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

11/07/2024

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

RE: Amber Hills Assisted Living # 2616

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 49982 (Completion Date 11/07/2024) and 45612 (Completion Date 09/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/07/2024 and found no deficiencies.

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

The Department staff who did the On Site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, 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: 142248
Compliance Determination #: 45612
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 08/14/2024 through 09/11/2024
Complainant Contact Date(s): 09/11/2024

Allegation(s):

1) A resident had an unwitnessed fall.
2) A resident had rug burns to their knees.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster House policies Incident investigation Hospital records Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:

1) Observations showed that the residents had ambulatory assistive devices available to them. Residents appeared safe and in good spirits. Interviews and record review showed that a named resident had an unwitnessed fall. The named resident was unable to state how they fell. The facility did not report the unwitnessed fall to the Department. Failed practice identified. WAC 388-78A-2630. 2) Observations showed that the named resident was no longer in the facility. Interviews and record review showed that the named resident had substantial injuries that were not reported to the Department. Failed practice identified. WAC 388-78A-2630.

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 # 45612
Plan of Correction	Amber Hills Assisted Living	Completion Date
Page 1 of 4	Licensee: Greenlake Management Prosser, LLC	09/11/2024

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 08/14/2024 and 08/14/2024 of:

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

This document references the following complaint number(s): 142248, 142745

The following sample was selected for review during the unannounced on-site visit: 3 of 37 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.

Stephanie Jones

Residential Care Services

09/23/2024

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)

9-24-24
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) staff failed to report an unwitnessed accident/substantial injury to the Complaint Resolution Unit for 1 of 3 residents (Resident 1). This failure placed the resident at risk for further injuries.

Findings included...

Review of the Department of Social and Health Services "Assisted Living Facility Guidebook", dated February 2018, showed guidelines for reporting to the Department for incidents including unwitnessed accidents or injuries. The guidebook showed that substantial injuries include but are not limited to abrasions, burns, or lacerations. The guidebook further showed that substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect must be reported to the Department as soon as made knowledge of the allegation or incident.

Review of the ALF's policy titled, "Accidents, Incidents, and Unusual Occurrences," revised 02/15/2024 showed that an accident is defined as any unforeseen or unplanned event that occurs in the facility. The policy showed the facility would notify any appropriate agencies as applicable.

Review of Resident 1's facility record showed that they were admitted to the facility on [redacted]/2023 and required assistance to get in and out of bed.

Review of Resident 1's incident report, dated 08/10/2024, showed that Staff A, Medication Technician found Resident 1 in their bedroom laying on their right side, on the floor between their nightstand and bed on 08/10/2024 at 8:30 AM. The report showed that the incident was not witnessed by staff. The report showed that Resident 1 was unable to state what had happened.

Review of Resident 1's incident report, dated 08/11/2024, showed that staff found

Administrator (or Representative) Date

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Review of Resident 1's facility record showed that they were admitted to the facility on [redacted]/2023 and required assistance to get in and out of bed.

Review of Resident 1's incident report, dated 08/10/2024, showed that Staff A, Medication Technician found Resident 1 in their bedroom laying on their right side, on the floor between their nightstand and bed on 08/10/2024 at 8:30 AM. The report showed that the incident was not witnessed by staff. The report showed that Resident 1 was unable to state what had happened.

Review of Resident 1's incident report, dated 08/11/2024, showed that staff found

Resident 1 on the floor again. The report showed the incident was unwitnessed and that Resident 1 was unable to state what had happened.

In an interview on 08/12/2024 at 4:39 PM Collateral Contact 1 (CC1), Emergency Responder, stated that they transported Resident 1 to the hospital after they were found on the floor at the facility on 08/10/2024. C1 stated they observed large significant "rug burns" to both knees. CC1 stated that Resident 1 had three "rug burns" on the outside of their right knee and one "large rug burn" to their left inner knee. CC1 stated that they felt that Resident 1 was fearful and was unable or willing to state how the injuries occurred. CC1 stated that facility staff were unsure of how Resident 1 got the rug burns and did not think that Resident 1 could have crawled on the floor to develop the rug burns.

Review of Resident 1's hospital record, dated [redacted]/2024, showed that the resident was brought to the emergency room on [redacted]2024 and [redacted]/2024 for frequent falls. The hospital record showed that Resident 1 was unable to tell hospital staff how they fell in their room. The hospital record showed photographs of Resident 1's abrasions/injuries to both knees and a large bruise covering their right shoulder.

In an interview on 09/10/2024 at 10:21 AM, Staff A stated that Resident 1 was confused when found on the floor on 08/10/2024. Staff A stated that Resident 1 was not able to recall how they ended up on the floor or how they acquired the "abrasions". Staff A stated that normally Resident 1 would be able to state their needs but not on that day.

In an interview on 09/11/2024 at 1:22 PM Staff B, Administrator acknowledged that the incident/injuries should have been reported to the Department.

Review of the Department's reporting database showed no facility reports for the resident's unwitnessed falls that occurred on 08/10/2024 and 08/11/2024.

This is a recurring deficiency previously cited on 03/14/2023.

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) 10-15-24.

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

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In an interview on 09/10/2024 at 10:21 AM, Staff A stated that Resident 1 was confused when found on the floor on 08/10/2024. Staff A stated that Resident 1 was not able to recall how they ended up on the floor or how they acquired the "abrasions". Staff A stated that normally Resident 1 would be able to state their needs but not on that day.

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Administrator (or Representative) Thomas McDonald Date 9.24.24

Administrator (or Representative) Date