STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

05/20/2025

San Juan County Public Hospital Dist #1
Village at the Harbor
543 Spring St
Friday Harbor, WA 98250

RE: Village at the Harbor # 2608

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 59831 (Completion Date 05/20/2025) and 48510 (Completion Date 03/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/20/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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

(4) Protect residents during the course of the investigation.

The Department staff who did the On Site verification:
Karen Glover, Nursing Consultant Institutional
Cristina Gonzalez, Nursing Consultant Institutional

If you have any questions, please contact me at (253)281-1245.

Sincerely, Anthony Devito

Anthony Devito, Field Services Administrator
Region 2, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Village at the Harbor
Provider Type: Assisted Living Facility
License/Cert.#: 2608
Compliance Determination #: 48510
Intake ID: 149130
Investigator: Teresa Pederson-Tuley
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 10/10/2024 through 03/10/2025
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) was being yelled at by the Identified Staff (IS).

Investigation Methods:

Sample:
Total residents: 34
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Staff to resident interactions

Interviews:
Identified resident
Identified staff (IS)
Nursing staff
Residents
Executive Director (ED)

Record Reviews:
Medical records
Incident investigation
Facility policies
Staff training records

Investigation Summary:
Interview with the NR stated they wanted to complete care tasks on their own with minimal assistance. The NR stated the caregiver had rushed them to finish their care and then yelled at them. Interview with the IS stated they had become frustrated with the NR because they took longer than 30-minutes to complete their care and that other residents had to wait for care because of this. Interview with the ED stated the IS was suspended pending the outcome of the investigation. The Assisted Living Facility (ALF) investigated the incident, notified family, physician, nursing staff, case worker, the ED but did not report the to the hotline. The investigation showed the IS raised their voice to the NR, was written up and allowed to return to work. Failed practice was identified and a citation was issued at 388-78A-2371(1)(2)(3)(4).

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 10/10/2024 of:

Village at the Harbor
543 Spring St
Friday Harbor, WA 98250

This document references the following complaint number(s): 149130

The following sample was selected for review during the unannounced on-site visit: 3 of 34 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Teresa Pederson-Tuley, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit Z
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Anthony Devito
Residential Care Services

03/17/2025
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.

Jim Smith
Administrator (or Representative)

3/21/25
Date

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

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(2) Determine the circumstances of the event;

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(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to investigate allegations of suspected abuse for 1 of 3 residents (Resident 1). This failure resulted in Resident 1 being yelled at by a staff member and placed all residents at risk of not having their allegations looked at.

Findings included...

Review of Revised Code of Washinton 74.34.020 showed: (2) "Abuse" means the intentional, willful, or reckless action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings: (c) "Mental abuse" means an intentional, willful, or reckless 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.

A review of the ALF's undated policy titled Procedures for "Abuse and Neglect"; Mental Abuse: Willful action or inaction which includes but is not limited to coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity and verbal assault that includes ridiculing, intimidating, yelling or swearing.

Resident 1

Resident 1 admitted to the ALF on [redacted]/2016 with a diagnosis of [redacted] and [redacted]. A review of the Service Plan dated 10/31/2023 showed the resident was a fall risk, required safety checks and required physical assistance of 1 for bathing, bed mobility, dressing and toileting needs.

On 10/10/2024 at 7:38 AM Collateral Contact, Case Worker, stated that Resident 1 had reported to them that Staff C, Caregiver had yelled at them. Collateral Contact stated that they had reported the incident to Staff A, Executive Director (ED) on 09/22/2024. Collateral Contact stated that this was the first time Resident 1 had been yelled at by Staff C.

On 10/10/2024 at 10:30 AM Resident 1 stated that Staff C had yelled at them when performing their personal care and told them to hurry up. Resident 1 stated this had upset them.

On 10/10/2024 at 10:42 AM Staff D, Caregiver, stated that Resident 1 had told them Staff C had yelled at them.

On 10/10/2024 at 11:16 AM Staff C stated that they had raised their voice to the resident and had felt pressured to make the resident hurry up and finish cares.

On 10/10/2024 at 11:30 AM Staff A stated that the Collateral Contact had reported the incident to them on 09/22/2024, Resident 1 had reported the incident to them the same day and the investigation did not begin until 10/10/2024.

On 10/10/2024 at 11:30 AM in a record review of Resident 1's Progress Notes showed no investigation of the allegations had been performed.

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, Village at the Harbor is or will be in compliance with this law and / or regulation on (Date) 3/20/25 .

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

Lori Smith — Administrator (or Representative)

3/20/25 — Date