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

09/24/2024

COUNTRY MEADOW VILLAGE INC
COUNTRY MEADOW VILLAGE
2020 A St SE Suite 101
Auburn, WA 98002

RE: COUNTRY MEADOW VILLAGE License # 1020

Dear Administrator:

This letter addresses Compliance Determination(s) 47517 (Completion Date 09/20/2024) and 44809 (Completion Date 08/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/20/2024 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-3090-1-a, WAC 388-78A-3090-1-c, WAC 388-78A-2270-1, WAC 388-78A-2210-2-a, WAC 388-78A-2305-1, WAC 246-215-03351-1-b, WAC 246-215-03351-1-a

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor

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

Sincerely,

Kim Ripley

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

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

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

08/09/2024

COUNTRY MEADOW VILLAGE INC
COUNTRY MEADOW VILLAGE
2020 A St SE Suite 101
Auburn, WA 98002

RE: COUNTRY MEADOW VILLAGE # 1020

Dear Administrator:

This document references the following complaint numbers 137832, 137971.

The Department completed a full inspection of your Assisted Living Facility on 08/02/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Kimberley Ripley, Field Manager
Residential Care Services

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Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-112A-0010 What definitions apply to this chapter? The following definitions apply to this chapter:

(34) "70-hour home care aide basic training" means the 70-hours of required training that a new long-term care worker must complete within 120 days of hire. It has three components: Core competencies, practice of skills, and population specific topics, which may include specialty and nurse delegation training.

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

The Assisted Living Facility (ALF) failed to ensure Seventy-hour long-term care worker basic training and mental health specialty training was completed within 120 days of hire for one of five staff. The ALF staff completed the training 183 days and 186 days after hire. The Administrator misunderstood the waivers for trainings and the staff completed the trainings before the inspection.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or

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deficiencies stated in this letter and not listed on the enclosed report.

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:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (360)651-6846.

Sincerely,

Kim Ripley

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

Enclosure

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

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

Statement of Deficiencies	License #: 1020	Compliance Determination # 44809
Plan of Correction	COUNTRY MEADOW VILLAGE	Completion Date
Page 4 of 13	Licensee: COUNTRY MEADOW VILLAGE INC	08/02/2024

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 the unannounced on-site full inspection and complaint investigation on 07/29/2024, 07/30/2024 and 07/31/2024 of:

COUNTRY MEADOW VILLAGE
1501 COLLINS RD
SEDRO WOOLLEY, WA 98284

This document references the following complaint numbers: 137832, 137971.

The following sample was selected for review during the unannounced on-site visit: 7 of 47 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor
Judith Mellon, RN, Licensor
Allison Nunn, Long Term Care Surveyor

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.

Kim Ripley
Residential Care Services

08/09/2024
Date

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

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: 8/9/2024

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to keep 2 of 2 floors (First floor and Second floor) safe and sanitary. These failures resulted in all residents living in an unsafe and unsanitary environment and placed all 47 residents at risk for injury and a decreased quality of life.

Findings included...

The ALF consisted of two floors. During a facility tour on 07/29/2024, the following was observed:

First floor:

At 10:06 AM, a circular 1.5 inch by 1.5 inch piece of wood flooring was missing from the floor in the bingo room exposing a light brown surface underneath.

On 07/29/2024 at 10:07 AM, Staff A, Executive Director, stated that the floor in the bingo room was going to be replaced.

At 10:10 AM, the vent in the commercial laundry room had a buildup of dust.

At 10:15 AM, a white bucket filled with water was underneath a pipe coming out of the back of the washing machine. Two blue mop heads were on the floor next to the bucket behind the washing machine. The bottom edge of the washing machine was rusty and corroded.

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At 10:16 AM, a yellow bucket with wheels had a mop that was sitting in cloudy brown water stored behind the door in the commercial laundry room.

In an interview on 07/29/2024 at 10:15 AM, Staff A stated that the bucket was to catch water that was leaking from the washing machine. The mop heads were on the floor to soak up any water that was on the floor. Staff A stated that they were waiting for the repair person to come and fix the leak.

At 10:18 AM, the ceiling vent over the kitchen entrance door had a buildup of dust.

At 10:24 AM, a beige plastic cord used to open and close the blinds in the dining room was broken and laying on the floor next to the window creating a trip hazard for residents.

On 07/29/2024 at 10:26 AM, Staff A stated that the cord would be taped to the wall to prevent a fall until the Maintenance Director could fix it.

At 10:33 AM, the light fixture in the housekeeping room had a dried brown substance in it.

On 07/29/2024 at 10:33 AM, Staff A stated that it was from a leak a long time ago and the light fixture should have been cleaned.

At 10:34 AM, the door to apartment 306 had black surface abrasions near the bottom of the door and the door jam.

At 10:38 AM, the door to apartment 316 had surface abrasions and black scuffs.

At 10:39 AM, the ceiling vent in the bathroom had a buildup of dust.

Second floor:

At 10:46 AM, the light fixture in the hallway near apartment 407 had eight dead bugs in it.

At 10:48 AM, the light fixture in the hallway near apartment 409 had 18 dead bugs in it.

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At 10:45 AM, the ceiling vent by apartment 410 had a buildup of dust.

At 10:51 AM, the light fixture in the hallway near apartment 415 had nine dead bugs in it.

At 10:52 AM, the activity storage room had tissue and debris on the floor.

At 10:53 AM, the metal frame of the window screen in the hallway near apartment 501 was bent causing the screen to not fit in the window correctly.

At 10:57 AM, the ceiling vent in the resident laundry room located in the 600 hallway had a buildup of dust.

At 11:02 AM, the janitor's closet had a large amount of paper and used painters tape crumpled up in the corner of the closet.

On 07/29/2024 at 11:02 AM, Staff A stated that the crumpled paper and tape was left over from the hallway's being painted.

At 11:03 AM, the light fixture in the hallway near apartment 620 had seven dead bugs in it.

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, COUNTRY MEADOW VILLAGE is or will be in compliance with this law and / or regulation on (Date) 9/16/2024.

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

Administrator (or Representative) — Date: 8/9/2024

WAC 388-78A-2270 Resident controlled medications.

(1) The assisted living facility must ensure all medications are stored in a manner that prevents each resident from gaining access to another resident's medications.

This requirement was not met as evidenced by:

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Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 5 residents (Resident 1 and 8), who were deemed independent with medication storage, secured their medication in a manner that prevented other residents from potentially gaining access to these medications. This failure resulted in 23 bottles of medications being accessible to anyone at the ALF and placed all 47 residents at risk of harm related to ingestion of unprescribed medications.

Review of the ALF's policy titled, "Medication Management Program," dated 02/10/2023, showed the ALF was to ensure that all medications were stored safely and securely. The policy showed that all residents would be assessed upon move in and routinely thereafter for their ability to safely manage their own medication. A resident would be deemed independent in medication administration if the resident could safely and accurately order, obtain, store, and administer their own medication.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2022 with multiple medical diagnoses including [redacted] ([redacted]) and [redacted] ([redacted]).

Review of an assessment dated 05/29/2024 showed that Resident 1 was able to independently manage their medication. The assessment showed that Resident 1 was able to store medications safely in their apartment away from other residents.

On 07/30/2024 at 2:18 PM, 16 medication bottles were observed in Resident 1's room. The medication bottles were placed on a desk, TV stand, nightstand, and bathroom counter.

On 07/30/2024 at 2:41 PM, Resident 1 stated that they need to either put all their medications in a locked drawer located in the apartment or lock their apartment door when they leave the apartment to keep their medication secure.

On 07/31/2024 at 10:07 AM, Resident 1's apartment was observed unlocked with medications unsecured throughout the apartment. Resident 1 was not in their apartment. The following medications were accessible to anyone at the ALF:

- Absorbine Plus Pain Relieving Liquid (a medication used to relief pain associated with arthritis) in a 4 fluid ounce (fl oz) (a unit of measurement) bottle
- Acetaminophen (a medication used to treat minor aches/pains and reduce fevers that can be extremely damaging to the liver in cases of overdose) in 500 mg doses. Two open bottles were observed in Resident 1's room.
- Align Women's Health Prebiotic and Probiotic Supplement Gummies (a supplement for gut and urinary health)

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- Alprazolam (a controlled-medication used to treat anxiety that can cause dependence and overdose if not taken correctly) in 2 milligram (mg) doses. Two open bottles were observed in Resident 1's room.
- Docusate sodium (a medication used to treat constipation) in 100 mg doses
- Famotidine/Calcium Carbonate/Magnesium Hydroxide (a medication used to treat heartburn) in 10/800/165 mg doses.
- Fleet glycerin suppositories (a medication used to treat constipation within 15 minutes to an hour) in a 12-pack box
- Fluticasone (a medication used to treat allergies via nasal spray) in a 0.54 fl oz bottle
- Lidocaine cream (a medication used for pain relief) in a 1.75 fl oz bottle
- Metamucil (a fiber supplement) in 6 G (gram) doses.
- Omeprazole (a medication used to treat heartburn and stomach ulcers) in 20 mg doses
- One A Day Women's 50+ (a multivitamin)
- Polyethylene glycol (a medication used to treat constipation) in a 17.9 fl oz bottle
- Prednisone (a prescribed medication used to treat conditions related to inflammation) in 50 mg doses

On 07/31/2024 at 10:10 AM, Staff J, Administrative Assistant, stated that Resident 1 had left the ALF for an appointment at 9:40 AM.

Resident 8

Resident 8 was admitted to the ALF on [redacted]/2024 with multiple medical diagnoses including [redacted] ([redacted]).

Review of an assessment dated 07/12/2024 showed that Resident 8 lived in an apartment at the ALF with a roommate. The assessment showed Resident 8 was responsible for storing medications safely in their apartment away from other residents. Resident 8 was able take their medications after set-up by their roommate. The assessment showed that Resident 8's roommate handled all other aspects of Resident 8's medication management.

On 07/31/2024 at 11:31 AM, Resident 8's apartment was observed unlocked with medications unsecured in the apartment. The following medications were accessible to anyone at the ALF:

- Bismuth subsalicylate (a medication used to treat diarrhea, heartburn, nausea, and upset stomach) in a 12 fl oz bottle
- Clear eyes lubricant eye drops (a medication used to relieve eye irritation and dryness) in a 0.5 fl oz bottle
- Diphenhydramine (a medication used to relieve allergy symptoms and promote

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sleep) in 25 mg doses
- Ibuprofen caplets (a medication used to treat minor aches and pains) in 200 mg doses
- Ibuprofen liquid gel capsules in 200 mg doses
- Rolaids Calcium carbonate/magnesium hydroxide (a medication used to treat heartburn and ingestion) in 675/135 mg doses
- Tums Calcium carbonate (a medication used to treat heartburn and ingestion) in 1000 mg doses

On 07/31/2024 at 9:34 AM, Staff G, Resident Care Director, stated that residents who are independent with medication management have several options to safely store their medications including a locked drawer, a locked cabinet, or locking the apartment door when the resident leaves their apartment. Staff G stated that if a resident leaves the apartment, the door should be locked if medications are not kept in the locked drawer or cabinet.

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, COUNTRY MEADOW VILLAGE is or will be in compliance with this law and / or regulation on (Date) 9/16/2024 .

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

SL — 8/9/2024

Administrator (or Representative) — Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 7 residents (Resident 4) received their medications as prescribed. This failure resulted in Resident 4 taking a medication that was not as prescribed and placed Resident 4 at risk for medical complications.

Findings included...

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Review of the ALF's policy titled, "Medication Management Program," dated 02/10/2023, showed the ALF would ensure that each resident would receive their medication as prescribed if the resident required medication assistance.

Resident 4 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted] ([redacted]).

Review of an assessment, dated 07/23/2024, showed Resident 4 required assistance with medications. ALF staff were to order medications from the pharmacy, deliver Resident 4 their medications as ordered, and watch Resident 4 take them.

Review of a Negotiated Service Agreement, dated 07/23/2024, showed ALF staff were to assist Resident 4 to take medications per their doctor's orders.

Review of an After-Summary Visit Report, dated 04/10/2024, showed Resident 4 had new medication orders after a hospital visit. Resident 4's doctor prescribed Oxycodone (a narcotic used to treat pain) to be taken every five hours as needed for pain for a maximum of 10 doses and Polyethylene Glycol 3350 (a laxative medication used to treat constipation) to take every day while on Oxycodone.

Review of an Electronic Medication Administration Record (EMAR), dated April 2024, showed Resident 4's had been prescribed Miralax once a day while on Oxycodone on 04/15/2024. The EMAR showed Resident 4 had been prescribed Oxycodone on 04/15/2024 with a discontinue date of 04/30/2024.

Review of a faxed Physician Notification, dated 04/19/2024, showed Resident 4's oxycodone was attempted to be re-ordered. The physician's reply showed that the new prescription request was denied as the Oxycodone was for short-term use only.

Review of an EMAR, dated May 2024, showed Resident 4's prescription for Miralax that was to be administered once a day while on Oxycodone remained in the ALF's medication administration system for staff to give. The EMAR showed Resident 4 received Miralax on 05/01/2024 to 05/11/2024 and on 05/14/2024, 05/15/2024, 05/19/2024, 05/22/2024, 05/24/2024, and 05/29/2024 for a total of 17 doses. The EMAR showed no prescription for Oxycodone in the month of May.

On 07/31/2024 at 10:48 PM, Staff G, Resident Care Director, stated that when staff asked for Resident 4's Oxycodone to be refilled and the doctor declined to fill the order, they had discontinued the Oxycodone order. Staff G stated that the Miralax order that was prescribed to be taken with the Oxycodone should have been discontinued as well.

Plan/Attestation Statement

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

Administrator (or Representative) SL Date 8/9/2024

WAC 246-215-03351 Preventing contamination from the premises Food storage (FDA Food Code 3-305.11).

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

(a) In a clean, dry location;

(b) Where it is not exposed to splash, dust, or other contamination; and

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure 40 of 40 pieces of pie were covered and placed in an area of the Kitchen to prevent contamination. This failure placed all 47 residents at risk for a food-borne illness.

Findings included...

On 07/29/2024 at 10:55 AM, the ALF's main kitchen was observed to have a metal cart with three shelves that had 40 pie slices sitting on individual saucers. All 40 pie slices were uncovered. The metal cart was sitting next to a walkway area for dishwashing and food prep areas. Kitchen staff were observed walking past the pie slices multiple times on their way through the kitchen.

In an interview on 07/29/2024 at 11:10 AM, Staff I, Dietary Cook, stated that the pies on the cart were pulled out of the freezer early to defrost and were left uncovered because they were frozen.

On 07/29/2024 at 11:20 AM, Staff H, Dietary Supervisor, demonstrated cleaning a food slicer in the dishwashing area. Staff H washed the food slicer and used a high-powered

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water sprayer to rinse the soap off. The water spray, splashed to the walkway area next to the area where the cart with the pies were sitting.

On 07/29/2024 at 11:45 AM, a kitchen refrigerator was then observed to have the same metal cart with the 40 pie slices placed inside the refrigerator. All the pie slices were left uncovered in the refrigerator.

In an interview on 07/29/2024 at 11:46 AM, Staff H stated that the pies were put into the kitchen refrigerator and that the pies should not have been left uncovered.

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, COUNTRY MEADOW VILLAGE is or will be in compliance with this law and / or regulation on (Date) 8/9/2024 9/16/2024

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

Administrator (or Representative) — Date: 8/9/2024

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