STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Veda Living Spokane Cataldo LLC
Colonial Court Assisted Living and Memory Care
12016 E Cataldo Ave
Spokane Valley, WA 99206

RE: Colonial Court Assisted Living and Memory Care # 2674

Dear Administrator:

This document references Compliance Determination 48452 (10/30/2024), which included complaint number(s) 150352, 151141.

The Department completed a complaint investigation of your Assisted Living Facility on 10/30/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Raul Gatchalian, Community Complaint Investigator

Consultation:

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

The
facility reported the incident to law enforcement but not to the department. The facility provided staff in-services and education related to mandatory reporting. Moving forward the facility will make sure that incidents or allegations are reported to the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the facility to determine if you have corrected all deficiencies.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Colonial Court Assisted Living and Memory Care
License/Cert.#: 2674
Compliance Determination #: 48452
Investigator: Raul Gatchalian
Investigation Date(s): 10/09/2024 through 10/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 150352
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
Resident was touch inappropriately by staff.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident representative Nursing staff Residents Family members Nurse administrator
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
The identified resident (AV) was not available (out of the facility). The identified resident representative was interviewed and stated that the facility notified them of the incident and completed an investigation. The identified resident representative did not think that AV was touched purposely, "it was the call pendant (necklace type) that touched the AV". The resident had no injury. The facility notified law enforcement and initiated an investigation. Law enforcement did not have any findings related to sexual abuse. All sampled staff denied any sexual abuse

occurring in the facility. All sampled staff had clear background check and completed training required to perform their duties.
The facility failed to report it the incident to the department. The facility investigated the incident and unsubstantiated it. The facility provided staff in-services and education related to mandatory reporting. Moving forward the facility will make sure that any suspected abuse or neglect will be reported to the department. Failed practice consultation under WAC 388-78A-2630 (1) (a) and (b).

Conclusion / Action:

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