STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

06/30/2026

Legacy1864, LLC
Willow Grove
1620 E Mead St
Spokane, WA 99218

RE: Willow Grove # 2399

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 79778 (Completion Date 06/30/2026) and 77583 (Completion Date 06/01/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/30/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

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, Community Field Manager
Region 1, Unit B
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Willow Grove
Provider Type: Assisted Living Facility
License/Cert.#: 2399
Compliance Determination #: 77583
Intake ID: 223600
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 05/18/2026 through 06/01/2026
Complainant Contact Date(s):

Allegation(s):
Resident got a urinary tract infection resulting in sepsis due to inappropriate catheter care.

Investigation Methods:

Sample:
Total residents: 21
Resident sample size: 2
Closed records sample size: 1

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

Interviews:
Care Administrator
Residents
Alleged Victim's Representative
Owner/Administrator
Home Health Nurse
Home Health Nurse Case Manager
Urology Clinic Triage Nurse
Resident Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Catheter Care Policy
*Resident face sheets
*Resident care plans
*Staff in-service education
*Progress notes
*Condom Catheter Care Policy
*Hospital records

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Investigation Summary:

Interview and record review showed that the facility failed to ensure that urinary catheter care was provided in accordance with current acceptable infection control standards. Failed facility practice identified and cited under WAC 388-78A-2610 Infection control (2)(D).

Conclusion / Action:

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

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

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

Statement of Deficiencies	License #: 2399	Compliance Determination # 77583
Plan of Correction	Willow Grove	Completion Date
Page 1 of 4	Licensee: Legacy1864, LLC	06/01/2026

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 05/18/2026 of:

Willow Grove
1620 E Mead St
Spokane, WA 99218

This document references the following complaint number(s): 223600

The following sample was selected for review during the unannounced on-site visit: 2 of 21 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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Statement of Deficiencies	License # 2390	Compliance Determination # 77583
Plan of Correction	Willow Grove	Completion Date
Page 2 of 4	Licensee: Legacy1884, LLC	06/01/2026

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 — 06/03/2026 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) — 6/8/2026 Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that urinary catheter care was provided in accordance with current acceptable infection control standards for 2 of 2 residents (Resident 1 and Resident 2). This failed practice placed the residents at risk for ongoing recurrent urinary tract infections.

Findings included...

Review of an undated facility policy, titled, "Catheter Care," showed that after the collection bag was removed from a urinary catheter, it was to be taken directly to the bathroom and emptied into the toilet.

An article by the Center for Disease Control (CDC), titled, "Clinical Safety. Preventing Catheter-associated Urinary Tract Infections," dated 08/27/2025, showed that the CDC recommended maintaining a catheter's closed, sterile drainage system in order to help prevent Catheter-Associated Urinary Tract Infections (CAUTIs). The article showed that healthcare facilities should follow the 2009 CDC Guidelines for Prevention of Catheter-associated Urinary Tract Infections.

The 2009 CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections,

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Residential Care Services | Date

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Administrator (or Representative) | Date

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The 2009 CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections,

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last updated 06/06/2019, showed that the proper technique for urinary catheter maintenance was to maintain a closed drainage system following insertion of the urinary catheter. The guidelines showed that the collection bag should be emptied regularly into a separate, clean collecting container for each patient. The guidelines showed that splashing and contact of the drainage spigot (a type of valve used to control the flow of liquid from a reservoir) with the nonsterile collection container were to be avoided. Review of the guidelines showed that changing a drainage bag at routine, fixed intervals was not recommended. Further review of the guidelines showed that routine installation of antiseptic or antimicrobial solutions into urinary drainage bags was also not recommended.

In an interview on 05/18/2026 at 11:08 AM, Staff A, Care Administrator, stated that the facility had two residents with catheters including Resident 1 and Resident 2. Staff A stated that Resident 2 switched from a day bag to a night bag each evening. Staff A stated that catheter care was done for both Resident 1 and Resident 2 in the morning and at night and anytime the catheter bag was emptied. Staff A stated that when a catheter bag was emptied, the tubing along with the bag were removed and taken to the bathroom to be emptied into the toilet. Staff A stated that a vinegar and water solution was then flushed through the catheter tubing and down into the bag using a squeeze bottle. Staff A stated that both Resident 1 and Resident 2 had a history of Urinary Tract Infections (UTIs).

During an observation on 05/18/2026 at 11:20 AM, Staff A demonstrated how they flushed a urinary catheter tubing and collection bag set-up. Staff A was observed to have hung the collection bag from the back of the toilet seat lid. It was observed that the open drainage spigot from the collection bag was about one centimeter from the toilet seat during the flushing process. It was observed that the toilet in room 6 was shared between both Resident 1 and Resident 2.

In an interview on 05/27/2026 at 3:12 PM, when asked if there was a process for protecting the end of the catheter itself when staff stepped away after removing the urinary catheter tubing and the bag, Staff B, Owner/Administrator, said there was not. Staff B stated they had been using their current catheter flushing process for the last 17 years. Staff B stated that Resident 1 had a history or urinary tract infections.

In an interview on 06/01/2026 at 9:25 AM, CC1, Home Health Nurse Case Manager, stated that urinary catheters were supposed to be closed systems which were not supposed to be opened.

In an interview on 06/01/2026 at 9:52 AM, CC2, Urology Clinic Triage Nurse, stated that they had never heard of a vinegar solution being used to flush urinary catheters. CC2 stated that typically, they would only recommend flushing a catheter if it was clogged or full of sediment.

Review of hospital records for Resident 1, dated 05/09/2026, showed that Resident 1

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Statement of Deficiencies	License # 2369	Compliance Determination # 77593
Plan of Correction	Willow Grove	Completion Date
Page 4 of 4	Licensee: Legacy1864, LLC	06/01/2026

had a history of recurrent UTIs. Review of the hospital records showed that Resident 1 was admitted to the hospital on [redacted]2026 due to septic shock (the most severe, life-threatening stage of sepsis, which occurs when an infection triggers a runaway immune response) secondary to Enterococcus faecalis (a bacteria naturally found in the human gastrointestinal tract that can cause severe infections in other parts of the body) bacteremia (the presence of bacteria in the blood stream) and UTI. Review of the hospital records showed that Resident 1's urine culture was also positive for Proteus (a bacteria frequently found in the human gut that commonly causes CAUTIs).

In an interview on 06/01/2026 at 12:42 PM, CC3, Resident Representative, stated that Resident 2 had UTIs almost monthly since they moved into the facility about nine months ago. CC3 stated that facility staff had been flushing Resident 2's catheter with vinegar.

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6/15/2026

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

Administrator (or Representative) — Date: 6/8/26

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

_____ _____

Administrator (or Representative) Date

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