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

Van Mall Retirement, LLC
Van Mall Retirement
7808 NE 51ST ST
VANCOUVER, WA 98662

RE: Van Mall Retirement # 2702

Dear Administrator:

This document references Compliance Determination 53001 (04/10/2025), which included complaint number(s) 159159, 159271, 163435, 165765, 165926, 168225.

The Department completed a complaint investigation of your Assisted Living Facility on 04/10/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Jason Rose

Clinton Fridley

Consultation:

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

Accusations that the facility had not been fully providing agreed service regarding showers, mediations management, meal escort, and meal delivery were corroborated by multiple residents. This was identified by the new executive director. These were issues addressed by additional staffing, new staffing roles, retraining, and replacement

of staff. Resumption of full services has been corroborated by multiple residents.

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

Accusations that the facility had not been fully providing agreed service regarding showers, mediations management, and meal escort and delivery were corroborated by multiple residents. This was identified by the new executive director. These were issues addressed by additional staffing, new staffing roles, retraining, and replacement of staff. Resumption of full services has been corroborated by multiple residents.

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:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:
- Please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Van Mall Retirement
Provider Type: Assisted Living Facility
License/Cert.#: 2702
Compliance Determination #: 53001
Intake ID: 165765
Investigator: Jason Rose
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 01/13/2025 through 04/10/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/ Treatment: Bathing, Cpap, cleaning, and laundry not getting done.
2. Dietary Services: Missing meals – not being brought to meals.
3. Falsification of records/ reports. Medications marked as being given but not given (Surplus of medications marked as given).

Investigation Methods:

Sample:
Total residents: 74
Resident sample size: 10
Closed records sample size: 3

Observations:
Dining
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Executive Director/ administration
identified residents
residents
housekeeping staff
caregivers
resident families
Dr. Office staff.

Record Reviews:
MARS
Service Plans
Progress notes
refusal of care notes
Incident reports
staff schedules
After visit summaries/ communication with providers

Investigation Summary:

1. Quality of Care/ Treatment: Bathing, C-pap, cleaning, and laundry not getting done. Resident had moved out of the facility and could not corroborate laundry issues with other residents. Issue such as bathing, and meals were corroborated by multiple residents and that it was identified and addressed by new Executive Director. Consultation provided.
Consultation: Accusations that the facility had not been fully providing agreed service regarding showers, mediations management, meal escort, and meal delivery were corroborated by multiple residents. This was identified by the new executive director. These were issues addressed by additional staffing, new staffing roles, retraining, and replacement of staff. Resumption of full services has been corroborated by multiple residents.
2. Dietary Services: Missing meals – not being brought to meals. Current residents report this had been an issue and has been addressed and the situation has improved. Consultation provided.
3. Falsification of records/ reports. Medications marked as being given but not given (Surplus of medications marked as given).Resident was out of the facility for an extended time that may account for surplus medications. Unable to substantiate falsification of records with identified resident or collateral resident samples. [Other medication issues were identified and cited by licensing inspection in CD # 57560.]
No failed practice identified.

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: Van Mall Retirement
Provider Type: Assisted Living Facility
License/Cert.#: 2702
Compliance Determination #: 53001
Intake ID: 159159
Investigator: Jason Rose
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 01/13/2025 through 04/10/2025
Complainant Contact Date(s):

Allegation(s):

1. Administration/Personnel: Not enough staffing to meet resident needs.
2. Dietary Services: Resident(s) not getting receiving meals.
3. Quality of Care/Treatment: Resident(s) not getting showers.

Investigation Methods:

Sample:
Total residents: 74
Resident sample size: 10
Closed records sample size: 3

Observations:
Dining
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Executive Director/ administration'
identified residents
residents
housekeeping staff
caregivers
resident families

Record Reviews:
MARS
Service Plans
Progress notes
refusal of care notes
Incident reports
staff schedules
After visit summaries/ communication with providers

Investigation Summary:

1. Administration/Personnel: Not enough staffing to meet resident needs. Facility staffing was an identified issue limiting the facility 's ability to fulfill the negotiated contracts. This was identified by the new executive director and addressed. Consult provided.

2. Dietary Services: Resident(s) not getting receiving meals. This issue has been addressed and improved by new executive director. Residents corroborate this is longer an issue. Consultation for addressed issue.
3. Quality of Care/Treatment: Resident(s) not getting showers. Inconsistency with showers was corroborated by multiple residents. Multiple residents now corroborate these have been addressed and improved by new executive director. Consultation provided.

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: Van Mall Retirement
Provider Type: Assisted Living Facility
License/Cert.#: 2702
Compliance Determination #: 53001
Intake ID: 163435
Investigator: Jason Rose
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 01/13/2025 through 04/10/2025
Complainant Contact Date(s):

Allegation(s):

1. Administration/ personnel: Insufficient staffing to fulfill negotiated service agreement, such as showers.
2. Admission, transfer, discharge. Needs a higher level of care.
3. Quality of Care/Treatment. Poor catheter care is leading to reoccurring UTI's and hallucinations. Not getting medications.
4. Quality of Life. Having hallucinations, asking for people to harm him.
6. Fraud false billing. Facility agreed to accept resident they knew they could not meet the needs of for financial gain.
5. Physical environment. Apartment not clean.

Investigation Methods:

Sample:
Total residents: 74
Resident sample size: 10
Closed records sample size: 3

Observations:
Dining
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Executive Director/ administration'
identified residents
residents
housekeeping staff
caregivers
resident families
Dr.'s office staff.

Record Reviews:
MARS
Service Plans
Progress notes
refusal of care notes
Incident reports
staff schedules
After visit summaries/ communication with providers

Investigation Summary:

1. Administration/ personnel: Insufficient staffing to fulfill negotiated service agreement, such as showers. This was identified and addressed by adding, replacing, and retraining staff by the new executive director. Consultation provided.
2. Admission, transfer, discharge. Needs a higher level of care. Resident exceeded facility level of care. More appropriate living arrangements were found. Unable to substantiate failed practice.
3. Neglect: Quality of Care/Treatment. Poor catheter care is leading to reoccurring Urinary Tract infections (UTI's) and hallucinations. Not getting medications. Unable to directly identify medication or catheter care issues with this identified resident. [Other medications issues were addressed in Licensing inspection #57560] Unable to substantiate failed practice.
4. Quality of Life. Having hallucinations, asking for people to harm him. Appears to be illness related. Resident was sent to the hospital. Unable to substantiate failed practice.
5. Physical environment. Apartment not clean. The facility does not clean dishes. Reportedly resident is resistant to services or movement of personal belongings. No agreement for extra housekeeping. Needs exceed negotiated service agreement. Rest of facility clean upon multiple inspections. Unable to identify failed practice.
6. Fraud false billing. Facility agreed to accept resident they knew they could not meet the needs of for financial gain. Identified resident's needs continued to evolve and could not identity malicious or fraudulent intent. No failed practice identified.

Conclusion / Action:

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