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

WWGHR LLC
WHEATLAND VILLAGE
1500 CATHERINE STREET
WALLA WALLA, WA 99362

RE: WHEATLAND VILLAGE License # 1640

Dear Administrator:

This letter addresses Compliance Determination(s) 36398 (Completion Date 02/15/2024) and 33723 (Completion Date 12/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/15/2024 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:
Robin Rainville, Assisted Living Facility Licensor

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: WHEATLAND VILLAGE
Provider Type: Assisted Living Facility
License/Cert.#: 1640
Compliance Determination #: 33723
Intake ID: 106462
Investigator: Robin Rainville
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 12/11/2023 through 12/22/2023
Complainant Contact Date(s):

Allegation(s):
A named resident fell resulting in a fractured arm, and later that day they passed away unexpectedly.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 2 Closed records sample size: 3
Observations:	Residents Dining Resident rooms Staff to resident interactions general facility environment
Interviews:	Administrator Resident care coordinator Nursing staff Residents Family members
Record Reviews:	Medical records (face sheet, care plans progress notes, medication records, hospital discharge summaries) Incident investigation Facility policies Resident characteristic roster

Investigation Summary:
Record review showed that the resident fell mid morning, was sent to the hospital and returned with a diagnosis of a [redacted] but was alert and lucid upon return from the hospital. the resident passed away suddenly and unexpectedly that day after dinner. The resident had a total of six falls documented in their record in a two week period before they passed away. The Assisted Living Facility (ALF) assessed and monitored the resident and made the appropriate notifications. The ALF failed to fully investigate the resident's six falls and their unexpected death, and failed to implement preventative measures for falls. Failed practice identified in the statement of deficiencies dated 12/22/2023, under WAC 388-78a-2371.

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: WHEATLAND VILLAGE **Provider Type:** Assisted Living Facility
License/Cert.#: 1640
Compliance Determination #: 33723 **Intake ID:** 108939
Investigator: Robin Rainville **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 12/11/2023 through 12/22/2023
Complainant Contact Date(s):

Allegation(s):
The Identified Resident had an unwitnessed fall on 12/02/2023 and sustained a shoulder fracture.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 2 Closed records sample size: 3
Observations:	Residents Dining Resident rooms Staff to resident interactions general facility environment
Interviews:	Administrator Resident care coordinator Nursing staff Residents Family members
Record Reviews:	Medical records (face sheet, care plans progress notes, medication records, hospital discharge summaries) Incident investigation Facility policies Resident characteristic roster

Investigation Summary:
The Identified Resident no longer lived in the facility. The staff reported they needed frequent reminders to use their walker and call for assistance when needed. The record review showed the Identified Resident needed staff assistance for all mobility and activities of daily living. The record review included a facility investigation conducted, that did not include the details of the incident, including staff interviews to determine events that occurred prior to the fall and The ALF failed to fully investigate the fall, and failed to implement preventative measures for falls. Failed practice identified in the statement of deficiencies dated 12/22/2023, under WAC 388-78a-2371.

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 #: 1640	Compliance Determination #:33723
Plan of Correction	WHEATLAND VILLAGE	Completion Date
Page 1 of 5	Licensee: WWGHR LLC	12/22/2023

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 12/11/2023 and 12/15/2023 of:

WHEATLAND VILLAGE
1500 CATHERINE STREET
WALLA WALLA, WA 99362

This document references the following complaint number(s): 106462, 108938

The following sample was selected for review during the unannounced on-site visit: 2 of 80 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Robin Rainville, Assisted Living Facility Licensor
Krista Connelly, Community Nurse Consultant

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

01/05/2024 — 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

1200 Alder Street, Union Gap, WA 98903

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 12/11/2023 and 12/15/2023 of:

WHEATLAND VILLAGE
1500 CATHERINE STREET
WALLA WALLA, WA 99362

This document references the following complaint number(s): 106462, 108939

The following sample was selected for review during the unannounced on-site visit: 2 of 80 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Robin Rainville, Assisted Living Facility Licensor
Krista Connelly, Community Nurse Consultant

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.

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.

Administrator (or Representative) — Date: 1/16/2024

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life,

(2) Determine the circumstances of the event,

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated, and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to thoroughly investigate, determine the circumstances of the event, and institute preventative measures, for 2 of 2 discharged residents (Residents 1, 2) reviewed for accidents and incidents. These failures placed the residents at risk of harm from these incidents and potential future incidents.

Findings included...

Review of the facility's policy and procedure titled, "Internal Incident Report and State Incident Report," dated 12/15/2021, showed the facility must investigate, document investigative actions and findings for any alleged abuse, neglect, financial exploitation; accident or incident jeopardizing or affecting the resident's health or life. The procedure directs the facility to determine the circumstances of the event, when necessary, institute and document appropriate measures to prevent similar future situations.

Resident 1

Resident 1's 06/06/2023 Negotiated Service Agreement (NSA) showed that the resident had diagnoses which included [redacted], [redacted], [redacted] and [redacted]. The NSA showed that Resident 1 walked independently without the use of assistive devices and sometimes wandered into other residents' rooms looking for the bathroom. The NSA did not show that the resident had a history of falls, nor did it show interventions to prevent Resident 1 from falling.

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to thoroughly investigate, determine the circumstances of the event, and institute preventative measures, for 2 of 2 discharged residents (Residents 1, 2) reviewed for accidents and incidents. These failures placed the residents at risk of harm from these incidents and potential future incidents.

Findings included…

Review of the facility's policy and procedure titled, "Internal Incident Report and State Incident Report," dated 12/15/2021, showed the facility must investigate, document investigative actions and findings for any alleged abuse, neglect, financial exploitation; accident or incident jeopardizing or affecting the resident's health or life. The procedure directs the facility to determine the circumstances of the event, when necessary, institute and document appropriate measures to prevent similar future situations.

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Review of progress notes in Resident 1's record showed the following incidents were documented by staff:

• On 11/06/2023 at 5:50 PM Resident 1 fell to the ground and their blood pressure was very low they were sent to the hospital. There was no investigation of why the resident's blood pressure had dropped.

• On 11/07/2023 at 11:00 AM, Resident 1 was found on the bathroom floor with a wound on their right elbow. There was no investigation of how the resident had fallen, nor were there any interventions listed to prevent future events.

• On 11/11/2023 at 5:30 PM, Resident 1 had been restless, agitated and fell. There was no investigation of how the resident had fallen, nor were there any interventions listed to prevent future events.

• On 11/11/2023 at 9:48 PM, Resident 1 had fallen on the evening shift. There was no investigation of how the resident had fallen, nor were there any interventions listed to prevent future events.

• Review of a progress note written in Resident 1's record on [redacted]/2023 at 10:50 AM, showed that Resident 1 had an unwitnessed fall and was found on the floor in another resident's apartment. There was no investigation of how the resident had fallen, nor were there any interventions listed to prevent future events.

On 12/11/2023 at 12:00 PM, the incident investigations for Resident 1's falls in the past month were requested. Staff A stated that per their corporate policy, the facility incident reports were privileged and confidential, not to be disclosed and not a part of the resident's medical records. Staff A stated that the only documentation of falls that could be provided were in the resident's progress notes.

On 12/13/2023 at 1:33 PM, Staff A stated in an email that Staff D, Assisted Living Director, had completed a written investigation for the [redacted]/2023 fall and unexpected death of Resident 1.

Review of the incident investigation completed by Staff D dated 11/15/2023 showed that Resident 1 had fallen on 11/15/2023 while trying to transfer themselves independently, and later passed away unexpectedly. The investigation was inaccurate for the date of the incident and did not reflect what was documented in Resident 1's record. Additionally, the

Review of progress notes in Resident 1's record showed the following incidents were documented by staff:

• On 11/06/2023 at 5:50 PM Resident 1 fell to the ground and their blood pressure was very low they were sent to the hospital. There was no investigation of why the resident's blood pressure had dropped.

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• On 11/11/2023 at 9:48 PM, Resident 1 had fallen on the evening shift. There was no investigation of how the resident had fallen, nor were there any interventions listed to prevent future events.

• Review of a progress note written in Resident 1's record on [redacted]/2023 at 10:50 AM, showed that Resident 1 had an unwitnessed fall and was found on the floor in another resident's apartment. There was no investigation of how the resident had fallen, nor were there any interventions listed to prevent future events.

On 12/11/2023 at 12:00 PM, the incident investigations for Resident 1's falls in the past month were requested. Staff A stated that per their corporate policy, the facility incident reports were privileged and confidential, not to be disclosed and not a part of the resident's medical records. Staff A stated that the only documentation of falls that could be provided were in the resident's progress notes.

On 12/13/2023 at 1:33 PM, Staff A stated in an email that Staff D, Assisted Living Director, had completed a written investigation for the [redacted]/2023 fall and unexpected death of Resident 1.

Review of the incident investigation completed by Staff D dated 11/15/2023 showed that Resident 1 had fallen on 11/15/2023 while trying to transfer themselves independently, and later passed away unexpectedly. The investigation was inaccurate for the date of the incident and did not reflect what was documented in Resident 1's record. Additionally, the

investigation did not show that the resident had a decline in their condition prior to being found deceased on [redacted]/2023.

Resident 2

The record review for Resident 2 included an NSA, dated 10/17/2023, that showed the resident had a history of heart disease, needed one staff assistance to transfer, walked using a walker, and needed assistance to the toilet on a scheduled plan. The NSA showed Resident 2 needed reminders to use their walker and call for assistance when needed. The NSA showed the resident was at risk of falls and directed the staff to provide safety checks every two to three hours.

Review of a progress note dated 12/02/2023 at 10:32 AM, showed that staff found Resident 2 lying on the floor inside their apartment. The progress note showed Resident 2 had a bloody nose, complained of right shoulder pain, and was sent to the hospital for emergency evaluation.

The next progress note dated 12/02/2023 at 11:25 AM, showed Resident 2 returned from the hospital with a right shoulder fracture, with a sling in place to support their arm.

Review of a progress note in Resident 2's record, dated 12/04/2023 at 1:05 PM, showed it was written by Staff E, Registered Nurse. The note showed Resident 2's right shoulder was swollen, with bruising and large skin tear. Staff E documented they did not suspect abuse or neglect due to the resident not using their walker or their call light to request staff assistance. The note showed Resident 2 had removed their sling which may have resulted in the large skin tear, and they were in too much pain to recall what they tripped on.

The investigation did not include staff interviews to determine the events leading to up to the fall, including safety checks every two to three hours, to determine if the care planned interventions were in place and whether they were effective or not.

During an interview on 12/15/2023 at 1:31 PM, Staff D stated that when a resident had a change in condition, fell or had any incident resulting in an injury, the staff member that identified the change or found a resident had fallen, (the first responder,) was directed to initiate an internal incident form and notified the facility nurse and/or Staff D for additional directions.

Staff D stated after the first responder initiated the form, it was passed on to the facility nurse, and either they or the facility nurse completed the investigation and developed interventions to prevent another incident from occurring. Staff D reported the investigation notes were included in the resident record, in the progress notes.

When Staff D was asked to provide the investigation of Resident 1's fall resulting in their

investigation did not show that the resident had a decline in their condition prior to being found deceased on [redacted]/2023.

Resident 2

The record review for Resident 2 included an NSA, dated 10/17/2023, that showed the resident had a history of heart disease, needed one staff assistance to transfer, walked using a walker, and needed assistance to the toilet on a scheduled plan. The NSA showed Resident 2 needed reminders to use their walker and call for assistance when needed. The NSA showed the resident was at risk of falls and directed the staff to provide safety checks every two to three hours.

Review of a progress note dated [redacted]/2023 at 10:32 AM, showed that staff found Resident 2 lying on the floor inside their apartment. The progress note showed Resident 2 had a bloody nose, complained of right shoulder pain, and was sent to the hospital for emergency evaluation.

The next progress note dated [redacted]/2023 at 11:25 AM, showed Resident 2 returned from the hospital with a right shoulder fracture, with a sling in place to support their arm.

Review of a progress note in Resident 2's record, dated 12/04/2023 at 1:05 PM, showed it was written by Staff E, Registered Nurse. The note showed Resident 2's right shoulder was swollen, with bruising and large skin tear. Staff E documented they did not suspect abuse or neglect due to the resident not using their walker or their call light to request staff assistance. The note showed Resident 2 had removed their sling which may have resulted in the large skin tear, and they were in too much pain to recall what they tripped on.

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Staff D stated after the first responder initiated the form, it was passed on to the facility nurse, and either they or the facility nurse completed the investigation and developed interventions to prevent another incident from occurring. Staff D reported the investigation notes were included in the resident record, in the progress notes.

When Staff D was asked to provide the investigation of Resident 1's fall resulting in their

shoulder fracture, Staff D reported the progress note, written by Staff E and dated 12/04/2023 was the complete investigation conducted.

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, WHEATLAND VILLAGE is or will be in compliance with this law and / or regulation on (Date) 2/5/2024.

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

Administrator (or Representative) Date 1/16/2024

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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, WHEATLAND VILLAGE 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