STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

SCRIBER GARDENS LLC

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

RE: SCRIBER GARDENS LLC License # 2203

Dear Administrator:

This letter addresses Compliance Determination(s) 53203 (Completion Date 01/16/2025) and 46622 (Completion Date 11/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/16/2025 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-2630-1-a

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: SCRIBER GARDENS LLC **Provider Type:** Assisted Living Facility

License/Cert.#: 2203
Intake ID: 147342
Compliance Determination #: 46622
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 09/05/2024 through 11/01/2024
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) had a fall.

Investigation Methods:

Sample:	Total residents: 38 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Incident investigation Facility policies Personnel files investigations Medical records call system checks Chart notes Medical records.

Investigation Summary:
The Assisted Living Facility (ALF) investigated the incident. The ALF determined that the Named Resident (NR) was found by the ALF staff lying on the floor of their apartment by the foot part of their bed during a safety check. The NR stated they were trying to return to bed when they fell. The ALF staff followed the care plan and protocol. The ALF staff called 911. The paramedics came, and assessed the NR. The Paramedics did not transport the NR to the hospital. The ALF staff called the NT's family and communicated with them during the incident. The ALF staff placed the

NR in an hourly safety check because the NR would often remove their call pendant and attempt to do activities of daily living without calling for help. The ALF staff placed the NR on alert charting and monitoring. All parties were notified. A review of incident reports showed the NR had five series of falls; four of the five were unwitnessed falls with injuries. The ALF failed to report the incidents to the Complaint Resolution Unit Hotline. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2630 (1)(a) Reporting abuse and neglect.

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: SCRIBER GARDENS LLC **Provider Type:** Assisted Living Facility

License/Cert.#: 2203
Intake ID: 145690
Compliance Determination #: 46622
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 09/05/2024 through 11/01/2024
Complainant Contact Date(s): 09/04/2024

Allegation(s):

1. The Named Resident (NR) stated that the Alleged Perpetrator (AP) touched them inappropriately.
2. The NR's family observed the NR naked except a sweater on top of them which front was opened and no blanket alone in their apartment.
3. The NR tested positive with COVID-19 and was extremely sore and weak.
4. The NR stated that the care was rough that their shoulder hurts too much to move.

Investigation Methods:

Sample:	Total residents: 38 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 Identified staff Nursing staff Residents Family members
Record Reviews:	Incident investigation Facility policies Personnel files investigations Medical records call system checks Chart notes Medical records.

Investigation Summary:

1. On 09/02/2024, the NR's family reported to the ALF's wellness Director that the NR stated to the family that the Named Staff (NS) touched them inappropriately. The NR reiterated the same complaint of being touched inappropriately during an unannounced visit by the Department of Social Health and Services investigator on 09/05/2024. The ALF followed their protocol, sent them home, and suspended the NS pending their investigation. The ALF did not substantiate the allegation, and the NS returned to work. The ALF updated the care plan and ensured that two female care staff members were to assist the NR directly with their daily activities. The ALF placed the NR on alert monitoring and was in close coordination with the NR's primary care physician regarding the NR's need for an increase in services. The NS and other male care staff were prohibited from providing care and services. All parties were notified. No failed practice was identified.

2. The NR had cognitive impairment. On 09/01/2024 at 12:17 PM, the NS went to provide care when they found the NR on the floor by their apartment door. The ALF staff notified the NR's family, who arrived at 4:00 PM and observed the NR naked in bed alone in their apartment room except for a little sweater top she had on with the front opened and splayed out. The ALF investigated the incident of the NR being left naked and determined that prior to the fall on 09/01/2024 at noon time, the NS was assigned in the morning to provide care to the NR. The NS helped the NR use the bathroom and wear their underwear and pants. The NR refused, yelled at, and told the NS not to touch them when the NS tried to help them put on their shirt. The NS helped the NR to bed upon their request. After the fall, on 09/01/2024 at 2:20 PM, a female nurse was assigned to provide care. Record review showed the NR refused to dress and became verbally aggressive with the staff. The ALF's investigation showed the NR was wearing their pajamas. The ALF placed the NR on alert charting and monitoring. The ALF updated the care plan and placed that only two female care staff would provide care and services to the NR. 09/01/2024 at 2:20 PM, a female licensed nurse was assigned to care for the NR. The ALF's wellness director updated the care plan and had two female care staff members provide care to the NR. All parties were notified. No failed practice was identified.

3 . The NR's Doctor informed the ALF that the NR tested positive with COVID-19. The NR was already off and removed from isolation during the unannounced visit but had another resident who tested positive with COVID-19 and was on isolation. The ALF reported the cases to the Local health jurisdiction. The ALF followed its protocol on infection control and the Center for Disease Control guidelines on infection control practices. The ALF placed the affected residents in isolation, monitored them, and placed them on alert charting. All parties were notified. No failed practice was identified.

4. The ALF updated the care plan and removed male care staff from caring for the NR. The ALF ensured that only two female care staff were to provide care to the NR. An interview and review of records showed the NR had several unwitnessed falls with injury. The NR complained of pain in their right shoulder when they had a fall on 09/01/2024. A review of records showed the NR had five unwitnessed falls, and four of the five falls were with injuries. The ALF failed to report the incidents to the Complaint Resolution Unit Hotline. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2630(1)(a) Reporting abuse and neglect.

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

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 09/05/2024 and 10/14/2024 of:

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

This document references the following complaint number(s): 141741, 145690, 147342

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:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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

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) failed to report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline when 1 of 1 resident (Resident 1) had five unwitnessed falls, four of the falls were with injuries. These failures resulted in an unreported pattern of frequent falls with injuries and placed Resident 1 at risk for continued falls.

Findings included…

Review of the ALF's policy titled "Reporting Abuse-Neglect-Exploitation" dated 10/04/2019 showed any staff member who has reasonable belief that an incident of abuse, abandonment, neglect or financial exploitation has occurred will immediately notify the Department of Social Health Services Complaint Resolution Unit (CRU) hotline.

Review of the Assisted Living Facility Guidebook dated February 2018, Appendix D contained guidelines intended to assist facilities in developing and implementing policies and procedures to help prevent resident abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation by any person. Appendix D on Reporting guidelines for ALFs showed the ALF would report to the Department of Social Health Services (DSHS) Hotline when repeated injuries, even when determined by a process of evaluation/assessment to be reasonably related to the residents' condition, diagnosis, known environmental interactions or known sequence of prior events, may become abuse or neglect if preventable measures are not taken.

Resident 1 was admitted on [redacted]/2023 with multiple diagnoses including [redacted] f).

Review of the Incident report (IR) dated 07/10/2024 showed Resident 1 had an unwitnessed fall. Resident 1 could not remember what happened but complained of left hip pain.

Review of the IR dated 08/16/2024 showed Resident 1 had an unwitnessed fall with injury. The IR showed Resident 1 sustained a skin tear on their left arm, which needed stitches. Resident 1 was not able to remember what happened.

Review of the IR dated 08/23/2024 showed Resident 1 had an unwitnessed fall with injury in their bathroom. Resident 1 sustained skin tears on their fingers.

Review of the IR dated 08/24/2024 showed Resident 1 unwitnessed fall with injury. Resident 1 sustained a skin tear on three fingers of their right hand. Resident 1 did not know and could not recall what happened.

Review of the IR and charting notes, both dated 08/30/2024, showed Resident 1 had an unwitnessed fall with injury. Resident 1 sustained bruising on their left knee.

Review of IR dated 09/01/2024 showed Resident 1 had an unwitnessed fall. Resident 1 could not recall how they fell but complained of pain in their right shoulder.

On 10/14/2024 at 1:20 PM, Staff B, Wellness Director, stated that they would report cases of unwitnessed falls and injury falls like bruising or fractures to the DSHS Hotline. Staff B stated they did not know that it needed to be reported and, since they know now, would be reporting to the DSHS hotline moving forward.

Review of the Department of Social and Health Service's (DSHS) database, Secure Tracking and Reporting System, showed the fall incidents were not reported to DSHS.

This is a recurring citation previously cited on 02/07/2024.

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, SCRIBER GARDENS LLC 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