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

Spokane AL, LLC
Avista Senior Living Spokane
7310 N Pine Rock St
Spokane, WA 99208

RE: Avista Senior Living Spokane License # 2678

Dear Administrator:

This letter addresses Compliance Determination(s) 47509 (Completion Date 09/23/2024) and 42890 (Completion Date 07/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/23/2024 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-2060-1, WAC 388-78A-2060-3, WAC 388-78A-2150-1, WAC 388-78A-2660-1, WAC 388-78A-2660-4, WAC 388-78A-2660-6, RCW 70.129.110.3.a, RCW 70.129.110.3.b

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

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: Avista Senior Living Spokane
License/Cert.#: 2678
Compliance Determination #: 42890
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 133929
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 06/18/2024 through 07/22/2024
Complainant Contact Date(s): 06/18/2024, 07/26/2024

Allegation(s):
Resident being discharged against resident and family's wishes.

Investigation Methods:

Sample:
Total residents: 38
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Executive Director
Alleged Victim
Director of Nursing
Hospice Nurse
Resident Representative

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-Resident assessments
-Progress notes
-Home health notes
-Hospice notes
-Provider notes
-Hospital records
-Termination and Refunds Policy
-Staff training records

Investigation Summary:

The Alleged Victim was admitted to the facility without a complete preadmission assessment. The facility was unable to provide a signed negotiated service agreement for the Alleged Victim. The Alleged Victim was discharged with no written notice from the facility even though their needs were met with additional hospice services. Failed facility practice was cited under WAC 388-78A-2060 Preadmission assessment (1)(3), WAC 388-78A-2150 Signing negotiated service agreement (1), WAC 388-78A-2660 Resident rights (1)(4)(6), and RCW 70.129.110 (3)(a)(b)(4)(a).

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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2678	Compliance Determination # 42890
Plan of Correction	Avista Senior Living Spokane	Completion Date
Page 1 of 8	Licensee: Spokane AL, LLC	07/22/2024

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 06/18/2024, 06/18/2024 and 06/18/2024 of:

Avista Senior Living Spokane
7310 N Pine Rock St
Spokane, WA 99208

This document references the following complaint number(s): 133929

The following sample was selected for review during the unannounced on-site visit: 3 of 38 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Residential Care Services — 07/29/2024 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.

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

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Avista Senior Living Spokane
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Spokane, WA 99208

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Amy Wright, NCI Complain Investigator

From:
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Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Residential Care Services

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.

Statement of Deficiencies	License #: 2678	Compliance Determination # 42890
Plan of Correction	Avista Senior Living Spokane	Completion Date
Page 2 of 8	Licensee: Spokane AL, LLC	07/22/2024

Administrator (or Representative) 8.6.2024 Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the preadmission assessment included the prospective resident's medical history and medical diagnoses for 1 of 1 resident (Resident 1). This failure placed Resident 1, and other newly admitted residents, at increased risk of unidentified needs, health complications, and decreased quality of life.

Findings included...

Review of Resident 1's facility AVSL Washington Nursing Assessment, dated 04/29/2024, showed that no medical history or diagnoses were included in the assessment.

Review of a transfer/move out report for Resident 1, dated [redacted]/2024, showed that the resident admitted to the facility on that day.

In an interview on 06/18/2024 at 11:36 PM, Resident 1 stated they were only evaluated over the phone prior to being admitted to the facility, and no one "looked at" them until 05/06/2024.

In an interview on 07/18/2024 at 10:38 AM, Staff A, Executive Director, stated that the assessments done on 04/29/2024 and 05/30/2024 were the only assessments completed by facility staff on Resident 1.

Review of facility records showed no documented preadmission assessments noting Resident 1's medical history or diagnoses.

Administrator (or Representative) Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the preadmission assessment included the prospective resident's medical history and medical diagnoses for 1 of 1 resident (Resident 1). This failure placed Resident 1, and other newly admitted residents, at increased risk of unidentified needs, health complications, and decreased quality of life.

Findings included…

Review of Resident 1's facility AVSL Washington Nursing Assessment, dated 04/29/2024, showed that no medical history or diagnoses were included in the assessment.

Review of a transfer/move out report for Resident 1, dated [redacted]/2024, showed that the resident admitted to the facility on that day.

In an interview on 06/18/2024 at 11:36 PM, Resident 1 stated they were only evaluated over the phone prior to being admitted to the facility, and no one "looked at" them until 05/06/2024.

In an interview on 07/18/2024 at 10:38 AM, Staff A, Executive Director, stated that the assessments done on 04/29/2024 and 05/30/2024 were the only assessments completed by facility staff on Resident 1.

Review of facility records showed no documented preadmission assessments noting Resident 1's medical history or diagnoses.

Statement of Deficiencies	License #: 2678	Compliance Determination # 42890
Plan of Correction	Avista Senior Living Spokane	Completion Date
Page 3 of 8	Licensee: Spokane AL, LLC	07/22/2024

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, Avista Senior Living Spokane is or will be in compliance with this law and / or regulation on (Date) 9.8.2024.

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

Hailah Dietsch — Administrator (or Representative)

8.6.2024 — Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the residents or their representatives for 2 of 2 residents (Residents 1 and 2). This failure placed Residents 1 and 2, and other facility residents, at increased risk for unidentified needs due to not signing and agreeing to their plan of care.

Findings included...

In an email communication sent on 07/22/2024 at10:46 AM, Staff A, Executive Director, stated the facility did not have Negotiated Service Agreements (NSAs) that were signed by the residents or their responsible parties.

<Resident 1>

In an interview on 07/18/2024 at 2:54 PM, Collateral Contact 1 (CC1), Resident Representative, stated they, nor Resident 1 ever saw or signed an NSA for Resident 1. CC1 stated they had no conversations with facility staff regarding how the facility planned to care for Resident 1.

Review of an undated NSA for Resident 1, showed that it was not signed by Resident 1 or their representative. The NSA showed that Resident 1 admitted to the facility on [redacted]/2024.

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, Avista Senior Living Spokane is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the residents or their representatives for 2 of 2 residents (Residents 1 and 2). This failure placed Residents 1 and 2, and other facility residents, at increased risk for unidentified needs due to not signing and agreeing to their plan of care.

Findings included…

In an email communication sent on 07/22/2024 at10:46 AM, Staff A, Executive Director, stated the facility did not have Negotiated Service Agreements (NSAs) that were signed by the residents or their responsible parties.

<Resident 1>

In an interview on 07/18/2024 at 2:54 PM, Collateral Contact 1 (CC1), Resident Representative, stated they, nor Resident 1 ever saw or signed an NSA for Resident 1. CC1 stated they had no conversations with facility staff regarding how the facility planned to care for Resident 1.

Review of an undated NSA for Resident 1, showed that it was not signed by Resident 1 or their representative. The NSA showed that Resident 1 admitted to the facility on [redacted]/2024.

Statement of Deficiencies	License #: 2678	Compliance Determination # 42890
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Review of facility records showed no signed NSA's for Resident 1.

<Resident 2>

Review of an undated NSA for Resident 2, showed that it was not signed by Resident 2 or their representative. The NSA showed that Resident 2 admitted to the facility on [redacted]2020.

Review of facility records showed no signed NSA's for 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, Avista Senior Living Spokane is or will be in compliance with this law and / or regulation on (Date) 9.5.2024 .

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

Hailah Dieterle — Administrator (or Representative)

8.6.2024 — Date

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

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

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

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Review of facility records showed no signed NSA's for Resident 1.

<Resident 2>

Review of an undated NSA for Resident 2, showed that it was not signed by Resident 2 or their representative. The NSA showed that Resident 2 admitted to the facility on [redacted]/2020.

Review of facility records showed no signed NSA's for 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, Avista Senior Living Spokane is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

(4)(a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged.

Based on interview and record review, the facility failed to accommodate a resident, whose needs could be met at the facility with hospice services, by discharging them without proper written notice for 1 of 2 residents (Resident 1) reviewed for discharge processes. This failure resulted in the resident having to discharge during their end of life process, increased emotional stress and a decreased quality of life.

Findings included…

Review of an undated facility policy, titled, “Termination and Refunds,” showed that before the community transfers or discharges a resident, the community will:

- First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;
- Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;
- Include in the written notice the following items:
  - The reason for transfer or discharge;
  - The effective date of transfer or discharge;

In an interview on 06/18/2024 at 11:10 AM, Staff A, Executive Director, stated they had a care conference on 06/06/2024 with Collateral Contact 1 (CC1), Resident Representative, about needing to find alternative placement for Resident 1. Staff A stated Resident 1 had lived at the facility for about one and a half to two months. Staff A stated Resident 1 had cancer and they were “terminal.” Staff A stated the reason Resident 1 needed to find other placement was because they had multiple stage 3 (full thickness tissue loss) pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin). Staff A stated that hospice was managing Resident 1’s wound care. Staff A stated that Resident 1 did not want to move to another facility. Staff A stated that Resident 1 was not given a written discharge notice but that CC1 was just told in conversation that they needed to find other placement for Resident 1. Staff A stated the facility’s discharge process required they give residents a 30-day notice.

In an interview on 06/18/2024 at 11:36 PM, Resident 1 stated they had stage 4 cancer (cancer which has spread to different parts of the body) which they stopped treatment for earlier this year. Resident 1 stated they had lived at the facility since [redacted]/2024 and they started on hospice last Monday. Resident 1 stated that CC1 was called into a meeting a couple of weeks ago and was told that it was against Washington state law for assisted living facilities to have residents with stage 3 pressure ulcers when not on hospice. Resident 1 stated they were not given a discharge notice in writing. Resident 1

stated the facility was aware the wound on their tailbone was a stage 3 when they admitted into the facility. Resident 1 stated the facility was “bugging” CC1 at work, telling them they needed to find other placement for Resident 1. Resident 1 stated that during the care conference, they were told by management that they were not a “good fit” for the facility. Resident 1 stated the hospice nurse was now managing their wound care, that the standard of care at the facility was good, they liked the care staff, they felt safe at the facility, and their needs were met at the facility. Resident 1 stated the facility wanted them out “yesterday.”

In an interview on 06/18/2024 at 4:15 PM, CC1 stated that Resident 1 was 67 years old and that Resident 1 got a verbal notice of discharge on 06/06/2024. CC1 stated the facility was well aware of Resident 1’s wounds while the resident was still at the rehabilitation facility, prior to admitting to the facility. CC1 stated that while Resident 1 was at the hospital prior to their rehabilitation stay, hospital staff had staged the pressure ulcer on Resident 1’s tailbone as stage 3, though it had since improved. CC1 stated that initially, the facility said they could not take Resident 1 because of the stage 3 pressure ulcer, then later said they would take them but that worst case scenario, Resident 1 would have to go on hospice. CC1 stated that Staff B, Health and Wellness Director, told them it was against state law to have a stage 3 pressure ulcer in an assisted living. CC1 stated they really wanted Resident 1 to stay at the facility because Resident 1 liked it there. CC1 stated that they, nor Resident 1, were ever given anything in writing related to Resident 1’s discharge. CC1 stated that Resident 1’s wound care was being managed by hospice. CC1 stated they bought Resident 1 an air cushion, at the facility’s request, about two weeks after Resident 1 moved in. CC1 stated there was supposed to be a care conference for Resident 1, but instead, the meeting consisted of Staff A and Staff B, Health and Wellness Director, telling Resident 1 they had to move out because they were not a “good fit” for the facility. CC1 stated they thought Resident 1 had just given up as Resident 1 had stage 4 cancer. CC1 stated the discharge situation had been an absolute nightmare.

In an interview on 07/18/2024 at 8:19 AM, CC1 stated they were moving Resident 1 to an adult family home. CC1 stated that Resident 1 was still on hospice and hospice was still managing Resident 1’s wound care. CC1 stated they still had not received anything in writing from the facility regarding their request that Resident 1 discharge. CC1 stated they sent an email to Staff A on 07/03/2024, asking for a written discharge notice, though Staff A never responded to the email. CC1 stated they did not feel Resident 1 was beyond the scope of care the facility could provide. CC1 stated that Staff A’s reason for discharging Resident 1 was the stage 3 pressure ulcer. CC1 stated that Resident 1 quit physical and occupational therapy because it was too hard on them due to terminal illness and pain. CC1 stated the day Resident 1 quit therapy was the day they were told Resident 1 had to move out. CC1 stated that Staff A called them four days after being asked to move Resident 1, and Staff A asked them which facilities they had contacted.

In an interview on 07/18/2024 at 10:38 AM, Staff A stated that Resident 1 was still a resident but would be moving to an adult family home the following weekend. Staff A stated the facility did not give Resident 1 any kind of written discharge notice, rather just told them they needed to find other placement in a care conference with CC1. Staff A stated that while Resident 1 wanted to remain at the facility. Staff A stated the facility could not meet Resident 1’s needs in relation to their stage 3 pressure ulcer.

Staff A stated that Resident 1 was being asked to discharge because of their wounds, they declined to participate in therapy, they screamed at the care givers, and they declined cares at times. Staff A stated that hospice was continuing to provide Resident 1's wound care.

In an interview on 07/18/2024 at 12:28 PM, Collateral Contact 2 (CC2), Hospice Registered Nurse, stated they saw Resident 1 the previous day. CC2 stated that Resident 1 only had one wound remaining, which appeared to be a stage two to three pressure ulcer on their tailbone and upper buttock area. CC2 stated the wounds on Resident 1's thighs had resolved. CC2 stated that Resident 1 got a hospital bed within the last week and that it should help with their wound. CC2 stated that Resident 1's dressing changes were twice weekly. CC2 stated that their visits with Resident 1 were usually 45 minutes to an hour and they had not noticed any unmet needs for Resident 1. CC2 stated they felt Resident 1 would be safe to remain in the facility. CC2 stated they had not heard anything from the facility regarding Resident 1 moving out. CC2 stated that typically, when a patient was accepted to hospice, they were expected to have less than six months to live.

In an interview on 07/18/2024 at 2:18 PM, Resident 1 stated they never received a written notice of discharge from the facility. Resident 1 stated that the whole situation with being asked to move made life "a whole lot more stressful." Resident 1 stated they could not understand how they were not a "good fit" for the facility when they never left their room. Resident 1 stated they had no unmet needs at the facility.

In an interview on 07/18/2024 at 4:12 PM, Staff A stated they were aware of the Washington administrative codes related to reasonable accommodation. Staff A stated they tried to accommodate Resident 1 by getting them an air cushion, encouraging them to stay of their "bum," and by enrolling them in physical and occupational therapy, which Staff A said Resident 1 "dismissed [themselves] from." Staff A stated they tried to accommodate Resident 1 by bringing in contracted wound care, though hospice was currently managing Resident 1's wound care. Staff A stated they were aware of the requirement that written notices be given when 30 days prior to requiring a resident to discharge. Staff A stated the facility's policy was "kindness," and that they tried to avoid giving eviction letters.

In a voicemail communication left on [redacted]/2024 at 1:05 PM, CC1 stated that Resident 1 discharged from the facility that day.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2678	Compliance Determination # 42890
Plan of Correction	Avista Senior Living Spokane	Completion Date
Page 8 of 8	Licensee: Spokane AL, LLC	07/22/2024

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, Avista Senior Living Spokane is or will be in compliance with this law and / or regulation on (Date) 9.5.2024 .

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

Hailah Dieterle — Administrator (or Representative)

8.6.2024 — Date

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, Avista Senior Living Spokane is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

Plan of Correction

Facility: Avista Senior Living Spokane 2678
Deficiency: Violation of WAC 388-78A-2060 Preadmission Assessment
Date of Correction Plan Submission: 8.7.2024
Compliance Date: 9.1.2024

[redacted] Executive Director Avista Senior Living	Signature	[redacted]
	Date	8.7.2024

Disclaimer:
Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Avista Senior Living with the facts, findings, or other statements as alleged in the survey findings dated 7.22.2024. Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Avista Senior Living specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal, or administrative action.

Statement of Deficiency:

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

Root Cause Analysis:

The deficiency occurred due to a lapse in the implementation of preadmission assessment protocols by the previous Health Services Director, Laura Toohey, RN, and the previous Executive Director, Martha Jones. Their oversight led to incomplete assessments.

Corrective Actions:

1. **Personnel Changes:**
   - The previous Health Services Director, Laura Toohey, RN, and Executive Director, Martha Jones, have been terminated as of June 16, 2024.
   - New management has been appointed: [redacted] as Executive Director and Sarah Gutierrez, LPN, as Health Services Director.
2. **Education and Training:**
   - **Training:** The new management team has undergone comprehensive training on WAC 388-78A-2060 regulations, focusing on the importance of including medical

history and a licensed medical or health professional's diagnosis in preadmission assessments.

3. **Audit and Monitoring:**
   - **Internal Audits:** Weekly audits will be conducted by the Health Services Director to review preadmission assessments and ensure all required information is included.
   - **Quarterly Reviews:** The Executive Director will conduct quarterly reviews of the preadmission assessment process to ensure ongoing compliance and address any issues promptly.
4. **Communication with Prospective Residents:**
   - **Informative Materials:** Prospective residents and their families will be provided with clear information regarding the requirements for preadmission assessments, including the necessity of providing medical history and a licensed medical or health professional's diagnosis.
   - **Support Services:** The facility will offer assistance in obtaining necessary medical records and diagnoses to ensure a smooth and compliant admission process.

Implementation Date:
The corrective actions outlined in this plan will be fully implemented by September 1st, 2024.

Responsible Parties:

- [redacted] **Executive Director**
- **Sarah Gutierrez, LPN, Health Services Director**

By implementing these corrective actions, Avista Senior Living is committed to meeting and exceeding the requirements of WAC 388-78A-2060 and ensuring the highest standards of care for our residents.

[redacted] Executive Director Avista Senior Living	Signature	[redacted]
	Date	8.7.2024

Sarah Gutierrez, LPN Health Services Director Avista Senior Living	Signature	
	Date	8/7/24

Plan of Correction

Facility: Avista Senior Living Spokane 2678
Deficiency: Violation of WAC 388-78A-2150 Signing Negotiated Service Agreement
Date of Correction Plan Submission: 8.7.2024
Compliance Date: 9.1.2024

[redacted] Executive Director Avista Senior Living	Signature	[redacted]
	Date	8.7.2024

Disclaimer:
Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Avista Senior Living with the facts, findings, or other statements as alleged in the survey findings dated 7.22.2024. Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Avista Senior Living specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal, or administrative action.

Statement of Deficiency:
WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign.

Root Cause Analysis:
The deficiency occurred due to a lapse in the implementation of admission protocols by the previous Health Services Director, Laura Toohey, RN, and the previous Executive Director, Martha Jones. Their oversight led to service agreements not being signed by residents or responsible parties.

Corrective Actions:

1. Personnel Changes:

- The previous Health Services Director, Laura Toohey, RN, and Executive Director, Martha Jones, have been terminated as of June 16, 2024.
- New management has been appointed: [redacted] as Executive Director and Sarah Gutierrez, LPN, as Health Services Director.

2. Education and Training:

- **Training:** The new management team has undergone comprehensive training on WAC 388-78A-2150. This training included detailed information on the importance of ensuring all negotiated service agreements are signed by residents or their representatives.

3. Implementation of Verification Responsibility:

- **Verification:** The ED and HSD will review and verify that all required signatures have been obtained before the admission process is finalized.

4. Monitoring and Auditing:

- **Monthly Audits:** Monthly audits of all negotiated service agreements will be conducted by the Health Services Director to ensure compliance with WAC 388-78A-2150.
- **Quarterly Reviews:** Quarterly reviews will be conducted by the Executive Director to ensure that the corrective measures are being followed and are effective in preventing recurrence.

5. Communication with Residents and Representatives:

- **Informing Residents and Representatives:** All residents and their representatives will be informed of the new protocols and the importance of signing the negotiated service agreements upon admission and quarterly. This communication ensures transparency and compliance from all parties involved.

6. Documentation:

- **Maintaining Records:** All signed negotiated service agreements will be maintained in the resident's EHR file and readily available to provide for review by regulatory agencies.

Implementation Date:
The corrective actions outlined in this plan will be fully implemented by September 1st, 2024.

Responsible Parties:

- [redacted], **Executive Director**
- **Sarah Gutierrez, LPN, Health Services Director**

This plan of correction addresses the deficiency identified and outlines the steps Avista Senior Living will take to ensure compliance with WAC 388-78A-2150, thereby preventing any future violations.

[redacted] Executive Director Avista Senior Living	Signature	[redacted]
	Date	8.7.2024

Sarah Gutierrez, LPN Health Services Director Avista Senior Living	Signature	
	Date	8/7/24

Plan of Correction

Facility: Avista Senior Living Spokane 2678
Deficiencies:
RCW 70.129.110 Disclosure, transfer, and discharge requirements
WAC 388-78A-2660 Resident rights
Date of Correction Plan Submission: 8.7.2024
Compliance Date: 9.5.2024

[redacted] Executive Director Avista Senior Living	Signature	[redacted]
	Date	8.7.2024

Disclaimer:
Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Avista Senior Living with the facts, findings, or other statements as alleged in the survey findings dated 7.22.2024. Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Avista Senior Living specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal, or administrative action.

Statement of Deficiency:

RCW 70.129.110 Disclosure, transfer, and discharge requirements.
(3) Before a long-term care facility transfers or discharges a resident, the facility must:
- (a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;
- (b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

WAC 388-78A-2660 Resident rights
- (1) Comply with chapter 70.129 RCW, Long-term care resident rights;
- (4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;
- (6) Reasonably accommodate residents consistent with applicable state and/or federal law;
- (4a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged.

RCW 70.129.110 Disclosure, transfer, and discharge requirements

Root Cause Analysis:
The deficiency occurred due to improper communication by the previous Health Services Director, Laura Toohey, RN, which led to an unintentional involuntary discharge.

Corrective Actions:

1. Personnel Changes:

- **Action Plan**: The previous Health Services Director, Laura Toohey, RN, has been terminated as of June 16, 2024.
- New management has been appointed: Sarah Gutierrez, LPN, as Health Services Director.

2. Education and Training:

- **Training:** The new Health Services Director, Sarah Gutierrez LPN, has undergone comprehensive training on RCW 70.129.110 Disclosure, transfer, and discharge requirements. This training included detailed information on the importance of the requirements of resident rights regarding a discharge.

3. Reasonable Accommodations to Avoid Transfer or Discharge:

- **Action Plan**: Implement measures ensuring that all possible reasonable accommodations are attempted before deciding to transfer or discharge a resident. This includes adjusting care plans, modifying the resident's environment, or providing additional support services.
- **Responsible Person**: Health Services Director, Sarah Gutierrez, LPN
- **Completion Date**: September 1st 2024
- **Monitoring**: Audit of all transfer or discharge cases to ensure compliance with the policy.

4. Notification in Writing and in an Understandable Manner:

- **Action Plan**: Ensure that written notifications of transfer or discharge are provided in a language and manner that the resident and their representatives understand. Follow the Washington state regulations for a discharge and the company policy titled Termination and Refunds, which adheres to the state guidelines.
- **Responsible Person**: Executive Director, [redacted]
- **Completion Date**: September 1st, 2024
- **Monitoring**: Quarterly reviews of discharge notices to ensure they meet the SOP requirements.

5. Include Reason for Discharge in the Notice:

- **Action Plan:** Ensure that all written notices of transfer or discharge include the specific reason for the discharge. This information must be clear and understandable to the resident and their representatives.
- **Responsible Person:** Health Services Director, Sarah Gutierrez, LPN
- **Completion Date:** September 1st, 2024
- **Monitoring:** Routine checks of discharge notices to verify that the reason for discharge is clearly stated.

6. Advance Notice of Transfer or Discharge:

- **Action Plan:** Establish a protocol that ensures residents and their representatives receive at least a 30-day advance notice of transfer or discharge, except in cases specified by law.
- **Responsible Person:** Executive Director, [redacted]
- **Completion Date:** September 1st 2024
- **Monitoring:** Regular training sessions for staff on the new protocol and periodic checks of discharge notices for compliance with the 30-day requirement.

Deficiency: WAC 388-78A-2660 Resident Rights

Corrective Actions:

1. Promotion and Protection of Resident Rights:

- **Action Plan:** Provide informational materials for residents and their families explaining these rights. Include a copy of the resident rights in the intake and discharge packets provided to residents and their families.
- **Responsible Person:** Executive Director, [redacted]
- **Completion Date:** September 1st, 2024
- **Monitoring:** routine refresher courses with staff to ensure they are following resident rights.

2. Staff Training and Education:

- **Training:** The new management team has undergone comprehensive training on RCW 70.129.110 and WAC 388-78A-2660 regulations.
- **Responsible Person:** Executive Director, [redacted]
- **Completion Date:** September 1st, 2024
- **Monitoring:** Ongoing training with be conducted routinely.

3. Documentation and Record Keeping:

- **Action Plan:** Improve documentation processes to ensure all actions taken to avoid transfer or discharge, notifications provided, and accommodations made are thoroughly recorded.
- **Responsible Person:** Health Services Director, Sarah Gutierrez, LPN

- **Completion Date**: September 1st, 2024
- **Monitoring**: Regular audits of resident records to ensure complete and accurate documentation.

Responsible Parties:

- [redacted], **Executive Director**
- **Sarah Gutierrez, LPN, Health Services Director**

By implementing these corrective actions, the facility aims to ensure full compliance with RCW 70.129.110 and WAC 388-78A-2660, thereby promoting the welfare and rights of all residents.

[redacted] Executive Director Avista Senior Living	Signature	[redacted]
	Date	8.7.2024
Sarah Gutierrez, LPN Health Services Director Avista Senior Living	Signature	
	Date	8/7/24