STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

926 DELAWARE LLC
DELAWARE PLAZA RETIREMENT INN
926 Delaware St
Longview, WA 98632

RE: DELAWARE PLAZA RETIREMENT INN License # 1574

Dear Administrator:

This letter addresses Compliance Determination(s) 26457 (Completion Date 07/13/2023) and 23701 (Completion Date 05/16/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/13/2023 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-2120, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: DELAWARE PLAZA RETIREMENT INN
License/Cert.#: 1574
Compliance Determination #: 23701
Investigator: Jacob Ubl
Investigation Date(s): 05/09/2023 through 05/16/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 80341
Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Quality of Care/Treatment: Allegation that alleged victim resident was not getting care needs meet at facility.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Residents Family members
Record Reviews:	Medical records Hospital records Incident investigation Staff patterns

Investigation Summary:

1. Quality of Care/Treatment: Failed practice identified. The facility was not meeting the alleged victims care needs.

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: DELAWARE PLAZA RETIREMENT INN
License/Cert.#: 1574
Compliance Determination #: 23701
Investigator: Jacob Ubl
Investigation Date(s): 05/09/2023 through 05/16/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 80317
Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Resident/Patient/Client rights: Allegation that alleged victim resident was not getting care with dignity at facility.

2. Quality of Care/Treatment: Allegation that alleged victim resident was not getting care needs meet at facility.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Residents Family members
Record Reviews:	Medical records Hospital records Incident investigation Staff patterns

Investigation Summary:

1. Resident/Patient/Client rights: Failed practice identified. The facility was not providing care needs with resident dignity.

2. Quality of Care/Treatment: Failed practice identified. The facility was not meeting the alleged victims care needs.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 1574	Compliance Determination # 23701
Plan of Correction	DELAWARE PLAZA RETIREMENT INN	Completion Date
Page 1 of 4	Licensee: 926 DELAWARE LLC	05/16/2023

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 05/09/2023 and 05/16/2023 of:

DELAWARE PLAZA RETIREMENT INN
926 Delaware St
Longview, WA 98632

This document references the following complaint number(s): 80341, 80317

The following sample was selected for review during the unannounced on-site visit: 3 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

05/18/2023
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) 5/23/2023 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to identify and meet the changing care needs for 1 of 3 residents (Resident 1) reviewed for unmet care needs. This failure placed R1 at risk for falls and injury.

5/23/2023

Findings included...

An unannounced visit was conducted on 05/09/2023 at 10:22 AM.

Record review of R1's Service Agreement, dated 05/09/2023, showed "[R1] will need to be toileted in the shower room as needed", "Maximum assist" with toileting, "Maximum assist" with dressing, "Maximum assist" with bathing, "Maximum assist" with transfers, "Transfer Status: two person assist at all times.", and "Maximum assist" with mobility.

Review of an undated face sheet showed R1 was admitted to the facility on [redacted] 2014 with Diagnoses of [redacted], and [redacted].

During an interview on 05/09/2023 at 10:29 AM, Resident 1 (R1) reported that often staff "almost drop R1" during transfers. R1 reported that sometimes staff have told R1 that not enough staff are available to transfer R1 and instruct R1 to soil R1's brief so that staff can do a brief change on R1, in bed.

In an interview on 05/09/2023 at 10:38 AM, anonymous Staff C reported that transferring R1 can be unsafe even with three or four staff because the resident is fearful of falling. This results in R1 making sudden unpredictable movements through the transfer, increasing R1's risk of falls. Staff C reported that if there are not enough staff available to safely transfer R1, then staff are forced to tell R1 to soil there brief so the brief can be changed while R1 is in bed. Staff C reported staff are not willing to jeopardize R1's safety by trying to transfer R1 with only one or two staff.

In an interview on 05/09/2023 at 10:44 AM, anonymous Staff D reported transferring R1 is generally unsafe with three or more staff. Staff D reported that if there are not enough staff available to safely transfer R1, then staff instruct R1 to soil R1's brief so the brief can be changed while R1 is in bed.

In an interview on 05/09/2023 at 10:53 AM, anonymous Staff E reported not feeling comfortable transferring R1 with two other staff because of safety concerns. Staff E reported that if there are not enough staff available to safely transfer R1, then staff are forced to tell R1 to soil R1's brief so the brief can be changed while R1 is in bed.

During an observation on 05/09/2023 at 10:58 AM, Staff I, Staff J, and Staff K were observed transferring R1 from R1's bed to a wheelchair and from the wheelchair to a commode. The transfers were observed to be uncontrolled, wobbly, and unbalanced with the resident making sudden unpredictable movements throughout the transfer.

In an interview on 05/09/2023 at 11:44 AM, anonymous Staff F reported that the Skilled Nursing Facility sent R1 "home too early" as R1 "needed more therapy and rehab in order to safely return back to the Assisted Living Facility". Staff F reported that even when there were three or four staff to transfer R1, the transfers were unsafe. Staff F stated they have witnessed transferring R1 as uncontrolled, wobbly, and unbalanced with the resident making sudden unpredictable movements throughout the transfer. Staff F stated that, in their opinion, R1's "needs exceed what can safely be provided at the Assisted Living Facility and they need to go to an increased level of care to optimally recover and improve before coming back to the Assisted Living Facility".

In an interview on 05/12/2023 at 8:30 AM, Collateral Contact 1 (CC1), Home Health Physical Therapist, reported that R1 required three persons to assist with transfers and that current transfers by the Assisted Living Facility staff were unsafe. CC1 reported that the Home Health Physical Therapy plan is to install transfer poles so that staff and R1 can be trained on safe transfers. CC1 reported that the facility's current plan of transporting R1 to the downstairs shower room for toileting on a commode is not an adequate long-term

solution.

In an interview on 05/12/2023 at 9:11 AM, Staff G, Director of Nursing Services, stated that she assessed that R1 required two staff to transfer R1 safely and did not agree with the Home Health Physical Therapist assessment that R1 required three-person assistance for transfers. Staff G reported that it was unacceptable for staff to instruct R1 to soil R1's brief in bed because there were always enough care staff on shift to transfer the resident to the toilet.

In an interview on 05/12/2023 at 9:44 AM, Staff H, Executive Director, reported that the Negotiated Service agreement documented that R1 was a two-person transfer and instead should be documented that R1 is temporarily a three-person transfer until R1 can regain strength and return to their baseline status. Staff H reported that the Negotiated Service agreement for R1 should be documented as a three person transfer according to the Home Health Physical Therapist assessed safety recommendation of three person transfers. Staff H reported that it was completely unacceptable for staff to instruct R1 to soil R1's brief in bed because there were always enough care staff on shift to transfer the resident to the toilet and the lack of care provided to R1 by staff was "infuriating".

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, DELAWARE PLAZA RETIREMENT INN is or will be in compliance with this law and / or regulation on (Date) 6/30/2023

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

Administrator (or Representative) — Date 5/23/2023