STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***

Pacifica Kenmore LLC
Kenmore Senior Living
7221 NE 182nd St
Kenmore, WA 98028

RE: Kenmore Senior Living License # 2566

Dear Administrator:

This letter addresses Compliance Determination(s) 34216 (Completion Date 12/20/2023) and 31639 (Completion Date 11/08/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/20/2023 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4

The Department staff who did the on-site verification:
Cathy Prentice, Complaint Investigator

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Kenmore Senior Living
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2566
**Compliance Determination #:** 31639
**Intake ID:** 103439
**Investigator:** Cathy Prentice
**Region/Unit #:** RCS Region 2 / Unit J
**Investigation Date(s):** 10/25/2023 through 11/08/2023
**Complainant Contact Date(s):** 10/24/2023, 11/08/2023

**Allegation(s):**

1. The named resident may have been sexually abused by another named resident: the named resident was touched on the leg and breast by another resident. 2. The possible sexual abuse was reported to the facility Administrator, Head Nurse and Medication Technicians who have not reported or done anything to stop the behaviors. 3. The behaviors were not charted in the record. 4. The named resident does not have the ability to tell the other named resident to stop the sexual behaviors. 5. An additional named resident was touched on the breast by another resident and was found in the named resident's room touching the named resident's breast under the shirt. 6. All reported incidents were reported to the facility supervisor. 6. A third named resident may have been sexually abused by another resident: the other resident touched the named resident's breast in the TV room and the named resident was visibly upset and nothing was done by the supervisor. 7. A fourth named resident may have been sexually abused by another resident: the other resident touched the named resident's inner thigh in the TV room and the named resident did not have the ability to tell the other resident to stop.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 84<br>Resident sample size: 5<br>Closed records sample size: 0 |
| **Observations:** | Named resident; delivery of care and services; staff interactions with residents; residents' appearance; environment; resident to resident interactions. |
| **Interviews:** | Named residents, staff, administration, collateral contacts. |
| **Record Reviews:** | Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies. |

**Investigation Summary:**

1. According to multiple interviews, the named resident was inappropriately touched by another resident. There was no facility investigation for this allegation of witnessed touching of the inner leg and breast. 2. According to interview and record review, the facility had no investigations of the sexual abuse incidents. 3. According to record

review, some inappropriate touching behaviors were recorded in the record for three involved named residents. There was no investigation of the witnessed abuse. 4. The named residents who were inappropriately touched were not able to be interviewed due to dementia. There was no investigation of the abuse allegation. 5. There was no investigation for the witnessed abuse of the named resident. 6. There was no investigation of the abuse of the named resident. 7. There was no investigation of the sexual abuse for the named resident. The named resident was not able to be interviewed due to dementia. The facility failed to investigate all of the above sexual abuse allegations and witnessed incidents for four named residents touched by another resident on the memory care unit..

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**Conclusion / Action:**

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

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| | | |
|---|---|---|
| Statement of Deficiencies | License #: 2566 | Compliance Determination # 31639 |
| Plan of Correction | Kenmore Senior Living | Completion Date |
| Page 1 of 4 | Licensee: Pacifica Kenmore LLC | 11/08/2023 |

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 10/25/2023 and 10/25/2023 of:

Kenmore Senior Living
7221 NE 182nd St
Kenmore, WA 98028

This document references the following complaint number(s): 103439

The following sample was selected for review during the unannounced on-site visit: 5 of 84 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

11/13/2023
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.

| Statement of Deficiencies | License #: 2566 | Compliance Determination # 31639 |
|---|---|---|
| Plan of Correction | Kenmore Senior Living | Completion Date |
| Page 2 of 4 | Licensee: Pacifica Kenmore LLC | 11/08/2023 |

Administrator (or Representative) 11.22.2023 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

(4) Protect residents during the course of the investigation.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to conduct and document investigations that ruled out abuse/neglect, included and implemented measures to prevent similar future occurrences or protected the residents when 1 of 1 resident (Resident 1) touched other female residents' breasts on three occasions. Not conducting investigations or implementing measures to prevent future incidents regarding Resident 1 may have contributed to the touching of other residents becoming a recurring event and placed six female residents at risk of sexual abuse and psychological harm.

Findings included...

Review of the ALF's Elder Abuse, Neglect, and Exploitation policy, dated 12/09/2021, showed upon the notice of reported observed, suspected, or at imminent risk of any form of abuse the facility would: a) Immediate steps would be taken to ensure the resident was protected from potential future abuse and neglect while the investigation is conducted. b) A thorough investigation would be conducted by the Resident Care Director or Executive Director.

Record review showed the ALF admitted Resident 1 to the Memory Care Unit (MCU) on [redacted]/2023 with multiple medical diagnoses including [redacted] Review of a Washington Resident Assessment (WRA), dated 10/16/2023, showed Resident 1 ambulated independently. A Needs and Services Plan (NSP-equivalent to a Negotiated Service Agreement), dated 04/11/2023, showed Resident 1 exhibited inappropriate sexual expression.

Record review showed the ALF admitted Resident 2 on [redacted]/2017 and Resident 3 on [redacted]/2019. Both Resident 2 and Resident 3 had diagnoses of [redacted] and resided on

the MCU. Record review showed the ALF had a total of six female residents in the MCU.

In an interview, on 10/24/2023 at 1:00PM, Collateral Contact 1 (CC1- Former ALF Employee) stated she had observed Resident 1 touching other residents inappropriately on numerous occasions in the past couple months. CC1 stated in just the last week, she had observed Resident 1 touching Resident 2's breast and trying to kiss her, also following her into the bathroom. CC1 stated she observed Resident 1 touching Resident 3's breast on multiple occasions, and found him in her apartment touching her breast under her shirt in bed. CC1 stated Resident 1 was observed touching two other female residents' breasts (Resident 4 and 5), in the past week. CC1 stated she reported every one of these witnessed incidents to the ALF Administrator. CC1 stated she did not feel the ALF was, "doing anything to protect the residents."

In an interview, on 10/25/2023 at 12:30PM, Staff C (Caregiver) stated he observed Resident 1 touching Resident 2, 4 and 5 on the breast about a week ago. Staff C stated these were ongoing behaviors as Resident 1 approaches the female residents from behind when they are seated in the common areas and the staff tell Resident 1 to stop. Staff C stated the staff reports these behaviors to the Medication Technicians.

Review of a Narrative Charting Note (NCN), dated 04/12/2023, showed Staff A (Medication Technician) documented Resident 1 was observed touching Resident 2's breasts. This incident occurred while Resident 1 and Resident 2 were in the dining room. The NCN showed Staff A re-directed and told Resident 1 to stop touching Resident 2's breasts.

In an interview, on 10/25/2023 at 12:30PM, Staff A confirmed Resident 1 was observed touching Resident 2's breasts on 04/12/2023. Staff A stated she reported the incident to the Administrator.

Record review showed the ALF had not conducted an investigation regarding Resident 1 touching Resident 2's breasts on 04/12/2023. There was no investigation that showed measures were put into place to prevent any similar future incidents where Resident 1 could exhibit inappropriate sexual behavior. There was no investigation that showed the ALF protected the residents.

Review of a NCN, dated 05/07/2023, showed Staff B (Medication Technician) documented Resident 1 was observed touching Resident 3's breasts. This incident occurred while Resident 1 and Resident 3 were in the dining room. The NCN showed Staff B re-directed and told Resident 1 to stop touching Resident 3's breasts.

In an interview, on 10/25/2023 at 3:30PM, Staff B confirmed Resident 1 was observed touching Resident 2's breasts on 05/07/2023. Staff B stated she reported the incident to the Administrator and the Director of Nursing.

Record review showed the ALF had not conducted an investigation regarding Resident 1

touching Resident 3's breasts on 05/07/2023. There was no investigation that showed measures were put into place to prevent any similar future incidents where Resident 1 could exhibit inappropriate sexual behavior. There was no investigation that showed the ALF protected the residents.

Review of a NCN, dated 05/27/2023, showed Staff B (Medication Technician) documented Resident 1 was observed touching Resident 3's breasts.

In an interview, on 10/25/2023 at 3:30PM, Staff B confirmed Resident 1 was observed touching Resident 2's breasts on 05/27/2023. Staff B stated she reported the incident to the Administrator and the Director of Nursing.

Record review showed the ALF had not conducted an investigation regarding Resident 1 touching Resident 3's breasts on 05/27/2023. There was no investigation that showed measures were put into place to prevent any similar future incidents where Resident 1 could exhibit inappropriate sexual behavior. There was no investigation that showed the ALF protected the residents.

In a duel interview, on 10/25/2023 at 10:30AM, the ALF Administrator and Staff D (Resident Services Director) denied either of them knew or were told about these incidents. The Administrator and Staff D stated and there were no investigations of the witnessed and documented sexual abuse incidents involving Resident 1.

This deficiency was previously cited on 12/06/2021.

**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, Kenmore Senior Living is or will be in compliance with this law and / or regulation on (Date) 12 8 2023 .

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

Administrator (or Representative) Date 11 22 2023