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) 42166 (Completion Date 06/04/2024) and 39401 (Completion Date 04/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/04/2024 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-2474-2-b

The Department staff who did the on-site verification:
Sandra Fast, 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: Summer Wood Alzheimer's Special Care Center
License/Cert.#: 2514
Compliance Determination #: 39401
Investigator: Sandra Fast
Provider Type: Assisted Living Facility
Intake ID: 125213
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 04/08/2024 through 04/23/2024
Complainant Contact Date(s): 04/15/2024

Allegation(s):

1. Improper hand washing and use of PPE.
2. Residents not toileted or repositioned.
3. Laying on resident's beds and texting.
4. Using foul language towards residents.
5. Making fun of residents.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Staff Staff to resident interactions Hand hygiene PPE use Resident apartment
Interviews:	Administrator Health Services Director Caregivers Medication aid Complainant
Record Reviews:	Disclosure of services Characteristic roster Staff list House policy on hand hygiene House policy on resident abuse and neglect House policy on employee conduct Abuse prevention WACs and RCWs Staff trainings Resident face sheets Resident care plans Resident individual service plans Facility investigation

Investigation Summary:

1. The facility provided refresher education with all staff regarding hand hygiene and the proper use of personal protective equipment (PPE). The administrator and the Health Services Director (HSD) stated that they were conducting random audits of hand washing and use of PPE on all shifts and on the weekends. The caregiver and medication tech staff understood when to wash their hands and when the use of PPE was indicated. The caregiver staff and the medication techs were observed using hand hygiene and appropriate PPE as needed for resident cares. No failed facility practice was identified.
2. The caregivers were observed toileting residents before their afternoon meal, and toileting and assisting residents into their lounge chairs after their meal. The residents showed no signs of discomfort or distress, and no lingering odors were noted near any residents. The staff were readily available and observed making sure the residents were safe and assisted them as needed with ambulation and toileting. No failed facility practice was identified.
3. The staff were observed appropriately interacting with residents and redirecting them as needed. No observation of staff on their cell phones occurred. The facility conducted staff education regarding their codes of conduct which addressed cell phones not being used while staff was on duty. The staff stated that cell phone use was not allowed while they were on duty. No staff were observed sitting or lying on resident beds. The administrator and HSD stated that they were conducting random audits on all shifts and the weekends to make sure this was not happening. No failed facility practice was identified.
4. The staff were observed interacting with and gently redirecting the residents when needed. The residents did not show signs of timidity or distress while interacting with the staff. No foul language was heard being used when the staff were interacting with the residents. Resident representatives stated that they had not heard any of the staff using foul language around the residents. The facility conducted education regarding the facility's code of conduct which included not using foul or inappropriate language around the residents. The caregivers and medication tech stated that foul language was not allowed while they were on duty. The facility conducted a detailed investigation regarding the allegations and the named caregivers were suspended during the investigation and removed from service shortly after the investigation concluded. No failed facility practice was identified.
5. The facility conducted education for staff on the facility's code of conduct, reporting of abuse and neglect and the WACs that applied. The facility staff stated that when the two named caregivers were together, they would "loaf off" and spend long periods of time in resident rooms. The caregiver staff also stated that they had seen the named caregivers on their cell phones occasionally. The facility removed the caregivers from the schedule while an investigation was conducted. Shortly after the investigation the named caregivers were removed from service. One of the named caregivers had not completed their HCA training within the allotted timeframe and had an expired license. A citation was issued for WAC 388-78A (2474) (4).

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 #: 2514	Compliance Determination # 33401
Plan of Correction	Summer Wood Alzheimer's Special Care Center	Completion Date
Page 1 of 2	Licensee: Summer Wood OpCo LLC	04/23/2024

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 04/08/2024, 04/08/2024 and 04/08/2024 of:

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

This document references the following complaint number(s): 125213, 125492

The following sample was selected for review during the unannounced on-site visit: 4 of 41 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community 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.

Residential Care Services

04/25/2024
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 # 339401
Plan of Correction	Summer Wood Alzheimer's Special Care Center	Completion Date
Page 2 of 2	Licensee: Summer Wood OpCo LLC	04/23/2024

Administrator (or Representative) — Date: 4/26/2024

WAC 388-76A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a caregiver completed the long-term care worker training requirements for 1 of 2 staff (Staff C). This failure placed residents at risk of receiving care and services from staff who were not adequately trained.

Findings included...

In an interview on 04/15/2024 at 11:15 AM, Staff A, Administrator, stated that Staff C, Caregiver, had not completed all their education hours on time.

Review of Staff C's training transcript showed that Staff C, who was hired on 08/21/2022, had only completed 20.5 hours of the required 70 hours of training for long-term care worker requirements (which had a due date of 10/31/2023, based on their hire date).

Review of the facility's staff schedule for the month of March 2024 showed that Staff C had worked 3 to 4 days each week.

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) May 23, 2024.

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

Administrator (or Representative) — Date: 4/26/2024