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

Greenlake Management Prosser, LLC
Amber Hills Assisted Living
125 N Wamba Rd
Prosser, WA 99350

RE: Amber Hills Assisted Living License # 2616

Dear Administrator:

This letter addresses Compliance Determination(s) 24376 (Completion Date 05/09/2023) and 18461 (Completion Date 03/14/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/09/2023 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-2630-1-a, WAC 388-78A-2600-1, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2600-1-c, WAC 388-78A-2600-2-a, WAC 388-78A-2600-2-f, WAC 388-78A-2600-2-i, WAC 388-78A-2600-2-j, WAC 388-78A-2600-2-j-i, WAC 388-78A-2600-2-j-ii, WAC 388-78A-2600-2-j-iii

The Department staff who did the on-site verification:
Felicia Cantu, 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Amber Hills Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2616
Intake ID: 64556
Compliance Determination #: 18461
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 01/12/2023 through 03/14/2023
Complainant Contact Date(s): 01/09/2023, 03/16/2023

Allegation(s):
1. Decline in condition
2. Lack of notifications
3. Falls with injuries
4. Lack of NSA and Assessments

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 2 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility polices Resident records(face sheet, care plan, assessments, chart notes, doctor orders) Hospital records

Investigation Summary:

1. Record reviews and interviews showed that the Named Resident had a decline in appetite, more frequent falls, and increased confusion.
2. The facility failed to monitor and notify doctor and family of the Named Resident's change of condition and failed to report various injuries and bruises of unknown source to the Department. The facility failed to report various injuries and bruises of unknown source to the Department.
3. The Named Resident was sent to the hospital.
4. Lack of notification of changes and lack assessments. Facility records showed named resident had a decline.

WAC 388-78A-2630 (1)(a) and WAC 388-78A-2600 (1)(a)(b)(c)(d) (2)(a)(f)(i) (j i, ii, iii)

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: Amber Hills Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2616
Intake ID: 64858
Compliance Determination #: 18461
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 01/12/2023 through 03/14/2023
Complainant Contact Date(s): 01/09/2023, 03/16/2023

Allegation(s):
1. Decline in condition
2. Lack of notifications
3. Falls with injuries
4. Lack of NSA and Assessments

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 2 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associate with the facility
Record Reviews:	Characteristic roster Facility polices Resident records(face sheet, care plan, assessments, chart notes, doctor orders) Hospital records

Investigation Summary:

1. Record reviews and interviews showed that the Named Resident had a decline in appetite, more frequent falls, and increased confusion.
2. The facility failed to monitor and notify doctor and family of the Named Resident's change of condition and failed to report various injuries and bruises of unknown source to the Department. The facility failed to report various injuries and bruises of unknown source to the Department.
3. The Named Resident was sent to the hospital.
4. Lack of notification of changes and lack assessments. Facility records showed

named resident had a decline.
Failed Practice found for WAC 388-78A-2630 (1)(a) and WAC 388-78A-2600 (1)(a)(b)(c)(d) (2)(a)(f)(i) (j i, ii, iii)

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
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2616	Compliance Determination #18461
Plan of Correction	Amber Hills Assisted Living	Completion Date
Page 1 of 11	Licensee: Greenlake Management Prosser, LLC	03/14/2023

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 01/12/2023 and 01/12/2023 of:

Amber Hills Assisted Living
125 N Wamba Rd
Prosser, WA 99350

This document references the following complaint number(s): 64556, 64858

The following sample was selected for review during the unannounced on-site visit: 2 of 35 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, 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

03/27/2023
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.

Administrator (or Representative) 4-7-23 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 immediately report significant incidents and injuries of unknown source to the Department's Complaint Resolution Unit (CRU) for 2 of 2 residents (Residents 1 and 2). This failed practice placed the residents at risk of neglect.

Findings included...

Per RCW 74.34.020 (15) Neglect means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100

Review of Department of Social and Health Services "Assisted Living Facility Guidebook" dated February 2018, showed guidelines for reporting to CRU incidents including injuries of unknown source and that repeated injuries "may become abuse or neglect if preventative measures are not taken."

Record review of the facility's policy titled "Internal Incident Report and State Incident Report" dated 08/10/2021, showed that injuries and unusual incidents will be reported in compliance with state regulatory requirement. An internal incident report was completed by staff for all unusual occurrences, injury, and incidents, and are reported immediately to family and physician. The ALF must immediately report to the Department any circumstances which threaten the ALF's ability to ensure continuation of services to residents. All incidents related to physical abuse or neglect must be reported.

Record review of the facility's policy titled, "Elder Abuse, Neglect, and Exploitation" dated

08/10/202, showed that facility staff is to immediately report any form of possible symptoms of abuse or neglect to the Department according to state requirements.

Record review of facility's policy titled, "Fall Response Procedures" dated 08/10/2021 showed that if a resident should fall, resident care staff are instructed to call for immediate assistance from the Wellness Director or Med Technician on duty. The physician is contacted immediately for further instructions, resident is placed on forty-eight-hour charting after any fall, update the Negotiated Service Agreement with intervention, and complete an internal incident report and state incident report, if required per state regulations.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2022. Review of an Assessment dated 06/30/2022 showed that Resident had severe memory impairment, was able to eat independently, and was at risk for potential falls.

Collateral Contact 3 (CC3), Representative and Durable Power of Attorney (DPOA), stated on [redacted]/2023 she walked into the ALF and observed Resident 1 slumped over in chair, screaming in pain, appeared malnourished, covered in bruises, one large bruise that covered entire upper left leg that proceeded to their backside. "Looked like they were dragged by a car, I had no idea how bad the falls were, there were so many unexplained injuries" DPOA stated she called 911 and demanded that Resident 1 would not return from the hospital to the ALF.

Record review of Resident 1's hospital admission record dated [redacted]/2023, showed that Resident 1 was assessed by a Physician and Registered Nurse, bruises were noted in various locations, which included right hand and left lower leg, with various stages of healing, including a large bruise that covers their entire right hip with what appears to be covered with a dressing, large skin tear to left knee, large scab on nose that is red and dried due to previous falls and unknown causes. Resident 1 was also treated for dehydration (a dangerous loss of water in the body).

On 02/09/2023 at 11:03 AM, CC3, DPOA, stated that Resident 1 had numerous falls, unknown injuries, was unkept, and had a significant change of condition many months prior to her taking Resident 1 to the hospital on [redacted]/2023. CC3 stated Resident 1 was continuously covered in bruises.

Review of the departments' reporting data based showed no facility report was received. No documentation or investigations to rule out abuse and neglect were provided.

On 01/12/2023 at 10:20 AM Staff A, Administrator, stated that he was not aware of Resident 1's bruising to left hip and other areas of their body. The usual process is to notify the Administrator and Facility Nurse of any significant injuries, and that they did not report to Department, and was not sure why they did not report the injuries.

Resident 2

Record review of Resident 2's chart notes showed that they were admitted to the ALF on [redacted]/2022 and had no concerns, incidents, or complaints. Resident 2's initial assessment and care plan dated [redacted]/2022 showed that Resident 2 had history of frequent urinary infections and needed to be monitor for changed behaviors. Assessment also showed that Resident 2 had no behaviors, frequent falls, suicidal thoughts, or exit seeking behaviors.

Record review of Resident 2's chart notes showed that on 11/17/2022 a caregiver found Resident 2 outside of the facility halfway into a ditch and stated that they wanted to die and be left alone. Resident 2 was brought back to facility by care staff.

Record review of hospital record dated 12/03/2022 showed that Resident 2 went to the Emergency Room (ER) for pain to right hand with significant bruise, injury to head, abrasions to feet, clearly depressed, and tired of living.

Record review of Resident 2's chart notes dated 12/04/2022 showed that Resident was found on floor, had swelling, and bruising to left hand. Resident 2 was taken to ER and returned to the ALF on 12/05/2022.

Record review of Resident 2's chart notes dated [redacted]/2022, showed that Resident 1 was yelling for help, and was found on floor in apartment. Resident 2 stated that they fell one day prior, and no one came to help. Resident 2 was helped up to recliner chair. Caregiver later found Resident 2 on floor again in same spot. Caregiver was unable to get Resident 2 back up and called 911.

On 02/13/2023 at 11:02 AM Staff A, stated on 12/04/2022 Resident 2 was sent to hospital when found on floor and had swelling and bruising to left hand. On [redacted]/2022 Resident 2 was found on floor and Resident 2 called 911 themselves because they were not feeling well and found out later, they had surgery for hip fracture. Staff A stated he did not know how the fracture occurred. Staff A also stated that Resident 2 had many incidents leading to hip fracture and was not aware that injuries and incidents of unknown sources should have been reported to the Department.

Record review of hospital record dated [redacted]/2022, showed that Resident 2 had sustained a hip fracture. The Emergency Room Doctor spoke to Staff A and Staff D. Staff A and D told the Doctor that Resident 2 was wheelchair bound, and it was common to find Resident 2 on the floor, facility staff was not sure if Resident 2 had been falling or lowering self to the floor.

Review of the departments' reporting data based showed no facility report was received. No documentation or investigations to rule out abuse and neglect were provided.

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, Amber Hills Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4-28-23

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

Thomas McDonald 4-7-23

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

(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;

(f) In response to medical emergencies;

(j) To supervise and monitor residents, including accounting for residents who leave the premises;

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to implement their policies and procedures for residents who experienced unusual occurrences, injury, incidents or changes in condition for 2 of 2 residents (Residents 1 and 2). These failures contributed to bruises to one resident's right hand and left lower leg, a large bruise that covered their entire right hip, a large skin tear to left knee, a large scab on nose, dehydration (a dangerous loss of water in the body) and a 21-day hospitalization for Resident 1 and for Resident 2, untreated suicidal thoughts and actions, repeated falls with

hospitalization with pain to right hand and a significant bruise, a head injury, abrasions to their feet, and a fractured hip.

Findings included...

Record review of the facility's policy titled "Internal Incident Report and State Incident Report" dated 08/10/2021 showed that an internal incident report is completed by staff for all unusual occurrences, injury, incidents, and are reported immediately to family and physician. The ALF must immediately report to the Department any circumstances which threaten the ALF's ability to ensure continuation of services to residents.

Record review of facility's policy titled, "Alert Charting", dated 08/10/2021 showed that alert charting will be implemented for residents who had a recent change in their expected function or other reason that needed closer monitoring such as a change in condition, had a fall, eloped the facility, exhibited a change in emotional, behavioral, or mental function. Care staff will immediately notify the Health and Wellness Director (HWD) /Licensed Nurse (LN) or designee if the resident exhibited a change in condition or other reason for concern, and changes in Negotiated Service Agreement (NSA) would be made.

Record review of facility's policy titled, "Change in Resident Status", dated 08/10/2021 showed that ALF staff have the responsibility to provide care to each resident and summon medical attention when the resident had a change in status. The HWD or Medication Technician were responsible to make notifications when there was a change in resident status such as, decline in cognitive (process of thinking and reasoning) function, increased agitation, unusual behavior, weight loss, depressive behaviors, exit seeking behaviors, and if there is a change in status or ability to function, the resident's physician should be immediately notified. The resident's responsible person should also be notified of the change in status. The facility shall take appropriate action in response to each resident's changing needs, and consult with the resident's physician, resident's representative, and other individuals designated by the resident whenever there is a significant change.

Record review of the facility's policy titled, "Elder Abuse, Neglect, and Exploitation" dated 08/10/2021 showed that facility staff is to immediately report any form of possible symptoms of abuse or neglect to the Department according to state requirements. A thorough investigation will be conducted by the HWD or Executive Director.

Record review of facility's policy titled, "Suicidal Action or Ideation" dated 12/15/2021 showed that any resident exhibiting suicidal actions or expressing suicidal thoughts will be assessed by a doctor or mental health professional. Additional instructions included, do not leave resident alone, and notify the HWD or nurse on duty. Anytime a staff member is in doubt of the situation, 911 should be called immediately and remove all sharp objects. A detailed note of all observations and actions taken should be documented in Resident chart notes.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2022. An assessment dated 06/30/2022 showed that Resident 1 had severe memory impairment, was able to eat independently,

and was at risk for potential falls. No behaviors were documented in the assessment.

On 01/09/2023 at 3:56 PM Collateral Contact (CC1), a Social Service Specialist from an outside agency, stated that Resident 1's Representative and Durable Power of Attorney (DPOA), CC3 had voiced concern about the ALF not responding to the resident's repeated falls, injuries and outbursts and felt the facility was unable to meet Resident 1's needs for a few months. CC1 was informed by CC3 that they (CC3) had told the facility Resident 1 needed to be sent to the hospital for an evaluation and to obtain social service assistance to assist with alternate placement. CC1 stated that their department did not receive notification from the ALF that Resident 1 was experiencing changes in behavior including outbursts, frequent falls as CC3 indicated.

Review of Resident 1's record showed:

- 09/17/2022, and on 09/20/2022 Resident 1 was aggressive, leaving the main doors, and fighting staff when staff tried assist Resident 1 back into the ALF.
- 11/2/2022 at 9:13 PM showed that Resident 1 pulled off guard rail from the wall.
- 12/16/2022 showed that Resident 1 was trying to leave the facility and became combative with staff.
- 12/20/2022 at 9:37 AM showed Resident 1 was found on floor in front entrance of the ALF.
- 12/23/2022 at 1:22 PM showed that Resident was aggressive to care staff and twisted care staff's arm.
- 12/26/2022 at 7:50 AM showed that Resident 1 was found in their apartment by caregiver and the resident was flipping over mattress on bed and end tables, because a little boy was trying to wake them up.
- 12/29/2022 at 12:55 PM showed that caregiver found Resident 1 asleep but found television on floor and two end tables on top of television with clothes thrown everywhere.
- 12/29/2022 at 12:57 PM showed Resident 1 was agitated and disrupted other residents.
- 12/29/2022 at 2:00 PM showed that Resident 1 was anxious, walking around facility with chairs.
- 12/31/2022 at 9:16 AM showed the caregiver found Resident's television on floor in apartment; Resident 1 could not recall what had happened. Incident report dated 12/31/2022 showed that Resident 1 was found on floor with red mark to knee.
- 01/01/2022 at 1:01 PM showed that Resident 1 had an unwitnessed fall and was found on floor, dragging self on the ground.
- 01/04/2023, showed that Resident 1 saved food in mouth and could not swallow food.

On 02/08/2023 at 11:03 AM, CC3 stated that on 11/23/2022 facility staff called to notify them of a fall but told her Resident 1 was not injured. In December 2022 facility staff called CC3 "at least three times a week" to notify her of falls with "no injuries, I felt this was a lie." CC3 stated Resident 1 was "continuously covered in bruises." On 12/17/2022 facility staff called to notify CC3 of Resident 1's increased behaviors. "I told [Staff A] that [Resident 1] needed to be evaluated, taken to the hospital and to hopefully the ALF would refuse acceptance back into the facility." Staff A stated that there was nothing he could do; "ER keeps bringing [Resident 1] back." On 12/31/2022 facility staff called CC3 to notify of another fall and was told that Resident 1 was not injured, "they kept telling me [Resident 1] was ok."

CC3 stated that early December 2022 facility staff told her that Resident 1 could no longer eat, swallow, or walk on their own. Staff had stated the Resident 1 had changes in behavior and was falling more frequently. Resident 1 needed more monitoring and needed

to be fed by facility staff. CC3 stated that months prior she asked Staff A, Administrator, if they could have a meeting to discuss Resident 1's needs and condition. Staff A asked her if she (CC3) could wait a month until a facility nurse was hired. Staff A assured CC3 that the facility was able to meet Resident 1's needs and that Resident 1 was "fine". CC3 stated that she had repeatedly told Staff A that they were concerned about Resident 1's safety.

During the interview CC3 stated that on [redacted]/2023 she walked into the ALF and observed Resident 1 slumped over in a chair, screaming in pain. The resident appeared malnourished, covered in bruises, with one large bruise that covered entire upper left leg which wrapped around to the resident's back, "looked like they were dragged by a car, I had no idea how bad the falls were, there were so many unexplained injuries." CC3 stated they called 911 and demanded that Resident 1 be admitted to the hospital and not return to the ALF.

Review of Resident 1's hospital record dated [redacted]/2023 showed that Resident 1 was brought to the hospital for evaluation of multiple falls, with multiple areas of bruises of varying ages and abrasions (an area damaged by scraping or wearing away) on legs and face. Resident 1 discharged back to the ALF on [redacted]/2023.

Review of Resident 1's hospital record dated [redacted]/2023 showed that Resident 1 was admitted to the hospital due to bruises which were noted in various locations including the right hand and left lower leg, in various stages of healing and a large bruise that covered their entire right hip. The record showed the Resident 1 also had a large skin tear to left knee, a large scab on nose which was red and dried due to previous falls and unknown causes. Resident 1 was also treated for dehydration.

On 01/12/2023 at 4:30 PM Collateral Contact (CC2), Social Worker from a local hospital, stated that she was trying to find alternate placement for Resident 1 due to the need for a higher level of care. CC2 stated that Resident 1 had been to the hospital several times in the month of December 2022, had several falls, and felt like Resident 1 was not appropriate to live at the ALF. CC2 stated she was concerned about the wellbeing of the residents that live in the ALF.

On 01/12/2023 at 10:20 AM Staff A, stated that Resident 1 had a decline in their condition about six-weeks ago and that their dementia (impaired ability to remember, think or make decisions, that interfere with daily activities), was getting worse. Staff A stated that he had not notified Resident 1's physician and did not seek assistance to find alternate placement for Resident 1's higher level of care needs. "I probably should have done that." Staff A also stated that he was not aware of Resident 1's bruising to left hip and other areas of their body and was not sure why the ALF did not report the injuries to the Department; an investigation was not completed.

On 01/12/2023 at 1:18 PM Staff Member D, Medication Technician, stated that she knew about bruising to Resident 1's left hip, and was unsure how the bruise occurred.

Records were requested from 12/01/2022 through 01/04/2023 of Resident 1's frequent falls, injuries, incidents, alert charting, investigations, physician notifications and reports to the Department. The facility was unable to provide documentation that the investigations had been completed.

On 02/21/2023 at 4:15 PM, CC3 stated that she felt like Resident 1 was not monitored by the ALF and that the ALF did not recognize that Resident 1 needed more care, and that the resident 1's condition was worsening, "I had to facilitate emergency room visits, Resident 1 was severely dehydrated, and was unsafe in the facility." Resident 1 spent twenty-one days in the hospital and was eventually placed at another ALF.

Resident 2

Record review of Resident 2's record showed that they were admitted to the ALF on [redacted]/2022.

Record review of Resident 2's initial assessment and care plan dated [redacted]/2022 showed that Resident 2 had a history of frequent bladder infections and needed to be monitored for changed behaviors. The assessment also showed that Resident 2 had no behaviors, suicidal thoughts, or exit seeking behaviors.

Record review of Resident 2's record showed:

- 11/17/2022 a caregiver found Resident 2 outside of the facility. The resident was halfway into a ditch and stated that they wanted to die and be left alone. The record did not show documentation on an incident report, assessment, alert charting, physician notification, or notification to the Department.
- 11/19/2022 Resident 2 made remarks about wanting to die and wanted to be left alone. The record did not show documentation of an incident report, alert charting, or physician notification.
- 11/27/2022 showed that their Emergency Response team were called by the facility because Resident 2 was attacking staff and had a fall.
- 11/27/2022 hospital record showed that Resident went to hospital feeling like "nobody cares" and behavioral changes. Resident was diagnosed a [redacted] Prescription for infection was sent back with Resident to the ALF.
- 11/28/2022, Resident 2 was found outside by caregiver. The resident was brought back to the facility. It was revealed that Resident 2 had cut off their wander guard bracelet (a monitoring device which alarms to help protect residents from elopement).
- 11/29/2022 showed that Resident 2 became combative and aggressive, kicking, screaming, and attempted to throw an object at another resident in the ALF.
- 12/01/2022 showed that Resident 2 was agitated and tried to escape the facility twice.
- 12/01/2023 hospital record showed that Resident 2 went back to the hospital for altered mental status. It was determined by hospital staff that Resident 2's prescription was not filled or started by the ALF on 11/27/2023.
- 12/04/2022 showed that Resident was found on floor, with swelling, and bruising to left hand. Resident 2 was taken to ER. Hospital record showed that Resident 2 had pain to right hand with significant bruise, injury to head, abrasions to feet, clearly depressed, and tired of living. Resident was discharged back to the ALF. Resident instructed to follow-up with hospital in three days even if feeling well. No documentation of follow-up visit found.
- 12/19/2022 showed that Resident 2 wanted to call 911 and go to hospital. No documentation of why Resident 2 wanted to go to hospital. Resident was not sent to hospital by care staff.
- [redacted]/2022, showed that Resident 1 was yelling for help, and was found on floor in apartment. Resident 2 stated that they fell one day prior, and no one came to help. Resident 2 was helped up to recliner chair. Caregiver later found Resident 2 on floor again, in same spot. Caregiver was unable to get Resident 2 back up and called 911.

[redacted]2022, hospital record showed that Resident 2 had sustained a hip fracture. The Emergency Room Doctor spoke to Staff A and Staff D. Staff A and D told the Doctor that Resident 2 was wheelchair bound, and it was common to find Resident 2 on the floor, facility staff was not sure if Resident 2 had been falling or lowering self to the floor.

Record review of the Resident 1's current care plan dated 11/25/2022 showed no interventions related to the residents change of condition which included suicidal remarks and increased behaviors.

Review of the resident's case manager (designated to coordinate care and services with the ALF), Communication Notes, dated November 2022 through December 2022, showed no notifications to the case manager regarding the resident's change of condition which included suicidal remarks, falls and increased behaviors.

Record review of Resident 2's facility's assessment dated 01/20/2023 showed that Resident 2 may not leave the ALF unassisted, had no history of aggressive behaviors, elopement, and no history of harming self or others. The record showed the resident was hospitalized on [redacted]/2022 and did not return to the ALF.

On 02/13/2023 at 11:02 AM, Staff A stated that he was aware of the incident when Resident 2 was found halfway into ditch and were stating that they wanted to die. Staff A stated that he was not aware of Resident's second comment of wanting to "die" and should have followed the ALF's suicide ideation policy and notified their doctor.

Staff A stated that on 12/04/2022 Resident 2 was sent to hospital when found on floor and had swelling and bruising to left hand. On [redacted]/2022 Resident 2 was found on floor and Resident 2 called 911 themselves because they were not feeling well. Staff A stated that Resident 2 had many incidents, and their mental status was declining four to five weeks prior. "I did not think of reporting at the time" and was not aware that injuries of unknown sources should have been reported to the Department. An investigation was not completed by the facility.

On 03/14/2023 at 1:12 PM, Collateral Contact 4 (CC4), Resident's Representative and DPOA stated they were not notified by the facility about Resident 2's suicide ideation or comments of "wanting to die" that occurred on 11/17/2022 and 11/19/2022. "[Resident 2] had so many incidents while living at the ALF."

Records were requested from 11/17/2022 through [redacted]/2022 of Resident 2's frequent falls, injuries, incidents, alert charting, investigations, and physician notifications and reports to the Department. The facility was unable to provide complete records and stated that the requested documents were not found.

Plan/Attestation Statement

Statement of Deficiencies	License # 2616	Compliance Determination # 18461
Plan of Correction	Amber Hills Assisted Living	Completion Date
Page of 11	Licensee: Greenlake Management Prosser, LLC	03/14/2023

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, Amber Hills Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4-28-23

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

Thomas McDaniel 4-7-23

Administrator (or Representative) Date