STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Kadie Glen Assisted Living LLC
Kadie Glen Assisted Living
451 North Baker Ave
East Wenatchee, WA 98802

RE: Kadie Glen Assisted Living License # 2580

Dear Administrator:

This letter addresses Compliance Determination(s) 39816 (Completion Date 04/24/2024) and 35712 (Completion Date 02/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/24/2024 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2660-1, WAC 388-78A-2660-7, WAC 388-78A-2630-1-a, WAC 388-78A-2300-1-e-ii, WAC 388-78A-2600-2-a

The Department staff who did the on-site verification:
Brittney Shull, 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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Kadie Glen Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2580
Intake ID: 116063
Compliance Determination #: 35712
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 01/24/2024 through 02/22/2024
Complainant Contact Date(s):

Allegation(s):
The named employee took food away from the named resident, made another resident cry and would not accommodate their meal preferences.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 3 Closed records sample size: 0
Observations:	Environment, Resident rooms, Residents, Staff to Resident Interaction, Kitchen, Dining Room, Designated smoking area.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Facility Policies, Resident Records, Incident Report and Investigation, Police Records, Personnel Records.

Investigation Summary:
Observation showed the named resident avoided interactions with the named staff member. Interview and record review showed that the facility failed to follow their process of a how to conduct a thorough investigation of the incident of the named residents, failed to ensure that residents were reasonably accommodated with food preferences, failed to report an allegation of abuse to the Department of Social and Health Services (DSHS), and failed to ensure residents were not abused. Reference citation for WAC 388-78A(2371), WAC 388-78A(2660), WAC 388-78A(2630), WAC 388-78A(2300) and WAC 388-78A (2600).

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Kadie Glen Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2580
Intake ID: 108852
Compliance Determination #: 35712
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 01/24/2024 through 02/22/2024
Complainant Contact Date(s):

Allegation(s):

1) The facility makes it hard for residents they want to discharge, has issues with privacy, has doors that do not lock, is laundering money, has resident items that go missing, has staff that gang up on residents, and does not give residents their money.
2) The named resident was told that they could not speak another language, was accused of having possession of drugs, was refused to be fed.
3) The named resident was not accepted back to the facility after being admitted to the hospital and does not abide by regulations for discharge.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 3 Closed records sample size: 0
Observations:	Environment, Resident rooms, Residents, Staff to Resident Interaction, Kitchen, Dining Room, Designated smoking area.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Facility Policies, Resident Records, Incident Report and Investigations, Police Records, Personnel Records, Discharge Notices.

Investigation Summary:

1) Observations showed staff to resident interaction was appropriate. Staff were observed to be available and were responsive to resident needs. Resident room doors were observed to lock. Interview showed that there were functioning locks on the doors and locking cupboards available for resident use. Interview and record review showed that residents could request to be present when staff entered their room. Interview and record review showed that the facility did not manage resident funds. It also showed that residents were able to keep their monthly participation. It lastly showed that the facility addressed grievances regarding missing items.
2) Observation and interview showed that the named resident could speak English and Spanish but preferred to speak in Spanish. Interview showed that staff were told to not speak Spanish to only the named resident. It also showed that staff were aware of resident needs and preferences with their diet. Interview and record review showed

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that the facility investigated the incident of the named resident with possible possession of drugs, followed their processes and made all notifications. It also showed that the facility failed to follow their processes and failed to thoroughly investigate the incident of the named resident being refused food, failed to ensure that residents were reasonably accommodated with food preferences, failed to report an allegation of abuse to the Department of Social and Health Services (DSHS), and failed to ensure residents were not abused. Reference citation for WAC 388-78A(2371), WAC 388-78A(2660), WAC 388-78A(2630), WAC 388-78A(2300) and WAC 388-78A (2600).
3) Observation, interview, and record review showed that the named resident currently resides at the facility. Interview and record review showed that the facility followed their process to notify residents of discharges and make appropriate safe discharge plans as required. It also showed that the facility had worked with residents to obtain payees in instances that they were unable to manage their monthly dues.

Conclusion / Action:

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

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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 #. 2580	Compliance Determination # 35712
Plan of Correction	Kadie Glen Assisted Living	Completion Date
Page 1 of 13	Licensee: Kadie Glen Assisted Living LLC	02/22/2024

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 01/24/2024, 02/01/2024 and 01/24/2024 of:

Kadie Glen Assisted Living
451 North Baker Ave
East Wenatchee, WA 98802

This document references the following complaint number(s): 108852, 111927, 115783, 116063

The following sample was selected for review during the unannounced on-site visit: 3 of 61 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, 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

03/06/2024 — 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.

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Administrator (or Representative)

3/12/2023
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to document what occurred for two allegations of abuse, document if abuse was ruled out, and determine preventative measures during the investigation for 2 of 2 residents (Residents 1, 2). These failures left the residents without interventions and placed the residents at risk of continued abuse.

Findings included...

Review of the facility's policy "Incident/Event/Abuse/Investigation," undated, showed that within the first 14 hours an abuse allegation, the facility staff should protect the resident, interview the resident, interview eyewitnesses, preform a physical assessment of the resident and preform a comprehensive record review. It also showed that after the first 24 hours, if reasonable cause was not determined, expand their interview sample to more eyewitnesses and residents.

Review of the facility's policy, "Policy and Procedures to Report Resident Abuse, Neglect and Financial Exploitation and Abandonment," undated, showed that the ALF would immediately upon knowledge, terminate an employee who is found to have abused a resident.

During an interview on 01/24/2024 at 3:05 PM with Staff A, Administrator, was notified the first time by the department that there was an allegation that Staff B, Dietary Manager, had taken food away from Resident 1 and kicked them out of the dining room. Staff A was also notified of an allegation that Staff B had made Resident 2 cry due to an interaction they had when Staff B refused to provide an alternative meal option. Staff A stated they would investigate the allegations and follow their facility policy.

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Record review of an untitled document dated 01/24/2024 provided by Staff A when asked for an incident investigation and report, showed that Staff A spoke to alleged perpetrator, Staff B about the allegations. The document did not indicate that Resident 1, Resident 2, nor any other residents or eyewitnesses had been interviewed, no observations completed, no records had been reviewed, and no preventative measures where documented. The document did not show whether abuse was ruled out.

During an interview on 02/01/2024 at 2:16 PM, Staff A stated that they had completed the investigation into the allegations regarding Staff B and did not substantiate anything.

During an interview on 2/08/2024 at 3:58 PM, Staff A stated that the untitled document dated 01/24/2024, was their investigation into the allegations. They further indicated that they did not interview Resident 1, Resident 2, other residents, or eyewitnesses, did not perform any observations or assessments, and did not review any resident records. Staff A acknowledged the investigation was incomplete and stated they would ensure all residents' safety.

During an interview on 02/16/2024 at 2:32 PM, Staff E, Director of Nursing Services, stated they were not aware of the allegations against Staff B regarding Resident 1 and 2. Staff E stated that they had not been informed of the details of the complaint investigation and that Staff B was still working in the kitchen.

During an interview on 02/16/2024 at 2:32 PM, Staff F, Regional Administrator, stated they were not aware that there was an allegation of abuse against Staff B.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 03/07/24.

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

Administrator (or Representative) 3/7/24 Date

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

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

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

This requirement was not met as evidenced by:

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Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure residents were protected from mental abuse and treated in a dignified manner for 3 of 3 residents (Residents 1, 2, 3). These failures resulted in Resident 1, 2 and 3 experiencing mental abuse, not having their dietary needs and preferences honored and resulted in the three residents feeling intimidated, humiliated, and ridiculed and also being yelled at in the dining room.

Findings included...

Per Washington Administration Code 388-78A-2020 defines mental abuse as a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

Resident 1

Record review of the facility's document titled, "Resident Information," dated 07/10/2023, showed that Resident 1 was admitted to the ALF on [redacted]/2023 and had the diagnoses of [redacted], [redacted], and [redacted].

Record review of the facility's "Assessment and Care Plan" dated [redacted]/2023, showed that Resident 1 used a wheelchair and had a balance problem. It also showed that they had no dentures or teeth and had difficulty chewing rubbery foods. It further showed that meals should be provided as scheduled, staff should remind Resident 1 of meal and snack times and encourage them to come to the dining room for all meals.

Record review of Resident 1's progress notes dated 12/01/2023 showed that Resident 1 had poor motor control resulting in an abnormal movement pattern. It also showed that Resident 1 had a coffee spill and was asked to leave the dining room.

Record review of a "Police Incident Report" dated 12/04/2023 at 3:12 PM, showed that Resident 1 had reported to law enforcement that they were told they had to leave the dining room and could not eat in there.

In an interview on 01/24/2024 at 1:51 PM, Staff D, Anonymous Staff, stated that one and a half months prior, Resident 1 had approached them crying, stating that Staff B, Dietary Manager, made them feel small and took food away from them. Resident 1 further told them that they did not want to return to the dining room because they were fearful of getting in trouble and they did not return to the dining room for at least two weeks after.

In an interview on 01/24/2024 at 2:38 PM, Staff A, Administrator, stated that Resident 1 was kicked out of the dining room by Staff B, Dietary Manager, for spilling their coffee and was not allowed to eat in the dining room for the remainder of the day. Staff A stated that they had told Staff B to have another staff member interact with Resident 1 because the two would clash. When asked if Staff B had ever taken food away from Resident 1, Staff A did not answer. They stated they would further investigate the incident.

In an interview on 02/01/2024 at 10:26 AM, Resident 3 stated that the facility staff have, "favorite residents" and treat others differently. They further stated that if they (Resident 1) were to do something wrong, they would, "really get it."

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Observation and interview on 02/01/2024 at 11:42 AM showed that Resident 1 could communicate in English but had a preference to speak in Spanish. Resident 1 stated that Staff B screams at people and doesn't want them to talk. They further stated that Staff C, Kitchen Staff, preferred to speak to them (Resident 1) in Spanish, but Staff B would not allow that. Staff B allowed Staff C to speak in Spanish to other residents. They further stated that Staff B told them that only Staff B could serve them meals. Resident 1 stated that they had received a plate of pasta from Staff B that was not cut, and they felt embarrassed to have to ask them to cut it and that they could choke on the pasta. They stated that one day, Staff C gave them a bowl of soup and that Staff B took it away and threw the spoon in the sink and told them to get out of the dining room and that they were not welcome. Resident 1 further stated they were not given another meal. When asked why, Resident 1 stated all they knew was that they had dropped coffee on accident. They further stated that they felt defensive because no one would listen when they would try to report, and nothing was done about the incidents. Resident 1 said that Staff C and Staff D were witnesses to the coffee and soup incidents. Resident 1 stated that they were not going to go to lunch that day and that they would go in the dining room after the meal service, to get coffee when Staff B was not there.

An observation on 02/01/2024 at 1:05 PM showed Resident 1 in the dining room after the noon meal and they served themselves coffee. Staff B was working but the door to the kitchen was closed, and they were not visible from the dining room.

An observation on 02/01/2024 at 1:22 PM showed a whiteboard in the kitchen with resident names which indicated resident preferences and needs such as allergies. The board showed Resident 1 needed a soft diet or food cut up.

In an interview on 02/01/2024 at 1:22 PM, Staff B stated that staff reference the whiteboard to know what residents need their food cut up and prepare it cut before they serve it to the residents. Staff B further stated they if a resident has behaviors, they ask them to leave the dining room.

In an interview on 02/08/2024 at 8:47 AM, Staff C, stated that Staff B had a grudge against Resident 1 and treated them differently than other residents. They stated that Staff B was verbally abusive to Resident 1 and Resident 2. Staff C stated that Resident 1 told them that they felt singled out and outcasted and appeared to be depressed. They stated that on one occasion they witnessed Staff B taking food away from Resident 1. Staff C further stated that Staff B told them that they could not speak to Resident 1 in Spanish but did not tell them not to speak to other residents in Spanish. Staff C stated that Resident 1 did not know some words in English and preferred to communicate Spanish. Staff C stated that they had previously told Staff A and Staff F, Regional Administrator about Staff B's interactions with residents. Staff B continued to be rude and disrespectful to residents.

In an interview on 02/08/2024 at 11:49 AM, Staff C stated that around November or December of 2023, Resident 1 stopped regularly going to the kitchen and told Staff C it was because of Staff B's temperament. Staff C stated that if they were serving, Resident 1 would go to the dining room to get food to go, but Staff B would not let them leave the dining room with their food, so Resident 1 would leave without eating. Staff C stated that Staff B had reported multiple times that Resident 1 had behaviors of throwing food, but Staff C never witnessed those behaviors and never heard of any other staff reporting it. Staff C stated that Resident 1 first stopped going to the dining room after Staff B and Resident 1 got into an argument and Resident 1 left the dining room before eating. That day, Staff A told Staff C to interact with Resident 1 if they returned to prevent further

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conflict between Staff B and Resident 1. Staff C stated that when Resident 1 returned, Resident 1 was interacting appropriately, and they provided them a meal of soup. Resident 1 had one bite of soup and Staff B took the food from Resident 1, and Resident 1 left the dining room. Staff C stated that Staff B told them that if Resident 1 was going to be disrespectful to them, they were not going to be allowed in the dining room. Staff C stated that they believed Resident 1 was being punished by Staff B for the interaction they had earlier. Staff C stated that Staff B had a pattern of ignoring Resident 1 when they would come into the dining room by not taking their order and they would also prevent other staff from taking Resident 1's order. Staff C stated they had alerted management on multiple occasions of Staff B's behavior and Staff B was taken off serving duties and placed back in the kitchen to cook. Resident 1 told them they felt picked on, that they were being abused and would only go to the dining room to get coffee. Staff C noted that on another occasion, they had observed that Resident 1 had spilled their coffee accidentally and was kicked out of the dining room by Staff B who said it was on purpose. Staff C stated that Resident 1 had symptoms of vertigo (a sudden spinning sensation), shaky hands, and did not have a good grip on their coffee.

Resident 2

A record review of a facility document titled, "Resident Assessment and Care Plan," dated 04/06/2023 showed that Resident 2 had Celiac disease (an immune reaction to eating gluten, a protein in wheat, barley, and rye that can damage the intestinal lining over time), that Resident 2 could make their dietary needs and preferences known, and that dietary staff should make reasonable accommodations. It also showed that Resident 2 had Post Traumatic Stress Disorder (PTSD), difficulty recovering from experiencing or witnessing a terrifying event in which triggers can cause intense emotional and physical reactions) and the dining room could trigger PTSD symptoms of uncontrollable crying. It showed that in that event, staff should reassure Resident 2 that they were safe and allow them to voice their feelings or needs.

In an interview on 01/24/2024 at 1:50 PM, Staff D stated that they witnessed Staff B not being nice to Resident 2, and that it made Resident 2 cry. They further stated that Staff B refused to make reasonable accommodations for Resident 2's diet because the facility did not cater to gluten free diets. Staff D stated that the kitchen always had available alternative options.

An observation on 02/01/2024 at 1:22 PM showed that Resident 2 had a gluten allergy listed on the kitchen whiteboard.

In an interview on 02/01/2024 at 1:23 PM, Resident 2 stated that 3 months ago, Staff B was rude to them [Resident 2], made them cry and that they had, "battled for a long time," and had argued about meal alternatives with Staff B. They further stated that they have Celiac disease and require a gluten free diet or they will have diarrhea, vomiting, and could face serious health concerns. They stated that on several occasions, when Staff B handed them a plate of food, they [Resident 2] would tell Staff B that they could not eat it. Staff B told Resident 2 they didn't care and told the other kitchen staff that they could not get an alternative option. Resident 2 stated that Staff B told them that they were picky and wanted special things, but that it was not true because they were vomiting from the diet.

In an interview on 02/08/2024 at 8:47 AM, Staff C stated that Staff B was verbally abusive to Resident 2, made Resident 2 cry, and declined to give them ice or other meal accommodations like yogurt. Staff C further stated that even when they had food available

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that was gluten free, Staff B would still send Resident 2 food that was not gluten free and would not ask what accommodations Resident 2 might like instead. Staff C stated that Staff B's behavior was unpredictable to everyone; that they would be polite one day, and the next they would throw and toss things around with anger in front of the residents and be rude. They stated that one of the other staff members had to tell Staff B to calm down on multiple occasions and the residents would complain to Staff C about Staff B's behavior.

In an interview on 02/08/2024 at 11:49 AM, Staff C stated that Staff B had told all kitchen staff with vulgar language that if residents didn't like what they were served, they could get out of the kitchen. Staff C stated that about a month ago, Resident 2 asked for something else such as a sandwich, when the meal was not gluten free, and Staff B told Resident 2 no and walked away from them and did not return, even though Resident 2 had not gotten anything to eat yet. Staff C stated that the facility usually had gluten free croissants, but that Staff B did not attempt to check for availability of an alternative food item or explain the situation to Resident 2.

Resident 3

A record review of a facility document titled, "Resident Information," dated 10/23/2023 showed that Resident 3 was admitted to the ALF on [redacted]/2023 with the diagnoses of [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted].

A record review of a progress note dated 12/19/2023 showed that Resident 3 told staff that Staff B had allegedly yelled at them across the property and that Staff B did not have authority over them.

In an interview on 02/01/2024 at 10:26 AM, Resident 3 stated that Staff B had screamed at them from across the parking lot, twice. Resident 3 further stated that it made them, "feel like crap." They stated that there were incidents in the dining room where Staff B had screamed at staff and residents in front of everyone, that they wouldn't let the other person get a word in, and this had caused staff to cry and quit their jobs. Resident 3 further stated that on one occasion they asked to have the alternative meal option of soup in addition to the main dish and they were refused and yelled at by Staff B because they were not allowed to mix and match from the menu although other staff had previously allowed it. They further stated that they try to get along with Staff B because they, "feel humiliated," when Staff B yells at them. Resident 3 stated that Staff B threw a fit when they tried to bring their food to their room due to their social anxiety and had to get a special nurse order to be able to eat in their room.

In an interview on 02/16/2024 at 2:32 PM, Staff F, Regional Director, stated that Staff A did not inform them that there were allegations of abuse regarding Staff B.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/7/24.

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

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Administrator (or Representative) 3/7/24 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 Assisted Living Facility (ALF) failed to report allegations of abuse to the Complaint Resolution Unit (CRU) for 2 of 2 residents (Resident 1 and 2). This failure placed residents at risk for abuse and prevented the Department from having knowledge of the incident.

Findings included...

Record review of an undated facility policy titled, "Policy and Procedures to Report Resident Abuse, Neglect, Financial Exploitation, and Abandonment," showed that staff were trained to report an allegation of abuse to the Department of Social and Health Services if they observed or heard about an incident of abuse. Staff were also required to make a report internally to the Residential Care Coordinator or the Administrator who would investigate they allegation and would also make an independent report to the department if the allegation was believed to have occurred.

In an interview on 01/24/2024 at 1:50 PM Staff D, Anonymous Staff, stated that Resident 1 and Staff B, Dietary Manager, did not get along. They further stated that one and a half months ago, Staff B took a plate of food away from Resident 1. Staff D stated that they believed it was bullying and that Staff B made Resident 2 cry when they refused to accommodate their alternative meal requests.

During an interview on 01/24/2024 at 3:05 PM with Staff A, Administrator, was notified the first time by the department that there was an allegation that Staff B, Dietary Manager, had taken food away from Resident 1 and kicked them out of the dining room. Staff A was also notified of an allegation that Staff B had made Resident 2 cry due to an interaction they had when Staff B refused to provide an alternative meal option. Staff A stated they would investigate the allegations and follow their facility policy.

In an interview on 02/01/2024 at 11:42 AM Resident 1 stated that they had told law enforcement and ALF staff about their interactions with Staff B, but no one had listened or done anything about it. They stated that they felt singled out by Staff B and that they had refused them food.

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In an interview on 02/08/2024 at 8:47 AM Staff C, Kitchen Staff, stated that Staff B made residents cry and declined food to residents even when there were reasonable accommodations for them. They further stated that they had previously told Staff A, Administrator and Staff F, Regional Administrator, but Staff B continued to be rude and disrespectful, and they did not think anything was done. Staff C stated that Staff B was verbally abusive to Resident 1 and Resident 2. Resident 1 told Staff C that they felt out-casted and singled out and appeared like they would cry. Staff C stated that they tried to report the abuse, but the reporting hotline poster was removed from the office, and they had to search for the phone number to call and it kept going to voicemail, so they did not leave a report. Staff C stated that other staff had observed Staff B mistreating residents, but they didn't think they would speak up because they had to work with Staff B and Staff B would also yell at staff and belittle them.

Record review on 02/26/2024 of the department's CRU reporting history showed that no report had been made by the ALF regarding any allegation involving Staff B and Resident 1 or Resident 2.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/7/24 .

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

Administrator (or Representative) Date 3/7/24

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(ii) Individual preferences to the extent reasonably possible.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure meals were adjusted for individual preferences for 2 of 2 residents (Resident 1 and 2). These failures resulted in residents not having their dietary needs or preferences met.

Findings included..

Record review of an undated facility policy titled, "Dining Services," showed that if a resident refuses the food served, appropriate substitutes of similar nutritive value would be

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offered. It also showed that individual and ethnic preferences would be taken into consideration to the extent reasonably possible. It also showed that residents were not allowed to take meal trays out of the dining room unless they miss a meal due to a medical appointment.

Record review of a facility policy titled, "Quality of life," dated 12/2013 showed that residents were encouraged to make choices about aspects of life in the facility that were signification to them.

Resident 1

Record review of a facility document titled, "Resident Information," dated 07/10/2023 showed that Resident 1 had admitted to the ALF on [redacted]/2023 and had the diagnoses of [redacted] and [redacted].

Record review of a facility document titled, "Assessment and Care Plan," dated [redacted]/2023 showed that Resident 1 had no dentures or teeth and had difficulty chewing rubbery foods. It further showed that meals should be provided as scheduled, staff should remind Resident 1 of meal and snack times and encourage them to come to the dining room for all meals.

In an interview on 01/24/2024 at 1:51 PM, Staff D, Anonymous Staff, stated that one and a half months prior, Resident 1 had gone to Staff D crying, stating that Staff B, Dietary Manager, took food away from them.

In an interview on 01/24/2024 at 2:38 PM, Staff A, Administrator stated that Resident 1 was kicked out of the dining room by Staff B, Dietary Manager, for spilling their coffee and Resident 1 was not allowed to eat in the dining room for the remainder of the day.

In an interview on 02/01/2024 at 11:42 AM, Resident 1 stated that they were not allowed to eat second helpings. They also stated that Staff B gave them a plate of pasta that was not cut, and they felt embarrassed to have to ask them to cut it but that they could choke on the pasta. They also stated that Staff B took a bowl of soup away from them [Resident 1] and told them to get out of the dining room; that they were not welcome. Resident 1 further stated they were not given another meal. When asked why, Resident 1 stated all they knew was that they had dropped coffee on accident.

An observation on 02/01/2024 at 1:22 PM showed that the kitchen had a whiteboard with resident names showing preferences and needs such as allergies. Resident 1 was noted to need a soft diet or food cut up.

In an interview on 02/08/2024 at 11:49 AM, Staff C stated that around November or December of 2023, Resident 1 and Staff B got into an argument and Resident 1 left the dining hall. When Resident 1 returned later, Staff C served them a meal of soup and Resident 1 was interacting appropriately. Staff B took the food away from Resident 1 after they had eaten one bite, and Resident 1 left the dining room. Staff B told Staff C that if Resident 1 was going to be disrespectful to them, they were not going to be allowed in the dining room.

Resident 2

A record review of a facility document titled, "Resident Assessment and Care Plan," dated

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04/06/2023 showed that Resident 2 had Celiac disease (an immune reaction to eating gluten, a protein in wheat, barley, and rye that can damage the intestinal lining over time), that Resident 2 could make their dietary needs and preferences known, and that dietary staff should make reasonable accommodations.

In an interview on 01/24/2024 at 1:50 PM, Staff D, Anonymous Staff, stated that they observed Staff B refusing to make reasonable accommodations for Resident 2's diet. Staff D further stated that the facility did not cater to gluten free diets, but that they always had available alternative options. Staff D said the interaction made Resident 2 cry.

An observation on 02/01/2024 at 1:22 PM showed that the kitchen had a whiteboard with resident names showing preferences and needs such as allergies. Resident 2 was noted to have a gluten allergy.

In an interview on 02/01/2024 at 1:23 PM, Resident 2 stated that they had, "battled for a long time," meaning they had argued about meal alternatives, to the point of crying with Staff B. They further stated that they have Celiac disease and require a gluten free diet, or they will have diarrhea, vomiting, and could face serious health concerns. They stated that Staff B handed them a plate and when they said they could not eat it, Staff B said they didn't care and told the other kitchen staff that they could not get an alternative option. Resident 2 stated that Staff B told them that they were picky and wanted special things, but that it was not true because they were vomiting from the diet.

In an interview on 02/08/2024 at 8:47 AM, Staff C stated that Staff B declined to give Resident 2 ice or other meal accommodations like yogurt. Staff C further stated that even when they had food available that was gluten free, Staff B would still send Resident 2 food that was not gluten free and would not ask what accommodations Resident 2 might like instead.

In an interview on 02/08/2024 at 11:49 AM, Staff C stated that Staff B had told all kitchen staff with vulgar language that if residents didn't like what they were served, they could get out of the kitchen. Staff C stated that about a month ago, Resident 2 asked for something else such as a sandwich, when the meal was not gluten free, and Staff B told Resident 2 no and walked away from them and did not return, even though Resident 2 had not gotten anything to eat yet. Staff C stated that the facility usually had gluten free croissants, but that Staff B did not attempt to check for them or explain the situation.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/7/24.

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

Administrator (or Representative) Date 3/6/24

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WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their policy and procedures related to suspected abuse for 2 of 2 residents (Residents 1, 2). These failures resulted in residents not being protected and experiencing ongoing mental abuse.

Findings included...

Review of the facility's policy "Incident/Event/Abuse/Investigation," undated, showed that within the first 14 hours an abuse allegation, the facility staff should protect the resident, interview the resident, interview eyewitnesses, preform a physical assessment of the resident and preform a comprehensive record review. It also showed that after the first 24 hours, if reasonable cause was not determined, expand their interview sample to more eyewitnesses and residents.

Review of the facility's policy, "Policy and Procedures to Report Resident Abuse, Neglect and Financial Exploitation and Abandonment," undated, showed that in the event of a staff to resident abuse allegation, the ALF would suspend the employee pending the outcome of the investigation. It also showed that the investigation process should conclude the investigation with logging and filing an event report.

During an interview on 01/24/2024 at 3:05 PM with Staff A, Administrator, was notified the first time by the department that there was an allegation that Staff B, Dietary Manager, had taken food away from Resident 1 and kicked them out of the dining room. Staff A was also notified of an allegation that Staff B had made Resident 2 cry due to an interaction they had when Staff B refused to provide an alternative meal option. Staff A stated they would investigate the allegations and follow their facility policy.

Record review of an untitled document dated 01/24/2024, which Staff A stated were the completed investigations. The document showed that Staff A spoke to alleged perpetrator, Staff B about the allegations. The investigation did not indicate that Resident 1, Resident 2, nor any other residents or eyewitnesses had been interviewed, or that the residents were protected during the course of the investigation. The investigation did not show if abuse had been substantiated or ruled out and Staff B was not suspended during the investigation. The document did not include any record review or assessments per the facility's policy.

During an interview on 02/01/2024 at 2:16 PM, Staff A stated that they had completed the

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investigation into the allegations regarding Staff B and did not substantiate anything.

During an interview on 02/08/2024 at 3:58 PM, Staff A stated that the untitled document dated 01/24/2024, was their completed investigation into the allegations. They stated that they did not interview Resident 1, Resident 2, other residents, or eyewitnesses, did not perform any observations, and did not review any resident records. Staff A stated that Staff B was told to sit in their office during their investigation and returned to work on 01/24/2024 after Staff A had completed the investigation. Staff A stated they did not place Staff B on suspension. Staff A acknowledged the investigation was incomplete and they did not use the Facility's Resident Incident Report or the process they usually follow for investigations.

Refer to WAC 388-78A-2660

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/7/24 .

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

Administrator (or Representative) Date 3/7/24

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