STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

11/15/2024

Caring Places Management, LLC
Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

RE: Artesian Place # 2542

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 50299 (Completion Date 11/15/2024) and 41663 (Completion Date 06/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/15/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(d) Retaliated against a staff person, resident or other individual for:

(i) Reporting suspected abuse, neglect, financial exploitation, or other alleged improprieties;

(ii) Providing information to the department during the course of an inspection of the assisted living facility; or

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

The Department staff who did the On Site verification:

Paul Aube, ALF NCI

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just

Jody Just, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Artesian Place
Provider Type: Assisted Living Facility
License/Cert.#: 2542
Compliance Determination #: 41663
Intake ID: 130095
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 05/22/2024 through 06/20/2024
Complainant Contact Date(s):

Allegation(s):

Financial Exploitation: Public report of facility failing to provide care and services as per resident contract, and reports of facility management retaliation when staff or residents express their concerns.

Investigation Methods:

Sample:
Total residents: 59
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Residents
Family members
Nursing staff
Management

Record Reviews:
Facility policies
Resident Handbook
Employee Handbook
Resident Service Agreements
Disclosure of Services
Incident Log

Investigation Summary:

Financial Exploitation: Resident Care provided as per resident Service Agreements. Unable to substantiate these claims. Multiple interviews with facility staff show a perception of fear from residents and staff, all fearing to report any concerns or issues to management out of fear of retaliation. Facility failed to follow policy and ensure residents and staff are not retaliated against, and failed to ensure residents were treated with dignity and respect. Failed practice identified.

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

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 05/22/2024 and 06/20/2024 of:

Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

This document references the following complaint number(s): 130095

The following sample was selected for review during the unannounced on-site visit: 3 of 59 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Jody Just
Residential Care Services

0624/2024
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.

Administrator (or Representative)

7.16.2024
Date

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(d) Retaliated against a staff person, resident or other individual for:

(i) Reporting suspected abuse, neglect, financial exploitation, or other alleged improprieties;

(ii) Providing information to the department during the course of an inspection of the assisted living facility; or

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure staff were not retaliated against for making required reports to the Department and failed to ensure residents were not retaliated against for making reports of their concerns to facility management, for 1 of 1 facility reviewed. This failure placed all 59 of 59 residents who reside in the ALF at risk for infringement of resident rights, potential ongoing abuse/neglect, and decreased quality of life.

Findings included...

Review of an undated facility policy titled, "Abuse, Neglect and Exploitation", stated, "Any staff member who has a reasonable cause to believe that an incident of abuse, abandonment, neglect, or financial exploitation of a vulnerable adult has occurred will notify the following departments immediately: In Washington-Department of Social and Health Services (DSHS) Hotline 1-800-562-6078 OR- Online." Under section 6, "Staff Responsibilities" it stated, "It is the responsibility of each staff member to immediately contact the department directly regarding suspected or alleged abuse or other improprieties. This facility will not retaliate against any Resident and/or staff member who reports an alleged incident of abuse in good faith."

Review of the Facility Employee Handbook, which was distributed to all new employees, last reviewed in 2024, it stated, "[Management] is committed to a work environment in which all individuals are treated with respect and dignity. Each [facility] employee has the right to work in a professional atmosphere that promotes equal employment opportunities and prohibits unlawful discriminatory practices, including harassment. Therefore, [Facility Management] expects that all relationships among persons in the office will be business-like and free of explicit bias, prejudice, and harassment. [Facility Management] has developed this policy to ensure that all its employees can work in an environment free from

harassment, discrimination, bullying and retaliation... [Facility Management] encourages reporting of all perceived violations of this policy and will investigate such reports promptly and thoroughly. [Facility Management] prohibits retaliation against any individual who reports a perceived violation(s) or otherwise participates in an investigation of such reports. Employees engaging in retaliatory behavior will be subject to immediate disciplinary action, up to and including termination of employment."

Review of an undated Resident Handbook for the facility, which was provided to all residents upon move-in, under the section titled "Resident Bill of Rights," it stated, "Each resident and legal representative has a right to: care which promotes, maintains or enhances respect for individuals and each person's dignity; be free of interference, coercion, discrimination and retaliation from the facility in exercising these rights or filing a complaint against the facility or staff; and be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."

Review of department records showed concerns made to the Department Complaint Resolution Unit (CRU) on 05/08/2024 which discussed multiple concerns they had with the facility. In this complaint, the concerns stated that they were afraid to disclose their name for fear of being retaliated against. It stated that multiple staff were targeted if they are suspected of reporting things to State, (DSHS).

During an interview with Former Staff 1 (FS1), a former facility caregiver, on 05/08/2024 at 10:04AM, FS1 stated that they were extremely worried about retaliation from management. FS1 stated that staff were instructed by facility management to not talk with, or make any reports to DSHS (State), and stated that staff that did make reports to State against management's wishes were retaliated against. FS1 was asked what they meant by retaliation by management staff. FS1 stated that staff members that reported or worked with state had been terminated by management because it was against their wishes. FS1 stated that all staff were afraid and could attest to their statement, but stated they were not sure staff would come forward due to their fear. FS1 was asked if there were any residents that also shared this fear of retaliation from management staff. FS1 stated, "There are residents that would tell you, but they would not tell you in a negative way. Some residents feel that if they ruffle any feathers they care going to get kicked out." During a second interview with FS1 on 05/30/2024 at 2:56PM, FS1 reported that they were terminated from their position at the facility. FS1 stated that the reasoning given for their termination was "insubordination." FS1 reported that they felt the true reason behind their termination was because Staff A, the Executive Director, felt that FS1 made a State report. During this interview FS1 became tearful and stated they were now fearful for the residents in the facility as there was no one in the facility that had the courage to stand up to Staff A.

During an interview with Collateral Contact 1 (CC1), an anonymous facility staff, on 05/08/2024 at 11:54AM while the staff member was asked if they felt comfortable going to management to discuss concerns, CC1 stated, "We are not comfortable... Retaliation is so bad here. So, we all just hold our tongue because we are worried about retaliation."

During an interview with Collateral Contact 2 (CC2), an anonymous facility staff, on 05/22/2024 at 10:47AM, CC2 was asked what they felt management's attitude was about

staff making reports to State. CC2 stated, “Not great. They try to intimidate us into not reporting things to State. They are saying that State is nice to our face but won’t hesitate to stab you in the back and get your fired.” CC2 stated there are new employees that are new to the healthcare field and stated that they believe what management has said about State to be true. CC2 reported that more recently, FS1 was suspended for this. CC2 stated, “I do not know if this is retaliation for sure, but it was really weird. Apparently, [Staff A] found out or thought that that [FS1] called State about an allegation of abuse of [Resident 1, R1], which [FS1] denied. But then probably 3 days later, [FS1] was here for about 5 minutes and [Staff A] called [FS1] into their office and spoke with them. Then [FS1] was told they had to leave. All of us feel it was retaliation, but we do not know what was said.” CC2 was asked if they ever failed to report something that was reportable to state because of that fear of retaliation. CC2 stated, “I have.” CC2 stated that they were aware of an allegation of staff abuse of R1 but stated, “I did not report it.” But I felt intimidated. I just did not want to get fired.”

During an interview with Collateral Contact 3 (CC3), an anonymous facility staff, on 05/22/2024 at 10:35 AM, CC3 was asked if they have ever witnessed or experienced retaliation from management. CC3 stated, “Not yet.” CC3 was observed to have looked around very quickly, leaned away, and changed their answer to “No.” CC3 was then asked if they have ever failed to report to State something that should have been reported out of fear of retaliation from management. CC3 stated “No, nothing yet.”

During an interview with Collateral Contact 4 (CC4), an anonymous facility staff, on 05/22/2024 at 11:02AM, CC4 was asked what they felt management’s attitude was about staff making reports to State. CC4 stated, “Sometimes they brush it off like state is not going to do anything about it. If we feel like someone in management is not treating a resident right and someone told state, there is retaliation.” CC4 was asked if they personally experienced retaliation. CC4 stated, “I have not experienced it personally no, but I have seen it.” CC4 was asked if they could provide greater detail on what they witnessed. CC4 stated, “When someone calls state, I have seen staff be let go. It is always a different reason, but we know in our hearts it is because they reported something, and state got involved. They don’t have to tell you why the fire you, they just let you go. They will cut your hours or put you on a schedule you don’t like, hoping you quit.”

During an interview and observation with Resident 1 (R1) on 05/22/2024 at 10:42 AM, R1 was asked to discuss their feelings regarding management. R1 requested to remain anonymous and stated that if management knew R1 was talking to the Department and voicing any of their concerns, that they were fearful the facility management would retaliate against them. R1 was asked to explain why they felt this way. R1 stated when they had brought up questions or concerns to Staff A, that Staff A got angry and intimidated them. R1 observed to become tearful as they spoke of their fear of being kicked out of the facility and becoming homeless if Staff A knew they were reporting their concerns. R1 stated, “I am scared to death to say anything. It’s been very stressful.”

During an interview with Collateral Contact 5 (CC5), a resident representative, on 05/22/2024 at 1:35 PM, CC5 was asked about the approachability and professionalism of the management staff. CC5 stated that Staff A frequently acted unprofessionally towards residents. CC5 requested to remain anonymous and confidential out of fear that Staff A would retaliate against their loved one. CC5 stated they were uneasy sharing specific details as they didn’t want to “stir the pot” and cause issues for their loved one, as Staff A

had a habit of taking complaints and concerns personally and responding emotionally, and unprofessionally.

During an interview with Resident 2 (R2), an anonymous resident, on 05/22/2024 at 2:19PM: R2 was asked if they felt comfortable going to Staff A with any of their concerns. R2 stated, "I won't do it." R2 was asked if they could explain their reasoning. R2 stated it would cause an argument, and stated they would be 'butting heads." R2 stated they try to avoid the stress [of interactions with Staff A].

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, Artesian Place is or will be in compliance with this law and / or regulation on (Date) 8.4.2024 .

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

Administrator (or Representative) 7.16.2024 Date

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure residents were treated with dignity and respect 1 of 1 facility reviewed. This failure placed all 59 of 59 residents who reside in the ALF at risk for mistreatment, and decreased quality of life.

Findings included...

RCW 70.129.140. Quality of life Rights. "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."

Review of an undated Resident Handbook for the facility, which was provided to all residents upon move-in, under the section titled "Resident Bill of Rights," it stated, "Each resident and legal representative has a right to: care which promotes, maintains or

enhances respect for individuals and each person's dignity; be free of interference, coercion, discrimination and retaliation from the facility in exercising these rights or filing a complaint against the facility or staff; and be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."

Review of department records showed concerns made to the Department Complaint Resolution Unit (CRU) on 05/08/2024 which reported that Staff A, the Executive Director, to be mistreating residents, and stated that Staff A "verbally attacked" residents.

During an interview with Former Staff 1 (FS1), a former facility caregiver, on 05/08/2024 at 10:04AM, FS1 was asked if there were any residents that were afraid to bring their concerns to management out of fear of mistreatment, or retaliation from management staff, FS1 stated, "There are residents that would tell you, but they would not tell you in a negative way. Some residents feel that if they ruffle any feathers they care going to get kicked out."

During an interview and observation with Resident 1 (R1) on 05/22/2024 at 10:42 AM, R1 was asked to discuss their feelings regarding management. R1 requested to remain anonymous and stated that if management knew R1 was talking to the Department and voicing any of their concerns, that they were fearful the facility management would retaliate against them. R1 was asked to explain why they felt this way. R1 stated when they had brought up questions or concerns to Staff A, that Staff A got angry and intimidated them. R1 observed to become tearful as they spoke of their fear of being kicked out of the facility and becoming homeless if Staff A knew they were reporting their concerns. R1 stated, "I am scared to death to say anything. It's been very stressful."

During an interview with Collateral Contact 5 (CC5), a resident representative, on 05/22/2024 at 1:35 PM, CC5 was asked about the approachability and professionalism of the management staff. CC5 stated that Staff A frequently acted unprofessionally towards residents. CC5 requested to remain anonymous and confidential out of fear that Staff A would retaliate against their loved one. CC5 stated they were uneasy sharing specific details as they didn't want to "stir the pot" and cause issues for their loved one, as Staff A had a habit of taking complaints and concerns personally and responding emotionally, and unprofessionally.

During an interview with Resident 2 (R2), an anonymous resident, on 05/22/2024 at 2:19PM: R2 was asked if they felt comfortable going to Staff A with any of their concerns. R2 stated, "I won't do it." R2 was asked if they could explain their reasoning. R2 stated it would cause an argument, and stated they would be 'butting heads." R2 stated they try to avoid the stress [of interactions with Staff A].

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, Artesian Place is or will be in compliance with this law and / or regulation on (Date) 8.4.2024 .

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

Administrator (or Representative)

7.16.2024
Date