated the incident and determined the resident followed visitors who were exiting the building. In addition to the breakaway stops, the facility was observed with alarms on doors and windows, and the facility provided visitors with information about preventing residents' unplanned exit from the facility. Written consultation was provided under Washington Administrative Code 388-78a-2120 Monitoring residents' well-being regarding evaluating the effectiveness of its interventions for problem behaviors.

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: Summer Wood Alzheimer's Special Care Center
License/Cert.#: 2514
Compliance Determination #: 27736
Investigator: Sylvia Shauvin
Investigation Date(s): 08/07/2023 through 08/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 92033
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1 - Resident to resident aggression, resulting in injury

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents' safety and well-being Any resident injuries Staff's response to residents' problem behaviors e.g. anxiety, agitation, aggression Supervision/monitoring of residents
Interviews:	Ten residents Resident representative Four caregivers Health Services Director/Facility licensed nurse Business Office Manager Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, behavior tracking, and Progress Notes Communication with prescribers Facility investigation documents Staffing schedules - June through August 2023 Activity schedule - Aug 2023 Facility policy - Management of aggression, and elopement Sample two staff's credentials Staff training content

Investigation Summary:
1 - No observations were made of residents' agitation/aggression. Alleged victim was observed with facial bruise the resident stated was from another resident hitting them. They had no concerns about staff's response to alleged incident. Alleged aggressor had no injuries or concerns about their personal safety. Other residents interviewed

had no concerns about their personal safety. Staff was observed readily available to redirect residents that exhibited behaviors, such as restlessness and anxiety. Facility investigated alleged incident and put interventions in place to address residents' safety. Written consultation was provided under Washington Administrative Code 388-78a-2120 Monitoring residents' well-being regarding evaluating the effectiveness of interventions for problem behaviors, such as agitation/aggression.

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: Summer Wood Alzheimer's Special Care Center
Provider Type: Assisted Living Facility
License/Cert.#: 2514
Intake ID: 92917
Compliance Determination #: 27736
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 08/07/2023 through 08/18/2023
Complainant Contact Date(s): 08/15/2023, 08/21/2023

Allegation(s):
1 - Resident slapped another resident
2 - Staff doesn't supervise residents

Investigation Methods:

Sample:
Total residents: 48
Resident sample size: 9
Closed records sample size: 0

Observations:
Residents' safety and well-being
Any resident injuries
Staff's response to residents' problem behaviors e.g. anxiety, agitation, aggression
Supervision/monitoring of residents

Interviews:
Ten residents
Resident representative
Four caregivers
Health Services Director/Facility licensed nurse
Business Office Manager
Administrator

Record Reviews:
Sample residents' Face Sheets, assessments, care plans, behavior tracking, and Progress Notes
Communication with prescribers
Facility investigation documents
Staffing schedules - June through August 2023
Activity schedule - Aug 2023
Facility policy - Management of aggression
Sample two staff's credentials
Staff training content

Investigation Summary:
1 - No observations were made of residents' agitation/aggression. Alleged victim was observed without injuries and signs of distress. Alleged victim had no concerns about personal safety. Alleged aggressor was observed quietly seated near the nursing

station, had no injuries or signs of distress, and was unable to furnish details about their routines. Other residents interviewed had no concerns about their personal safety. Staff was observed readily available to redirect residents that exhibited restlessness and anxiety. Facility investigated alleged incident and put interventions in place to address residents' safety. Written consultation was provided under Washington Administrative Code 388-78a-2120 Monitoring residents' well-being regarding evaluating the effectiveness of its interventions for problem behaviors, such as agitation/aggression.
2 - Refer to summary under Issue 1, above. Written consultation was provided under Washington Administrative Code 388-78a-2120(2)(b)(3) Monitoring residents' well-being regarding evaluating the effectiveness of its interventions for problem behaviors, such as agitation/aggression.

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: Summer Wood Alzheimer's Special Care Center
License/Cert.#: 2514
Compliance Determination #: 27736
Investigator: Sylvia Shauvin
Investigation Date(s): 08/07/2023 through 08/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 93586
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1 - Resident to resident aggression

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents' safety and well-being Any resident injuries Staff's response to residents' problem behaviors e.g. anxiety, agitation, aggression Supervision/monitoring of residents
Interviews:	Ten residents Resident representative Four caregivers Health Services Director/Facility licensed nurse Business Office Manager Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, behavior tracking, and Progress Notes Communication with prescribers Facility investigation documents Staffing schedules - June through August 2023 Activity schedule - Aug 2023 Facility policy - Management of aggression Sample two staff's credentials Staff training content

Investigation Summary:
1 - No observations were made of residents' agitation/aggression. Named residents were observed without injuries and signs of distress. One of the named residents had no concerns about their personal safety, and the other resident was unable to provide details about their safety. Other residents interviewed had no concerns about their

personal safety. Staff was observed readily available to redirect residents that exhibited restlessness and anxiety. Facility investigated alleged incident and put interventions in place to address residents' safety. Written consultation was provided under Washington Administrative Code 388-78a-2120 Monitoring residents' well-being regarding evaluating the effectiveness of its interventions for problem behaviors, such as agitation/aggression.

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 #: 2514	Compliance Determination # 27736
Plan of Correction	Summer Wood Alzheimer's Special Care Center	Completion Date
Page 1 of 3	Licensee: Summer Wood OpCo LLC	08/18/2023

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 08/07/2023, 08/07/2023, 08/18/2023 and 08/18/2023 of:

Summer Wood Alzheimer's Special Care Center
830 NW Sunburst Ct
Moses Lake, WA 98837

This document references the following complaint number(s): 91356, 91555, 91804, 92033, 92917, 93586

The following sample was selected for review during the unannounced on-site visit: 9 of 48 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

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. [illegible]

Residential Care Services

08/29/2023
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 #: 2514	Compliance Determination # 27736
Plan of Correction	Summer Wood Alzheimer's Special Care Center	Completion Date
Page 2 of 3	Licensee: Summer Wood OpCo LLC	08/18/2023

Administrator (or Representative) — Date: 8/30/2023

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement the negotiated service agreement for 1 of 10 sample residents (Resident 1) with a food allergy. This failure resulted in a health emergency and placed Resident 1 at risk of death.

Findings included...

Resident 1's negotiated service agreement (NSA), dated 06/16/2023, showed the resident should not eat peanuts because it could result in an anaphylactic reaction (severe allergic reaction that can result in death).

Resident 1's progress notes, dated 07/28/2023 at 2:43 PM and 07/28/2023 at 3:00 PM, showed Resident 1 was served a peanut butter cookie at lunch, and the resident became unresponsive. The progress note entries showed that 911 was called and emergency medical technicians (EMTS) had to give the resident an injection of Benadryl (medication to stop the allergic reaction). The progress notes showed the EMTs were able to stabilize Resident 1.

In an interview on 08/07/2023 at 11:25 AM, Staff A, Dietary Supervisor, stated that Resident 1 was allergic to peanuts. Staff A stated that resident allergies were typically posted at the kitchen tray line for several days after residents moved into the facility, and then the residents' allergy information was filed in a binder that was kept in Staff A's office.

Observation on 08/07/2023 at 11:30 AM, showed Resident 1's peanut allergy information was not posted at the tray line. A Dietary Communication form that showed Resident 1 was allergic to peanuts was observed in a binder that was kept in Staff A's office, and was not visible to kitchen staff.

In an interview on 08/07/2023 at 1:35 PM, Staff C, Caregiver, stated they were present in the back dining room during lunch when Resident 1 was served a pureed peanut butter cookie. Staff C stated they witnessed Resident 1 eating dessert and spitting out what appeared to be peanuts. Staff C stated the dessert smelled like peanut butter. Staff C stated the facility called 911 as Resident 1 became unresponsive.

In an interview on 08/07/2023 at 3:15 PM, Resident 1 stated they recently ate peanut butter that the facility served them. Resident 1 further stated they were allergic to peanut butter.

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, Summer Wood Alzheimer's Special Care Center is or will be in compliance with this law and / or regulation on (Date) 9/8/2023 .

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

Administrator (or Representative) — Date: 8/30/2023

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

Summer Wood OpCo LLC
Summer Wood Alzheimer's Special Care Center
830 NW Sunburst Ct
Moses Lake, WA 98837

RE: Summer Wood Alzheimer's Special Care Center # 2514

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 08/18/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Stephanie Jenks, Field Manager
Residential Care Services

Region 1, Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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

(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.

The facility failed to evaluate its interventions for residents' pattern of aggression.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration

Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

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

Enclosure