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

Olympia Special Care LLC
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

RE: GARDEN COURTE ALZHEIMER COMMUNITY License # 1111

Dear Administrator:

This letter addresses Compliance Determination(s) 45270 (Completion Date 08/06/2024) and 43293 (Completion Date 07/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/06/2024 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-2040-1, WAC 388-78A-2040-2, WAC 388-78A-2040

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Emily Boniface, Community Program Nurse Licensor
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit E
Residential Care Services

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

Statement of Deficiencies	License #: 1111	Compliance Determination # 43293
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 4	Licensee: Olympia Special Care LLC	07/02/2024

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 an unannounced on-site follow-up on 06/27/2024 and 07/02/2024 of:
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following SOD dated: 07/02/2024

The following sample was selected for review during the unannounced on-site visit: 88 of 88 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Emily Boniface, Community Program Nurse Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

07/15/2024
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.

Tammy Law 7/22/24

Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure fire safety doors were not propped open for 1 of 1 facility reviewed. These failures placed 88 of 88 residents, staff, and visitors' lives and safety at risk in the event of a fire or natural disaster.

Findings included...

"Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

Record review of the "Department of Social And Health Services" document, Completion date 05/13/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2040] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 05/28/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 06/05/2024."

Review of the facility policy, titled, "Fire and Smoke Barrier Doors", undated, showed "...Fire and smoke barrier doors must be closed at all times, except those that are held

open by an electric built-in magnetic device that will automatically close when the fire alarm system is activated or power failure occurs...Fire and smoke barrier doors are not to be blocked at any time or be held open by any means other than the automatic holding device built into the door."

Record review of the facility's "Plan of Correction" dated "05/09/2024 and 05/13/2024", under section titled, "doors propped", showed medication technicians and resident care managers and all staff were aware that doors were not to be propped open. Medication technicians and resident care managers understood that they were not to prop the doors open to the office and medication room even if they were in the rooms.

Record review of the facility's document titled, "medication technician meeting", dated 04/17/2024, showed "we can not prop the medication room, or any doors open. This is per the Fire Marshall. The only time the doors is propped open is if you are putting or taking the cart in the med room. If you need to talk to staff, please step outside of the medication room and speak with them. If you need privacy, you are more than welcome to use the resident care manager office or go to a private area.

Record review of the facility's document titled, "medication technician meeting", dated 05/15/2024, showed "reminder, do not prop the medication room or any doors open. This is per the Fire Marshall. The only time the doors is propped open is if you are putting or taking the cart in the med room. If you need to talk to staff, please step outside of the medication room and speak with them. If you need privacy, please go to the resident care manager office.

In an observation on 06/27/2024 at 11:20 AM, the South Side medication technician and charting room's door was propped open with a brown rubber stopper that was wedged under the bottom of the door. Staff C, Delegated Medication Technician, was observed to be inside of the room.

In an interview on 06/27/2024 at 11:30 AM, Staff B, Maintenance Assistant, said they had to make daily rounds to ensure facility doors were not propped open throughout the day.

In an observation on 06/27/2024 at 11:44 AM, Resident 1's door was propped open with a wooden wedge with a long handle. In front of the door was the housekeeping cart. Staff D, Housekeeping was observed inside of the room.

In an observation and interview on 06/27/2024 at 12:40 PM, Staff A, Executive Director, office door showed it was propped open with a wooden stopper that was wedged under the bottom of the door. Staff A said Maintenance staff collected all door stoppers through out the facility. Staff A said rubber stoppers should have been removed from the medication technician offices. Staff A said housekeeping staff used tall wedges with sticks to prop open resident room doors when they were inside cleaning resident rooms. Staff A said the medication technicians in the facility were in serviced and educated

about not using rubber stoppers and keeping all facility doors closed.

This is an uncorrected and recurring deficiency previously cited on 05/13/2024, 03/20/2024, 01/11/2024, and 03/22/2022, for subsection 388-78a-2040(1).

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7/24/24.

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

Laurya Vail — Administrator (or Representative)

7/22/24 — Date

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

Statement of Deficiencies	License #: 1111	Compliance Determination # 41010
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 11	Licensee: Olympia Special Care LLC	05/13/2024

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 an unannounced on-site follow-up on 05/09/2024 and 05/13/2024 of:
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following SOD dated: 05/13/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 81 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

05/23/2024
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)

5/28/24
Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure fire safety doors were not propped open for 1 of 1 facility reviewed. These failures placed 81 of 81 residents, staff, and visitors life and safety at risk in the event of a fire or natural disaster.

Findings included...

Review of the state Fire Marshall regulation codes showed the facility was out of compliance with, "Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

Record review of the "Department of Social And Health Services" document, Completion date 03/20/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2040] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 04/09/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 05/03/2024."

Review of the facility policy, titled, "Fire and Smoke Barrier Doors", undated, showed "...Fire and smoke barrier doors must be closed at all times, except those that are held open by an electric built-in magnetic device that will automatically close when the fire alarm system is activated or power failure occurs...Fire and smoke barrier doors are not to be blocked at any time or be held open by any means other than the automatic holding device built into the door."

Record review of the facility's "Plan of Correction" dated "04/01/2024 and 02/02/2024", showed staff were trained on the need to remove door props when they saw that the doors were propped open. All door wedges were removed. Signs were placed on the medication room doors which informed staff to keep the door shut.

In an observation on 05/09/2024 at 11:40 AM, the bathroom located in the reception area showed the door was propped open with a grey rubber stopper.

In an observation on 05/09/2024 at 11:43 AM, the Northside RCM (Resident Care Manager) office door was propped open with a rubber stopper.

In an observation on 05/09/2024 at 11:44 AM, the North Medication and Charting room's door was propped open with a gray rubber stopper that was wedged under the bottom of the door. Hung up on the medication and charting room door, was a sign that showed "Per the Fire Marshall THIS DOOR MUST REMAIN CLOSED AT ALL TIMES."

In an interview on 05/09/2024 at 11:47 AM, Staff D, Caregiver, stated doors within the facility were not supposed to be propped open. Staff D stated they had reviewed this information during their orientation when they were recently hired.

In an interview on 05/09/2024 at 11:52 AM, Staff E, Housekeeping, stated at times the facility staff members propped open facility doors.

In an observation on 05/09/2024 at 4:10 PM, the North medication and charting room door was observed to be propped open with a gray rubber stopper that was wedged under the bottom of the door.

In an interview on 05/09/2024 at 4:08 PM, Staff A, Executive Director, stated the staff were educated to not prop the doors open and all rubber stoppers were removed to prevent this from happening.

This is an uncorrected and recurring deficiency previously cited on 03/20/2024, 01/11/2024 and 03/22/2022 for subsection 388-78a-2040(1).

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 6/5/24 .

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

Administrator (or Representative) — Date: 5/28/24

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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of food and failed to ensure proper hand hygiene was performed with food preparation for 1 of 1 kitchen reviewed. These failures placed all 81 of 81 residents at risk for potential foodborne illness and decreased quality of life.

Findings included...

WAC 246-215-03526
"Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).
(1) Except when packaging food using a reduced oxygen packaging method as specified under WAC 246-215-03540, and except as specified in subsections (5) and (6) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than twenty-four hours must be clearly marked to indicate the date or day by which the food must be consumed on the premises, sold, or discarded when held at a temperature of 41°F (5°C) or less for a maximum of seven days. The day of preparation must be counted as day one.
(2) Except as specified in subsections (5) through (7) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant must be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four hours, to indicate the date or day by which the food must be consumed on the premises, sold, or discarded, based on the temperature and time requirements specified in subsection (1) of this section and:
(a) The day the original container is opened in the food establishment is counted as day one; and
(b) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.
(3) A refrigerated, ready-to-eat, time/temperature control for safety food ingredient or a portion of a refrigerated, ready-to-eat, time/temperature control for safety food that is combined with additional ingredients or portions of food must retain the date marking of the earliest-prepared or first-prepared ingredient.
(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:
(a) Using a method approved by the regulatory authority for refrigerated, ready-to-eat, time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;
(b) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (1) of this section;

(c) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or
(d) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authority upon request."

WAC 246-215-03300 "Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305."

WAC 246-215-03333 "Preventing contamination from equipment, utensils, and linens—In-use utensils, between-use storage (FDA Food Code 3-304.12) During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing utensils must be stored: (1) Except as specified under subsection (2) of this section, in the FOOD with their handles above the top of FOOD and the container; (2) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon; (3) On a clean portion of the FOOD preparation table or cooking EQUIPMENT only if the in-use UTENSIL and the FOOD-CONTACT SURFACE of the FOOD preparation table or cooking EQUIPMENT are cleaned and SANITIZED at a frequency specified under 04605 and 04705; (4) In running water of sufficient velocity to flush particulates to the drain, if used with moist FOOD such as ice cream or mashed potatoes; (5) In a clean, protected location if the UTENSILS, such as ice scoops, are used only with a FOOD that is not a TIME/TEMPERATURE CONTROL FOR SAFETY FOOD;..."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."

Record review of the facility's policy, titled, "Food Services-Preparation, Serving, Sanitation" undated, showed food would be covered and stored in containers with tightly fitting covers with metal plastic, plastic wrap or aluminum foil. Food would be stored above the floor level to prevent contamination and permit easy cleaning. Food would be labeled when removed from the original containers unless identify of the food was unmistakable. Employee hand hygiene must include washing hands for at least 20 seconds and include a 10-15 second scrubbing, a thorough rinsing and complete drying. Gloves must be thrown away after each task or when they get damaged or dirty.

Record review of the facility's policy titled, "Food Services- Food Storage and Handling", undated, showed "food whether raw or prepared, if removed from its original container, shall be stored in a clean, labeled, covered container except during necessary period of preparation or serviced. Once opened, any product remaining in the original container shall be covered."

Record review of the "Department of Social And Health Services" document, Completion date 03/20/2024, showed "As a result of the on-site visit(s) the department found that you

are not in compliance with the licensing laws and regulations [including WAC 388-78A-2305] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 04/08/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 05/03/2024."

Record review of the facility's "Plan of Correction" dated "04/01/2024 and 02/02/2024", showed the kitchen fridge and dry storage would be audited two times a week to ensure that foods were labeled and discarded when expired or passed three day hold time frame. The kitchen staff were trained on proper hand washing practices.

Storage and Labeling

In an observation on 05/09/2024 at 1:10 PM, the kitchen refrigerator located next to the handwashing sink showed a sign attached to the outside of the refrigerator door that read "residents food only date & label each item!!!" Inside of the refrigerator had a white Styrofoam container that was labeled "boss lady" there was no date available to review. There were 10 clear containers with lids that had a light green substance that filled the cup. There were 10 clear containers with lids that had dark brown substance that filled the cup. There were 14 clear containers with lids that had a light brown substance that filled the cup. None of the containers with lids were labeled or dated. There was a pitcher of orange liquid that had saran wrap covering the top. The pitcher was not labeled or dated.

In an observation on 05/09/2024 at 1:14 PM, inside the kitchen's walk-in refrigerator was a brown box with 10 cucumbers and 3 zucchinis. 7 of 10 cumbers were observed to have white fuzzy areas that resembled mold on them and were soft to touch. There was a brown box with multiple small tomatoes. Multiple of the tomatoes had black and fuzzy white areas on them that resembled mold. There was brown cardboard box with multiple green peppers inside. On one of the green peppers had a dark brown substance on it. There was a syrup container on the shelf above the green peppers that was labeled chocolate syrup that had chocolate syrup down the side of the container. On a metal rack on the top was a sheet of pink and yellow cake like substance. The sheet was not covered. There was no label or date on the sheet of cake substance for review. On the second shelf of the metal rack was a sheet with 6 dishes of red substance with white whip cream on top that were open to air. There was no date or label on the dishes for review.

In an interview on 05/09/2024 at 1:24 PM, Staff A stated the box of tomatoes that were in the kitchen's walk-in refrigerator were seen out on the counter yesterday. Staff A stated they would not serve the tomatoes and cucumbers to the residents. Staff A stated the chocolate sauce had not been accurately put away and had dripped onto the green peppers on the shelf below.

In an interview on 05/09/2024 at 3:47 PM, Staff F, Dietary Cook, said the food in the refrigerator was checked every three days. Staff F said they determined their produce was good to eat by checking the label on the box. Staff F said if a food item was opened, they would label what the item was and would include the month, day, and year when it was opened.

In an observation on 05/09/2024 at 3:57 PM in the dry pantry there was an open bag labeled "Oreo medium cookie pieces" inside a large zip lock bag. There was no date on the zip lock bag or the Oreo bag for review. There was an open bag of elbow noodles that did not have a date for review.

In an interview on 05/09/2024 at 3:50 PM, Staff J, Dietary Cook, said if an item had been opened then they would label it with the date. Staff J stated all items would be discarded after three days if they were unused.

Hand Hygiene

In an observation on 05/09/2024 at 1:06 PM, the entrance to the kitchen door showed two hand sanitizer devices attached to either side of the wall. The hand sanitizer on the right side had a blinking red light which indicated there was no product in the device. When the hand sanitizer on the left side of the walls handle was pumped no product came out of the device.

In an observation and interview on 05/09/2024 at 1:28 PM, Staff A, Executive Director, exited the kitchen door and acknowledged the hand sanitizers attached to the right and left side of the wall did not have hand sanitizer to use.

In an observation on 05/09/2024 at 1:08 PM, Staff B, Kitchen Aid, had entered the walk-in refrigerator and came out with a purple cabbage. Staff B put on blue disposable gloves and began cutting the purple cabbage. Staff B removed their blue disposable gloves and discarded them in the trash. Staff B entered back into the walk-in refrigerator and came out with a zip lock bag with shredded white particles that resembled shredded cheese and placed it on the counter. Staff B was not observed to wash their hands with soap and water or use of hand sanitizer prior to putting the disposable gloves on, removing the disposable gloves, and with the change of task.

In an observation on 05/09/2024 at 1:14 PM, Staff I, Caregiver, entered the kitchen and had gloves on their hands while they rolled two carts throughout the kitchen. Staff I did not perform hand hygiene when inside the kitchen. Staff I was observed to touch the kitchen counters.

In an interview on 05/09/2024 at 3:50 PM, Staff J stated they were supposed to perform hand hygiene when they entered the kitchen and if they left the kitchen and returned. Staff J stated they were supposed to perform hand hygiene before they put on gloves to complete a task. Staff J stated if they switched tasks then they would perform hand hygiene and put on another pair of gloves.

This is an uncorrected and recurring deficiency previously cited on 03/20/2024 and 01/11/2024 for subsections WAC 388-78A-2305 (1).

Plan/Attestation Statement

Statement of Deficiencies	License #: 1111	Compliance Determination # 41010
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 8 of 11	Licensee: Olympia Special Care LLC	05/13/2024

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 6/10/24 .

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

Administrator (or Representative) 5/28/24 Date

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure resulted in all 81 of 81 residents and visitors being without access to and being uninformed of the facility's inspections results.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 03/20/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including RCW 70.1290.070] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 04/08/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 05/03/2024."

Record review of the facility's "Plan of Correction" dated "04/01/2024 and 02/02/2024", showed the survey binder was updated with the statement of deficiencies.

In an observation on 05/09/2024 at 12:15 PM, the licensing survey binder showed the only inspection in the binder for review was the inspection dated 01/24/2024. There were no other inspections results in the binder for review.

In an interview on 05/09/2024 at 12:16 PM, Staff G, Receptionist, stated Staff A, Executive Director, had been responsible to keep the survey binder updated.

In an interview and observation on 05/09/2024 at 12:17 PM, Staff A stated they had been responsible for the upkeep of the survey binder. Staff A reviewed the contents of the survey binder and confirmed only one inspection dated 01/24/2024 was in the binder for review. Staff A stated they were unaware all inspections needed to be kept in the survey binder for review.

This is an uncorrected and recurring deficiency previously cited on 03/20/2024 and 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 6/10/24 .

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

Administrator (or Representative) 5/28/24 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the facility failed to ensure the facility was maintained in a safe, sanitary, and in good repair for 1 of 1 facility reviewed. These failures placed 81 of 81 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 03/20/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3090] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 04/08/2024. Staff A signed the

"Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 05/03/2024."

Review of the facility policy, titled, "Safe Storage and Handling of Supplies and Equipment", undated, showed the facility would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

Record review of the facility's policy, titled, "Maintenance- Safety and Upkeep of Community", undated, showed it was the facility's policy to assure that maintenance was conducted in a safe manner that would encompass the services that were contracted with outside contractors or service providers to keep the building in good repair and safe for all residents. The maintenance director's responsibility was to ensure the facility's building was properly maintained at all times. The executive director should make routine, weekly building inspections and report deficiencies to appropriate personnel.

Record review of the facility's "Plan of Correction", dated "04/01/2024 and 02/02/2024", showed all housekeeping staff were educated about deep cleaning schedules and to ensure to complete routine rounds in main living areas and public bathrooms throughout the shift. All employees needed to assist with communication and paying attention to areas of the building that required the need to be cleaned.

North Side

In an observation on 05/09/2024 at 12:32 PM, upon entering the bathroom NB5, there was a pungent smell that resembled urine. Inside the shower stall on top of the shower bench was a cream-colored rubber mat that had brown and black colors on it around the suction cup parts of the bathroom mat. Under the shower bench was a orange and brown outline on the floor of the shower that was the shape of the shower mat.

In an interview and observation on 05/09/2024 at 1:24 PM, Staff A, Executive Director, entered the bathroom NB5 and said that the bathroom rubber mat on the shower bench was not the facility's. Staff A stated the bathroom mat needed to be thrown away. When Staff A was asked what the discoloration was on the bathroom mat, Staff A stated that it was mildew. Staff A stated there was an odor to the bathroom and that the facility was working on getting new air fresheners installed. The bathroom NB5 did not have a working air freshener and Staff A stated the bathroom needed a new one installed.

South Side

In an observation on 05/09/2024 at 11:56 AM, at the top of the south stair "B thru 1" exit door on the left side of the wall halfway up was a large hole that had exposed copper colored pipe.

In an observation on 05/09/2024 at 12:57 PM, the bathroom and shower room located next to room S (South) 22 showed a crumpled-up napkin in the corner of the shower under the shower bench. The white shower floor had unknown brown particles near the drain.

In an interview and observation on 05/09/2024 at 1:00 PM, Staff C, Maintenance Manager, stated the hole in the wall on the top of the south stair exit door, had not been fixed. Staff C stated they needed to order new sheet rock for the project. Staff C could not provide an

estimated date on when the hole was supposed to be fixed. Staff C entered the bathroom next to room S22 and looked at the shower floor. Staff C stated they did not know what the brown stuff on the bottom of the shower was.

In an observation on 05/09/2024 at 3:38 PM, in the South dining room near the door to the kitchen, there was a piece of the brown flooring that had been torn and was missing. The floor was uneven and had black paper and brown raw wood exposed.

This is an uncorrected and recurring deficiency previously cited on 03/20/2024 and 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 6/10/24 .

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

Laurie Hall — Administrator (or Representative)

5/28/24 — Date

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

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 follow-up on 03/14/2024 and 03/20/2024 of:
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following SOD dated: 03/20/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 77 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Cory Cisneros, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit Z
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Jody Just
Residential Care Services

04/01/2023
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.

Lawrya Hall
Administrator (or Representative)

4/8/24
Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure oxygen tank cylinders were stored safely and secured and the facility failed to ensure fire safety doors were not propped open for 1 of 1 facility reviewed. These failures placed 77 of 77 residents, staff, and visitors life and safety at risk in the event of a fire or natural disaster.

Findings included...

Review of the state Fire Marshall regulation codes showed the facility was out of compliance with, "Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

"Code IFC 5303.5.3 2018: compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. Securing of compressed gas containers, cylinders and tanks shall be by one of the following methods: 1. Securing containers, cylinders and tanks to a fixed object with one or more restraints. 2. Securing containers, cylinders and tanks on a cart or other mobile device designed for the movement of compressed gas containers, cylinders or tanks. 3. Nesting of compressed gas containers, cylinders and tanks at container filling or servicing facilities or in sellers' warehouses not open to the public. Nesting shall be allowed provided that the nested containers, cylinders or tanks, if dislodged, do not obstruct the required means of egress. 4. Securing of compressed gas containers, cylinders and tanks to or within a rack, framework, cabinet or similar assembly designed for such use. Exception: Compressed gas containers, cylinders and tanks in the process of examination, filling, transport or servicing. "

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2040] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed oxygen tank racks were purchased and secured to the wall for tanks to be stored upright and secured position. Staff were in-serviced on the need to remove door props when they saw that the doors were propped open.

Review of the facility policy, titled, "Oxygen Use", undated, showed, "... The community also recognized oxygen presents a potential risk for fire, explosion, and injury from unsafe handling. The community will work closely with the resident, resident representative, and/or case manager if appropriate, the Office of the State Fire Marshall and local fire officials to promote safe use and storage of oxygen in the community. The community will assist residents to store and use oxygen in a safe manner."

Review of the facility policy, titled, "Fire and Smoke Barrier Doors", undated, showed "...Fire and smoke barrier doors must be closed at all times, except those that are held open by an electric built-in magnetic device that will automatically close when the fire alarm system is activated or power failure occurs...Fire and smoke barrier doors are not to be blocked at any time or be held open by any means other than the automatic holding device built into the door."

Doors

In an observation on 03/14/2024 at 11:01 AM, room N24 was observed propped open with a brown rubber door wedge. Room N25 was propped open with a black rubber door wedge. Room N28 was observed propped open with a brown rubber door wedge.

In an observation on 03/14/2024 at 11:05 AM, room N19 was observed propped open with a brown rubber door wedge.

In an observation on 03/14/2024 at 11:06 AM, room N15 was observed propped open with a gray rubber door wedge.

In an observation on 03/14/2024 at 11:08 AM, the medication/charting room's door was

propped open with a brown rubber door wedge. Taped up on the door was a sign that showed "per fire Marshall THIS DOOR MUST REMAIN CLOSED ALL TIMES".

In an observation on 03/14/2024 at 11:14 AM, room N11 was observed propped open with a wooden block.

In an observation on 03/14/2024 at 11:32 AM, the medication and charting room door on the South side of the building's was propped open with a rubber wedge underneath.

In an interview on 03/14/2024 at 11:37 AM, Staff C, Medication Technician, stated they were not to prop the medication/charting room door open.

In an observation and interview on 03/14/2024 at 1:26 PM, the North side of the facility's medication/charting room door was propped open with a brown rubber wedge. When asked if the door was to be propped open, Staff D, Medication Technician, stated they were not supposed to prop the door open, but it would get so hot in the room that they do.

In an interview on 03/14/2024 at 2:30 PM, Staff A, Executive Director, stated the facility in-serviced the staff that if they observed any resident doors to be propped open they were to remove the item or the rubber wedge that held the door open out of the way and ensure the door shut.

In an observation on 03/14/2024 at 5 PM, Staff A unlocked and opened the door to room N27. Upon opening the door Staff A kicked the rubber wedge and shoved it under the door with their foot to prop the door open.

In an interview on 03/14/2024 at 2:27 PM, Staff B, Maintenance Director, stated there was no resolution as to how to safely keep the doors open without using items or rubber stoppers. Staff B stated they educated and informed the medication technicians routinely they were not allowed to have the medication/charting room door propped open.

Oxygen Cylinder tanks

In an observation on 03/14/2024 at 11:44 AM, the storage room in the hallway by the kitchen was observed with three oxygen tanks lying on their sides on the top shelf of a four-shelf unit. One of the three oxygen tanks was full. On the floor in an unsecured orange basket was six full oxygen tanks that were not secured to the wall.

In an interview and observation on 03/14/2024 at 2:04 PM, the supply room by the kitchen that stored oxygen tanks was observed with Staff B, Maintenance Manager. When asked if the three oxygen tanks lying on their sides was the proper way to store the oxygen tanks, Staff B stated they were not to lie oxygen tanks on their side. When asked about the

unsecured orange basket with six oxygen tanks, Staff B stated the oxygen tanks needed to be secured to the wall and acknowledged they were not secured to the wall.

This is a uncorrected and recurring deficiency previously cited on 01/11/2024 and 03/22/2022.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Laurya Vau — Administrator (or Representative)

4/9/24 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a 30-day Service Plan Agreement (facility's version of Negotiated Service Agreement) for 3 of 3 newly admitted residents (Resident 1 [R1], Resident 2 [R2], and Resident 3[R3]). This failure resulted in staff not having pertinent information for care services for all 3 residents placing them at risk for unmet care needs.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2130] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/24/2024."

Record review of the facility's policy titled, "Negotiated Service Agreement", undated, showed the initial resident service plan (facility's version of the Negotiated Service Agreement) was based on discussions with the resident and the information gathered by the qualified assessor prior to admission. The negotiated service agreement would be completed within 30 days of the resident moving into the facility. The negotiated service agreement would be developed on building on the resident's strength and using the preadmission assessment, resident initial service plan, and the full assessment information.

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed nursing staff would complete the assessments and were re-in-serviced on the schedule for the assessments and frequency to ensure they were done in the required time frames. The resident care managers and the nurses would use the assessment due report in their electronic computer system that would be printed out monthly to ensure care conferences were held to review the service agreements within the requirements.

R1

Record review of R1's face sheet, dated 03/18/2024, showed R1 moved into the facility on [redacted]/2024, with multiple medical diagnoses that included [redacted].

Record review of R1's Master Assessment, dated 02/29/2024, showed the assessment was R1's 30-day assessment.

Record review of R1's Service Plan Agreement showed it was completed on 02/06/2024. There were no other service plan agreements provided that had been completed by 02/29/2024 for review.

R2

Record review of R2's face sheet, dated 03/18/2024, showed R2 moved into the facility on [redacted]/2024, with multiple medical diagnoses that included [redacted], and [redacted] and [redacted].

Record review of R2's Master Assessment, dated 02/29/2024, showed the assessment was R2's 30-day assessment.

Record review of R2's Service Plan Agreement showed it was completed on 02/06/2024. There were no other service plan agreements provided that had been completed by 02/29/2024 for review.

R3

Record review of R3's face sheet, dated 03/18/2024, showed R3 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R3's Master Assessment, dated 02/27/2024, showed it was R3's 30-day assessment.

Record review of R3's Service Plan Agreement showed it was completed on 02/06/2024. There were no other service plan agreements provided that had been completed by 02/29/2024 for review.

In an interview on 03/20/2024 at 9:10 AM, Staff A, Executive Director, stated the resident care managers and the licensed nurses work together to ensure the service plan agreements were completed by the required dates.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Administrator (or Representative) — Date: 4/8/24

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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of food and failed to ensure proper hand hygiene was performed with food preparation for 1 of 1 kitchen reviewed. These failures placed all 77 of 77 residents at risk for potential food borne illness and decreased quality of life.

Findings included...

WAC 246-215-03610
"Labeling—Food labels (FDA Food Code 3-602.11). (1) FOOD PACKAGED in a FOOD ESTABLISHMENT must be labeled as specified in LAW, including chapters 69.04 and 15.130 RCW; 21 C.F.R. 101 - Food Labeling; and 9 C.F.R. 317 - Labeling, Marking Devices, and Containers. (2) Label information must include: (a) The common name of the FOOD or,

absent a common name, an adequately descriptive identity statement; (b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD; (c) An accurate declaration of the quantity of contents; (d) The name and place of business of the manufacturer, packer, or distributor; (e) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or unusual name of the respective ingredient; (3) Bulk FOOD that is available for CONSUMER self-dispensing must be prominently labeled with the following information in plain view of the CONSUMER: (a) The manufacturer's or processor's label that was provided with the FOOD; or (b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section."

WAC 246-215-03300 "Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305."

WAC 246-215-03333 "Preventing contamination from equipment, utensils, and linens—In-use utensils, between-use storage (FDA Food Code 3-304.12) During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing utensils must be stored: (1) Except as specified under subsection (2) of this section, in the FOOD with their handles above the top of FOOD and the container; (2) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon; (3) On a clean portion of the FOOD preparation table or cooking EQUIPMENT only if the in-use UTENSIL and the FOOD-CONTACT SURFACE of the FOOD preparation table or cooking EQUIPMENT are cleaned and SANITIZED at a frequency specified under 04605 and 04705; (4) In running water of sufficient velocity to flush particulates to the drain, if used with moist FOOD such as ice cream or mashed potatoes; (5) In a clean, protected location if the UTENSILS, such as ice scoops, are used only with a FOOD that is not a TIME/TEMPERATURE CONTROL FOR SAFETY FOOD;..."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."

Record review of the facility's policy titled, "Food Services-Preparation, Serving, Sanitation" undated, showed food would be covered and stored in containers with tightly fitting covers with metal plastic, plastic wrap or aluminum foil. Food would be stored above the floor level to prevent contamination and permit easy cleaning. Food would be labeled when removed from the original containers unless identify of the food is unmistakable. Employee hand hygiene must include washing hands for at least 20 seconds and include a 10-15 second scrubbing, a thorough rinsing and complete drying. Gloves must be thrown away after each task or when they get damaged or dirty.

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2305] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A,

Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed the walk-in fridge was cleaned and all the food storage boxes were removed off the floor and put on shelves. The Kitchen fridge and dry storage was audited two time a week to ensure that foods were labeled and discarded when expired or passed three day hold time frame. Kitchen staff were in-serviced on proper storage and cleaning expectations. The administrator would audit the kitchen no less than quarterly for compliance March, June, September, and December. Staff were re-in-serviced throughout the month of February and would be continuously educated.

Storage and Labeling

In an observation on 03/14/2024 at 11:57 AM, inside the facility kitchen showed three ice scoops in a bin touching, with no means to drain. Observed inside the ice machine was white matter on the back walls and in the metal ice trays at the back of the machine. Brown food debris and matter was observed on the interior of the machine where the door slides.

In an observation on 03/14/2024 at 12:01 PM, the back of the cold holding machine in the kitchen, was observed to have a air flow vent grill covered in thick dust. The dust was observed moving with flow of air.

In an observation on 03/14/2024 at 12:03 PM, inside the facility kitchen, showed three large white bins with bags and items inside. One bin had flour open to air with a scoop inside the bag touching the flour, and there was no date or label. Next to the flour was an open bag of salt open to air with no label or date, and an open bag of bread crumbs with no dates or labels. One bin had brown sugar open to air with no label or date.

In an observation on 03/14/2024 at 12:06 PM, the walk-in freezer in the kitchen, showed boxes stored on the ground. The boxes stored on the floor were two boxes of Amorosos sliced Italian rolls and a box of meringue pies on the floor. There was a chicken piece on the floor along with debris and dirt. On the rack in the freezer was a bag of chicken strips, open to air, with no date or label, and observed to be covered in ice with freezer burn.

In an observation on 03/14/2024 at 12:10 PM, on the multi-level rack shelves there was a bag of tortillas that had been opened. The bag was not dated when it had been opened.

Hand Hygiene

In an observation on 03/14/2024 at 12:04 PM, Staff K, Dietary Cook, removed gray disposable gloves from their black apron pocket. Staff K put the gray disposable gloves on. Staff K did not wash their hands prior to putting the gloves on. Staff K removed the foil off of a large rectangle pan with ready to eat food. Staff K grabbed a black marker that was by the Styrofoam containers and used the marker. At 12:08 PM, Staff K placed the black marker into the pocket of their black apron with their gloved hands. Staff K grabbed clean plates and began to plate ready to eat food for the resident's food orders. Staff K was not observed to change out their disposable gloves or wash their hands during the entire observation.

In an interview on 03/14/2024 at 4:30 PM, Staff A, Executive Director, stated staff were not to store or carry disposable gloves in their pockets and then use them for resident care or services. Staff A stated staff's clothing was not considered clean and should be grabbing gloves from the box of disposable gloves.

This is an uncorrected deficiency previously cited on 01/11/2024 for subsections WAC 388-78A-2305 (1).

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24.

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

Administrator (or Representative) — Date: 4/8/24

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure resulted in all 77 residents and visitors being without access to and being uninformed of the facility's inspections results.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including RCW 70.1290.070] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's "Plan of Correction", dated 02/01/2024, showed the facility was in the process of updating the survey inspection binder with all citations.

In an observation on 03/14/2024 at 10:50 AM, upon entering the facility, the facility's inspection binder was not observed to be available. There was no inspection binder in the cabinet drawers in the lobby, was not on the counter or anywhere visible. Further observation of the lobby area showed there were no signs visible instructing anyone on the existence of the inspection binder, nor where it was located.

In an observation and interview on 03/14/2024 at 4:28 PM, Staff I, Receptionist, stated they were unsure where the survey inspection binder was stored and that it was either in Staff A, Executive director's office, or at the receptionist desk. Staff I reached under the receptionist desk and grabbed the survey binder for the Department to review. The location of the binder was not available for any resident or public visitor to access or see.

Record review on 03/14/2024 of the facility's state survey binder, showed the only inspection in the binder for review was the inspection dated 05/31/2019. There were no other inspections results in the binder for review.

In an interview on 03/14/2024 at 4:28 PM, Staff A stated the facility's survey binder was incomplete and was a work in progress. Staff A stated they had not put the last annual inspection that occurred on 01/11/2024 in the binder for residents and visitors to review. Staff A stated the binder was kept at the receptionist desk. Staff A stated the receptionist only worked during business hours. Staff A stated the survey binder was to be left on the counter when the receptionist was not available or after hours.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Administrator (or Representative) — Date: 4/3/24

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled new staff members (Staff E, Staff F, and Staff G) were screened for tuberculosis (TB, a communicable disease) with the required one or two step skin testing. This failure placed all 77 of 77 residents and staff at risk of TB infection.

Findings included...

Record review of the Centers for Disease Control and Prevention web site article titled, "TB Screening and Testing of Health Care Personnel", dated 08/30/2022, under the section, "baseline testing: Two-step testing", showed "if the Mantoux tuberculin skin test (TST) is used to test health care personnel upon hire (preplacement), two-step testing should be used. This is because some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection". The second TST test was to be administered one to three weeks after the first test.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2484] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed all staff's TB testing and results were kept on a tracking form that the human resources (HR) assistance created. The HR assistant has regular communication with the nursing team and staff to keep compliant. The tracking was monitored weekly for compliance.

Record review of the facility's policy, "TB testing", undated, showed all staff were screed for TB. All staff must have a baseline two-step skin test initiated within three days of being

hired unless the staff person had a documented history of a negative results from a previous two-step or there was a documented negative result from a one-step skin testing in the previous twelve months. The skin tests must be given no less than one or no more than three weeks apart and read between forty-eight and seventy-two hours following administration.

Record review of an email sent to the Department on 03/19/2024 at 3:23 PM, showed Staff E, Kitchen Aid, first day of employment was 02/01/2024.

Record review of Staff E's "[the facility] Employee Tuberculosis Screening" dated 02/28/2024, showed Staff E received their first step on 02/28/2024. The TB skin test was administered three days after the facility attested to be back in compliance with the regulation and 25 days after the required time frame it was to be completed.

Record review of an email sent to the Department on 03/19/2024 at 3:23 PM, showed Staff F, Caregiver, first day of employment was 01/22/2024.

Record review of the facility provide untiled document, dated 07/03/2023, showed Staff F had a QuantiFERON gold blood test (a blood test that detects if a person was infected with TB) on 06/29/2023 that was negative for TB. The facility was unable to provide any further documentation that showed Staff F had a one-step TB skin test completed three days after they were hired.

Record review of an email sent to the Department on 03/19/2024 at 3:23 PM, showed Staff G, Dietary Cook, first day of employment was 12/22/2023.

Record review of Staff G's "[the facility] Employee Tuberculosis Screening" dated 02/27/2024, showed Staff G received their first step on 02/27/2024. The TB skin test was administered two days after the facility attested to be back in compliance with the regulation and 33 days after the required time frame it was to be completed.

In an interview on 03/20/2024 at 9:10 AM, Staff A, Executive Director, stated the human resources assistance was responsible to communicate with the licensed nurses when staff's TB tests were needing to be given or read to stay in compliance.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Administrator (or Representative) — Date: 4/8/24

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the facility failed to ensure the facility was maintained in a safe, sanitary, and in good repair for 1 of 1 facility reviewed. These failures placed 77 of 77 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3090] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Review of the facility policy, titled, "Safe Storage and Handling of Supplies and Equipment", undated, showed the facility would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

Record review of the facility's policy titled, "Maintenance- Safety and Upkeep of Community", undated, showed it was the facility's policy to assure that maintenance was conducted in a safe manner That would encompass the services that were contracted with outside contractors or service providers to keep the building in good repair and safe for all residents. The maintenance directors responsibility was to ensure the facility's building was properly maintained at all items that included, paint should be free of peeling and fading. The executive director should make routine, weekly building inspections and report deficiencies to appropriate personnel.

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed all housekeeping staff were educated about deep cleaning schedules and to ensure to complete routine rounds in main living areas and public bathrooms throughout the shift.

All employees needed to assist with communication and paying attention to areas of the building that required the need to be cleaned. The facility replaced the ceiling tile in the northing dining room and staff were educated to not have residents sitting near the ceiling leak during meal times. The facility was to have another company out to assess and repair the ceiling leak.

In an observation on 03/14/2024 at 11:02 AM, inside the public bathroom NB4 at the base of the toilet there was white calking that was all the way around the base of the toilet and floor. Some of the white calking was missing and some of the calking was brown.

In an observation on 03/14/2024 at 11:04 AM, inside the public bathroom N22 at the base of the toilet there was white calking that was all the way around the base of the toilet and floor. Some of the white calking was missing and some of the calking was brown and yellow in color. The double door cabinet under the counter top of the sink, the cabinet door to the right, the hinge on the bottom of the cabinet door was broke. The cabinet door was unstable and wobbled when it was opened.

In an observation on 03/14/2024 at 11:24 AM, inside the bathroom by room S21, there was a pungent smell that resembled urine inside. Inside the trash by the toilet was a blue soiled disposable brief that had been discarded. In the shower stall was a white square shower bench that was observed to have brown splattered areas on the front and back legs of the bench.

In an observation on 03/14/2024 at 11:28 AM, inside the bathroom by room S8 under the countertop of the sink, the cabinet door to the left when opened wobbled and was unstable. The bottom hinge of the cabinet door was broken.

In an observation on 03/14/2024 at 11:28 AM, the fire extinguisher by room S16 was observed to have a cracked plastic cover held together with tape.

In an observation on 03/14/2024 at 11:31 AM, underneath the beauty salon's window, the handrail on the wall was observed to have paint missing and exposed the wood.

In an observation on 03/14/2024 at 11:50 AM, at the top of the south stair "B thru 1" exit door on the left side of the wall halfway up was a large hole that had exposed copper colored pipe and could see the sunlight shining in from the outside and could feel the cold outside air coming in. At 11:52 AM from the outside of the building, the copper pipe was connected to outside water faucet. On the ledge of the buildings siding above the hole and the water handle was a cigarette.

In an observation on 03/14/2024 at 1:40 PM, the clear plastic cover on the door of the box that housed a fire extinguisher that hung on the wall by room N30 was cracked.

In an interview on 03/14/2024 at 1:57 PM, Staff B, Maintenance Manager, stated there was still a hole in the roof in the North unit Dining room, but the facility placed a ceiling tile to cover the hole. Staff B stated they were supposed to have a company out in a week to work on fixing it. Staff B stated he could provide an estimate by the roof repair company. Staff B stated they also identified an issue with the fireplace expressing propane smell into the dining room and they had to shut the valve to the fireplace off in the dining room to prevent the smell from coming into the room.

Record review of the roof repair estimate provided by Staff B, dated 03/08/2024, showed

the estimate was not obtained until 03/08/2024, eight days after the facility's attestation to have the item corrected. The estimate report showed there were five identified holes or leaks located in various parts of the facility structure that need to be fixed, including the roof, walls, and chimney. Review of the estimate showed Staff A, Executive Director, did not sign off for approval until 03/13/2024.

In an interview on 03/14/2024 at 2:27 PM, Staff B stated they had not cut the new clear plastic to replace into the fire extinguisher clear plastic door covers.

In an interview on 03/14/2024 at 4:28 PM, Staff A stated in the north dining room the ceiling tiles were replaced, but the leak had not been repaired. Staff A stated the permanent fix was still pending.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Administrator (or Representative) — Date: 4/8/24

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to have Registered Nurse (RN) Delegation written consent for 1 of 2 sampled new residents(Resident 1 [R1]). The facility also failed to have documentation that new medication technicians were evaluated for the

first four weeks for insulin administration for 1 of 1 sampled residents (Resident 6 [R6]). These failures placed all residents receiving RN delegated services at risk for receiving care and services by untrained staff.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2320] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

"RCW 18.88B.070 Nurse delegated tasks. (3) The home care aide is accountable for his or her own individual actions in the delegation process. Home care aides accurately following written delegation instructions from a registered nurse are immune from liability regarding the performance of the delegated duties".

"WAC 246-840-910 Purpose. This rule defines a consistent standard of nursing care with the delegation of nursing tasks to nursing assistants or home care aides. The registered nurse delegator makes independent professional decisions of the delegation of a nursing task. A licensed registered nurse may delegate specific nursing care tasks to nursing assistants or home care aides meeting certain requirements and providing care to individuals in a community-based care setting defined by RCW 18.79.260 (3)(e)(i) and to individuals in an in-home care setting defined by RCW 18.79.260 (3)(e)(ii). Before delegating a task, the registered nurse delegator determines that specific criteria are met and the patient is in a stable and predictable condition. Registered nurses delegating tasks are accountable to the Washington state nursing care quality assurance commission. The registered nurse delegator, home care aide and nursing assistant are each accountable for their own individual actions in the delegation process. No person may coerce a registered nurse into compromising patient safety by requiring the registered nurse to delegate. Registered nurse delegators shall not delegate the following care tasks: (1) Administration of medications by injection (by intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) with the exception of insulin injections".

WAC 246-840-920 Definitions. (7) "Indirect supervision" means the registered nurse delegator is not on the premises. The registered nurse delegator previously provided written instructions for the care and treatment of the patient. The registered nurse delegator documents in the patient record the instruction to the nursing assistant or home care aide, observation of the delegated task, and confirmation of the nursing assistant's or home care aide's understanding the directions.

WAC 246-840-930 Criteria for delegation. (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under

chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

Record review of the Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", undated, under the section titled, "consent for delegation", showed the RN delegator was to obtain client or the clients authorized representative consent for delegation. The consent was to be obtained prior to initiating delegation. The RN delegator must have the form signed. Verbal consent was good for 30 days. After 30 days of the verbal consent the form must be signed.

Record review of the facility's policy "Delegation of Nursing Tasks", undated, showed upon determining the resident's need for nursing services, the registered nurse would discuss the option of nurse delegation with the resident and/or the resident's representative. Delegation would be in accordance with current nurse delegation regulations, assisted living facility regulations, and the nurse practice act of Washington State.

Record review of the "Nurse delegation: Consent for Delegation Process", dated 09/2021, showed "if verbal consent is obtained, written consent is required within 30 days of verbal consent."

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R1 and R6 required Registered Nurse (RN) delegated services.

Record review of the facility provided document titled "Medication Administration Competency Assessment Tool, dated 02/01/2024, for Staff L, Delegated Medication Technician, and Staff M, Delegated Medication Technician. The forms were not resident specific.

R1

Record review of R1's face sheet, dated 03/18/2024, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R1's "Nurse Delegation: Consent for Delegation Process" form, dated [redacted]/2023 showed there was verbal consent obtained from R1's power of attorney. There was no signature from R1's power attorney on the form for review.

R6

Record review of R6's face sheet, dated 03/18/2024, showed R6 moved into the facility on

[redacted]/2022 with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R6's Nurse Delegation: Nursing Visit form, undated, showed Staff L and Staff M were newer medication technicians. Under the section titled, "long term care worker training/competency" showed both Staff M and Staff L needed training. There was no documentation on the nursing visit form the weekly supervision and evaluation of insulin injection for Staff M and Staff L. There were no other documents for R6 in the RN delegation binder to show that Staff M and Staff L had 4 weeks of supervision and evaluation for insulin injection.

Record review of R6's Medication Administration Record, dated 03/01/2024 through 03/14/2024 showed R6 had an order for Humulin N insulin (long-acting insulin to help lower high blood sugar levels and maintain blood sugar levels in a normal range) to inject every morning. Review of the administrations showed Staff L administered R6's insulin 6 of 14 administrations. R6 had an order for lispro insulin (fast acting insulin to help lower high blood sugar levels quickly) to inject three times daily based upon blood sugar reading. Review of the administrations showed Staff L administered the insulin to R6 on 6 of 14 days.

In an interview on 03/19/2024 at 12:59 PM, Staff J, Registered Nurse (RN) Delegator, stated they obtained verbal consent for RN delegation from the resident's power of attorney or the resident's responsible party. Staff J stated that upon admission of a new resident to the facility, the resident's power of attorney or the resident's responsible party would sign a RN delegation consent form. Staff J stated the RN delegation consent form was not included in the new resident admission move in packet and was not completed. Staff J stated they fill out a medication competency administration tool for all new medication technicians prior to being delegated. Staff J stated once that form was filled out the medication technician's weekly supervision and training started. Staff J stated they do not document the day they complete their weekly supervision and evaluation on insulin injections with the medication technician. Staff J stated Staff L and Staff M were still in training.

In an interview on 03/19/2024 at 2:30 PM, Staff L, stated they were administering R6's nurse delegated task of insulin injections independently without any supervision from another delegated medication technician or licensed nurse.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Laurya Vau — Administrator (or Representative)

4/8/24 — Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to have the residents service plan agreement (facility's version of the negotiated service plan) updated with the most accurate information for 2 of 5 residents (Resident 1 [R1] and Resident 2 [R2]). This failure placed R1 and R2 at risk of unmet care needs and care staff uneducated and unable to provide the care and services that the residents required.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "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. I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations [including WAC 388-78A-2140] at all times." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's policy, "Negotiated Service Agreements", undated, showed agreements would be based on the resident's assessed needs and would be developed with the input, participation, and agreement of the resident, responsible parties, case manager, community staff and others as appropriate and to the extent possible. The negotiated service plan would be completed within 30 days of the resident moving into the community. The negotiated service plan would be developed with using the resident preadmission assessment, residents initial service plan, and the residents full assessment information. The negotiated service plan would be updated to be consistent with the residents needs when there has been an observed change in the resident's physical, mental, or emotional function, and when it no longer addressed the residents needs and/or preferences. The negotiated service plan would address the residents all reasonable risks and how the risks would be managed.

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed the resident's service plans for the community were reviewed by the nursing staff and resident care managers to assure that all elements of the care plan were reflective of residents need. The Nursing team created an audit tool to assist with ensuring documentation was completed timely and accurate.

R1

Record review of R1's face sheet, dated 03/18/2024, showed R1 moved into the facility on [redacted]/2024, with multiple medical diagnoses that included [redacted]. Record review of the facilities "Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R1 required nurse delegation services and their medications administered to them.

Record review of R1's Nurse Delegation: Instructions for Nursing Task, dated 02/20/2024, showed R1 required all oral (by mouth) medications to be nurse delegated tasks.

Record review of R1's Master Assessment, dated 02/29/2024, showed the assessment was R1's 30-day assessment. R1 required medications assistance for medication by mouth and applied on their skin. R1 was oriented to themselves only. R1 had moderate cognition impairment. R1 had difficulty with communication that resulted in word salad (words and phrases that were out of order or context). R1 used a manual wheelchair and two wheeled walker for assistive equipment.

Record review of the R1's Service Plan Agreement (facilities version of Negotiated Service Agreement), dated 02/06/2024, showed R1 required medication set up for administration. There was no documentation that R1 required all their medications to be nurse delegated tasks. R1 was independent with mobility and did not use any assistive devices. R1 had a history of using a walker but did not use one at present time.

R2

Record review of R2's face sheet, dated 03/18/2024, showed R2 moved into the facility on [redacted]/2024, with multiple medical diagnoses that included [redacted] and [redacted] and [redacted].

[redacted] and [redacted].

Record review of the facilities "Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R2 was independent with their medications and had cognitive impairments. R2 had history of falls and used ambulation devices.

Record review of R2's Master Assessment, dated 02/29/2024, showed R2 used a four wheeled walker for ambulation. R2 required one person assistance for transfers. R2 required one person assistance with shaving with an electric razor. R2 was incontinent (loss of control of urine and/or feces) of bowel and bladder.

Record review of R2's Service Plan Agreement, dated 02/06/2024, showed R2 used a wheelchair for ambulation. R2 was independent with getting in and out of bed. R2 required minimal assistance with shaving. R2 was continent (ability to control urine and feces) urine and stool.

In an interview on 03/14/2024 at 9:10 AM, Staff A, Executive Director, stated the service plan agreements were updated by the licensed nurses. The licensed nurses collaborate with the caregivers, all the nursing assessments, and previous service plan agreements to update the new service plan agreements.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Administrator (or Representative) — Date: 4/8/24

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to maintain safe hot water temperatures on 2 of 2 units (North unit and South Unit) reviewed. This failure placed all 77 residents, visitors, and staff at risk of injury from unsafe water temperatures.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2950] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed water temperatures were checked. The facility used their "TELS" system schedule to ensure the hot water temperatures were checked regularly to ensure the hot water temperatures did not go out of range.

Record review of the facility provided document titled, "logbook documentation", dated 03/05/2024, showed it was guidance on how to test and log the hot water temperatures for the facility. For burn prevention, federal guidelines advise that the facility kept domestic water temperatures below 120 degrees Fahrenheit (F). The facility was to check the hot water temperature in shower areas, resident rooms at each end of the wing on a rotating basis, common area bathrooms, public bathrooms, and any areas having sinks should be checked and recorded as well. The hot water temperatures results were to be recorded on the water temperature log. Any discrepancies were to be noted, hot water heater settings would be adjusted as required and retest the water as needed.

Record review of the facility provided document for their hot water policy titled, "F-689 Accidents-Water Temperatures", undated, showed the facility must ensure that the residents environment remains free of accident hazards. The purpose of recording the facilities water temperatures was to assure, that the facility was remaining free from accidental burns and scalds as possible and that any issues are addressed in a prompt and consistent manner. The Surveyor's often test the water temperatures at hand sinks and bathing tubs with a thermometer under the water and feel if it is too hot. Under the section State Regulations, showed it was enforced by the State Department of Health. Each state has their own regulation on maximum water temperature allowed, but typically would fall between 105 to 115 degrees F. Facility was to check with their Surveyor for the maximum hot water temperature.

Record review of the facility's untitled document, dated 03/12/2024, showed it was a list of hot water temperatures. On 02/26/2024 the basement mop sink's hot water temperature was 122.2 degrees F and the kitchen sink was 123.1 degrees F. Under the comments section, there was nothing documented. The facility's hot water was checked on 03/04/2024, the basement mop sink's water temperature was 122.6 degrees F and the kitchen sink's hot water temperature was 123.5 degrees F. Under the comments section showed "N/A" (not applicable).

In an observation on 03/14/2024 at 1:32 PM, the hot water in the public bathroom NB2's temperature was 125.2 degrees F.

In an observation on 03/14/2024 at 1:23 PM, the water temperature in the North activity room sink was 121.4 F. Residents were observed in the activity room and the sink was accessible to residents.

In an observation on 03/14/2024 at 1:25 PM, room N14's bathroom sink water temperature was 122.7 F.

In an observation on 03/14/2024 at 1:35 PM, room S18's bathroom sink water temperature was 127.0 F.

In an interview and observation on 03/14/2024 at 2:04 PM, room S18's water temperature was 125.7 F when tested with Staff B's, Maintenance Manager, thermometer. Staff B acknowledged that the temperature was too high and beyond the requirements. Staff B stated the maintenance assistant checked water temperatures weekly on Sunday.

In an observation on 03/14/2024 at 2:16 PM, the North activity room sink water temperature was 124.7 F when tested with Staff B's thermometer.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/3/24 .

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

Lawrence 4/8/24

Administrator (or Representative) Date

WAC 388-78A-2381 General design requirements for memory care.

(1) When planning for new construction, renovations or change of service to include memory care services, the facility must document design considerations appropriate to residents with dementia, mental health issues, or cognitive and developmental disabilities within its functional program consistent with WAC 388-78A-2380 .

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to allow residents access to their rooms without staff assistance for 2 of 2 units (North unit and South unit) reviewed. This failure placed all 77 of 77 residents at risk of decreased quality of life and independence of not having free will to go in their room at any given time.

Findings included...

Washington Administrative Code (WAC), "388-110-220 Enhanced adult residential care service standards. (3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must (n) Ensure residents have access to their own rooms at all times without staff assistance".

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2381] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed the facility had to replace the self-locking mechanism on each resident's door. The facility alleged to have the south side resident's door locks changed out and completed by 03/31/2024. The resident's door locks on the south side were to be completed by 04/30/2024.

In an interview on 03/14/2024 at 12:29 PM, Staff A, Executive Director, stated the facility had to replace all the door handles to all the resident bedroom doors to allow the doors to be unlocked. Staff A stated Staff B, Maintenance Manager, was responsible to get 32 door handles ordered to replace the door handles. Staff A was unsure if the door handles were ordered.

In an observation on 03/14/2024 at 11:27 AM, R5's handle to their bedroom was locked.

In an observation on 03/14/2024 at 11:30 AM, R4's handle to their bedroom was locked.

In an interview on 03/14/2024 at 2:27 PM, Staff B stated the door handles were not ordered yet and there was no date to get the door handles changed. Staff B stated there were 64 total door handles that needed to be replaced for the North and South unit's of the facility.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 4/1/24 .

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

Administrator (or Representative) — Date: 4/8/24

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:

(a) Orientation and safety;

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 3 sampled new Staff members (Staff E, Staff F, and Staff G) had completed their facility orientation training. The facility failed to have 1 of 1 sampled staff (Staff H) complete the Department of Health and Social Services (DSHS) 5-hour Orientation and Safety. These failures placed 77 of 77 residents at risk for staff being unaware of the facility's expectations and not having the required education and training.

Findings included...

WAC 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is

available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."

Record review of the State of Washington document titled, Proclamation by the Governor 20-10, dated 02/09/2020, showed the requirement for the facility's to have staff completed their training requirements in relation to orientation and safety, continued education, and all the training requirements in chapter 388-112A Washington Administrative Code.

Record review of the Department of Social and Health Services letter 2023-017, dated 04/28/2023, showed the required long-term care workers basic training deadline dates they needed to complete by.

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "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. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's policy "Staff Training and Education", undated, showed all staff would have an orientation to the facility prior to routine interaction with residents.

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed the facility's previous human resource employee was unable to retrieve the missing documents for staff members. The facility hired a new human resources employee that created an audit tool to ensure all the required documents were completed and placed in the employee's file. The facility alleged that all missing documents for the staff members would be updated and completed by April 15th, 2024.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff E, Kitchen Aid, was hired at the facility and first day of employment was on 02/01/2024.

Record review on 03/14/2024 of Staff E's personnel file showed they had an orientation and skills checklist for new employee's form. The form was incomplete and blank with nothing documented on the form.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff F, Caregiver, was hired at the facility on 01/16/2024 and first day of employment was on 01/22/2024.

Record review on 03/14/2024 of Staff F's personnel file showed they had an orientation and skills checklist for new employee's form. The form was incomplete and blank with nothing documented on the form.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff G, Dietary Cook, was hired at the facility and first day of employment was on 12/22/2023.

Record review on 03/14/2024 of Staff G's personnel file showed Staff G had an orientation and skills checklist for new employee's that was undated. The form was incomplete other than the employee's signature and date of 12/23/2023. There was no signature of whom the trainer was or signature from the final review/approval.

Record review of the facility provided untitled and undated document that had a list of

employees, showed Staff H, Delegated Medication Technician, was hired at the facility on 05/29/2023 and first day of employment was on 06/02/2023.

Record review on 03/14/2024 of Staff H's personnel file showed there was no certificate of the DSHS orientation and safety for review.

In an interview on 03/14/2024 at 4:30 PM, Staff A, Executive Director, stated the facility's orientation and safety was the document that was titled "orientation and skills checklist for new employees". Staff A stated they were to be completed on the staff members first day of employment. Staff A stated they were aware that there was not a system in place to ensure that staff had the facility orientation and all required trainings and certificates.

This is an uncorrected deficiency previously cited on 01/11/2024 for subsections WAC 388-78A-2474 (2)(a)(3).

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/2/24 .

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

Tammy Lay — 4/8/24

Administrator (or Representative) — Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 2 locations within the facility (North side and South side units). This failure placed 77 of 77 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed the facility primarily served residents with dementia (the loss of cognitive functioning — thinking, remembering, and reasoning — to such an extent that it interferes with a person's daily life and activities.)

Record review of the "Department of Social And Health Services" document, Completion date 01/11/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3100] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 02/01/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 02/25/2024."

Record review of the facility's policy "Chemical/Hazardous Chemicals", undated, showed extra chemicals not on the housekeeping cart would be secured away from resident areas and kept locked. They may be stored in locked housekeeping closets with carts when not in use. The maintenance director was responsible for directing the storage of hazardous chemicals/chemicals for the community.

Record review of the facility's written "Plan of Correction", dated 02/01/2024, showed all supplies were kept behind locked doors in designated closet spaces. No supplies such as cleaning products or hair products would be left out in an unsecured area.

In an observation on 03/14/2024 at 11:07 AM, the NB1 bathroom was observed unlocked and open to residents. On the counter in bathroom was soothe and cool barrier moisture barrier ointment, and the label showed "keep out of reach of children." Inside the shower was "Clean on me" body wash, "Head and Shoulders" shampoo, two bottles of "Dermacen" shampoo and body wash.

In an observation on 03/14/2024 at 11:11 AM, the hallway cabinet by room N11 had "Soothe and cool cleanse", a total body cleanser and intensive skin therapy dimethicone cream to protect skin, accessible to residents in the unlocked cabinet. The label of the items in the cabinet stated, "keep out of reach of children."

In an observation on 03/14/2024 at 11:23 AM, the restroom by room S21 showed it was unlocked and accessible to residents. Inside the bathroom, in the unlocked cabinet, were cleaning disinfectant wipes.

In an interview on 03/20/2024 at 9:10 AM, Staff A, Executive Director, stated all staff members were responsible to ensure all chemicals, shampoos, solutions, or soaps were locked up and out of access to the memory care residents.

This is an uncorrected deficiency previously cited on 01/11/2024.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/31/24 .

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

Tammy Cavlan — 4/8/24

Administrator (or Representative) — Date

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 33985
Investigator: Anissa Bearden
Investigation Date(s): 12/12/2023 through 01/11/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 109787
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
allegation that a medication technician administered a resident medication that was prescribed in another residents name.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 11 Closed records sample size: 0
Observations:	Identified resident Resident care equipment Staff to resident interactions Medication/chart rooms. Medication administration
Interviews:	Identified resident Identified staff Nursing staff Management
Record Reviews:	Medical records Facility policies Personnel files Staff training records

Investigation Summary:
After observation, interview, and record review the medication technician did administer another residents medication to different resident. Failed practice identified for safe management of medication services.

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: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 33985
Investigator: Anissa Bearden
Investigation Date(s): 12/12/2023 through 01/11/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 109547
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Resident was administered medication that was another residents supply, that resulted in the resident that took the medication had a change of condition with ER visit.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 11 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Medication administration Staff to resident interactions
Interviews:	Family members Residents Nursing staff Identified resident Identified staff
Record Reviews:	Medical records Hospital records Personnel files Staff training records Incident investigation Facility policies

Investigation Summary:

After interview and record review the resident was identified to have been administered medication that was prescribed for another resident. unable to substantiate the medication resulted in the resident's change of condition and visit to the emergency department. The facility had failed practice with a system in place to ensure residents have their medications available when needed to administer and failed to have safe medication services administered for the residents.

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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

01/24/2024

Licensee: Olympia Special Care LLC
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

RE: GARDEN COURTE ALZHEIMER COMMUNITY License # 1111

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 01/11/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Jody Just, Field Manager
Residential Care Services
Region 3, Unit Z
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• 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.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

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)397-9556.

Sincerely,

Cory Cisneros

Jody Just, Field Manager
Region 3, Unit Z
Residential Care Services

Enclosure

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

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 12/12/2023 and 01/11/2024 of:
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint numbers: 109787, 109547, 108216, 108112, 107833.

The following sample was selected for review during the unannounced on-site visit: 11 of 81 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Anissa Bearden, Licensor
Cory Cisneros, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit Z
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

01/24/2024
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: 2/1/24

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure fire extinguishers were serviced timely and doors were not propped open for 1 of 1 facility reviewed. These failures placed 81 of 81 residents, staff, and visitors life and safety at risk in the event of a fire.

Findings included...

Review of the state Fire Marshall regulation codes showed the facility was out of compliance with, "Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

"Code 906.2 General Requirements. 906.2 General requirements.
Portable fire extinguishers shall be selected, installed and maintained in accordance with this section and NFPA 10.

Exceptions:
1.The distance of travel to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2.Thirty-day inspections shall not be required and maintenance shall be allowed to be once every 3 years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
2.1.Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.

2.2.Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3.The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4.Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5.A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA 10.
3.In Group I-3, portable fire extinguishers shall be permitted to be located at staff locations."

"Code IFC 5303.5.3 2018: compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. Securing of compressed gas containers, cylinders and tanks shall be by one of the following methods: 1. Securing containers, cylinders and tanks to a fixed object with one or more restraints. 2. Securing containers, cylinders and tanks on a cart or other mobile device designed for the movement of compressed gas containers, cylinders or tanks. 3. Nesting of compressed gas containers, cylinders and tanks at container filling or servicing facilities or in sellers' warehouses not open to the public. Nesting shall be allowed provided that the nested containers, cylinders or tanks, if dislodged, do not obstruct the required means of egress. 4. Securing of compressed gas containers, cylinders and tanks to or within a rack, framework, cabinet or similar assembly designed for such use. Exception: Compressed gas containers, cylinders and tanks in the process of examination, filling, transport or servicing. "

Review of the facility policy, titled, "Oxygen Use", undated, showed, "... The community also recognized oxygen presents a potential risk for fire, explosion, and injury from unsafe handling. The community will work closely with the resident, resident representative, and/or case manager if appropriate, the Office of the State Fire Marshall and local fire officials to promote safe use and storage of oxygen in the community. The community will assist residents to store and use oxygen in a safe manner."

Review of the facility policy, titled, "Fire and Smoke Barrier Doors", undated, showed "...Fire and smoke barrier doors must be closed at all times, except those that are held open by an electric built-in magnetic device that will automatically close when the fire alarm system is activated or power failure occurs...Fire and smoke barrier doors are not to be blocked at any time or be held open by any means other than the automatic holding device built into the door."

Doors

In an observation on 12/12/2023 at 2:10 PM, on the northside of the facility, the medication/charting room door was propped open with the medication cart. On the door of the medication/charting room was a sign that showed they were not to prop the door open per the state Fire Marshall.

In an observation on 12/13/2023 at 9:52 AM, Resident 6 was observed sitting in his living room with the door to his room observed to be propped open with a small object under the door.

In observations made on 12/14/2023 at 12:11 PM, resident rooms N25 and N27 were

propped open with a small statue or object, preventing the door from closing. Room N19 was observed to be propped open with a wedge.

In an interview on 12/14/2023 at 5:13 PM, Staff A, Executive Director, stated that the resident doors should not be propped open.

In an interview on 12/19/2023 at 4:50 PM, Collateral Contact 4, State Fire Marshal, stated that wedges or items in front of a door to prevent doors from closing were not allowed in the facility and that the facility had been made aware of this concern previously.

Oxygen tanks

In an interview and observation on 12/12/2023 at 9:52 AM, the storage closet behind the kitchen showed there was one red and white sharps containers sitting on the bottom shelf and the second shelf, and a large empty red sharps disposal trash can on the floor with a red biohazard bag inside. The sharps containers were observed to have used needles and blood products observed inside and the white lid showed in red lettering "FULL". When asked if full sharps containers should be sitting on the shelves where they could be knocked over, Staff L, Maintenance Manager, stated they were not sure why the full sharps containers were sitting on the shelves. Staff K, Maintenance Assistant, stated the full sharps containers were to be stored in the red round biohazard trash can. Down the hall was another storage closet identified to have oxygen inside. Inside the closet were five oxygen tanks lying on their side on the bottom shelf that was labeled "empty". On the shelf above were five more oxygen tanks lying on their side with a label that showed "full". All the oxygen tanks on the shelves were unsecured. On the floor next to the shelves were 10 oxygen cylinders in racks that were not secured to the wall. There was one oxygen cylinder that was free standing next to the oxygen tank crates. On top of the tanks on the floor, pressing down on the valve lever on top of one of the oxygen tanks, was an oxygen tank cart (fits a single oxygen tank into a metal sleeve with 2 wheels and a handle). Staff L stated that he was unsure about oxygen storage requirements, and stated he thought if the oxygen tank was full it was not okay to be on the shelf, if it was empty, it could be stored on the shelf. Staff L stated he knew it was "110% not supposed to stack on top of the cylinders."

Fire Extinguishers

In an observation on 12/12/2023 at 8:05 AM, in the basement of the facility there was a fire extinguisher that had a tag that showed it was last checked on 08/2023 (no day listed).

In an observation on 12/12/2023 at 8:18 AM, inside the laundry room there were two fire extinguishers with tags that showed they were last checked on 08/2023 (no day listed).

In an interview on 12/12/2023 at 9:39 AM, Staff K, Maintenance Assistant, stated the fire extinguishers were checked every month and serviced yearly.

This is a recurring deficiency previously cited on 03/22/2022.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide privacy when they walked into resident rooms unannounced for 3 of 3 residents (Resident 2 [R2], Resident 3 [R3], Resident 8 [R8]). The facility failed to allow family and visitors to accompany and visit 1 of 1 residents (Resident 7 [R7]) during a mealtime. These failures placed all 81 of 81 residents at risk for not feeling comfortable in their home and decreased quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Dignity

In an observation on 12/12/2023 at 5:40 AM, Staff F, Medication Technician, walked to R2 bedroom door. Staff F unlocked the door and walked inside. Staff F did not knock on the door or announce whom they were prior to entering R2's room.

In an observation on 12/12/2023 at 5:45 AM, Staff F walked to R3's bedroom door. Staff F unlocked R3's door and walked inside. Staff F did not knock on the door or announce whom they were prior to entering R3's bedroom door.

In an observation on 12/12/2023 at 9:54 AM, Licensor was in R8's room, when the door was heard to unlock and open. Once the door was already opening, there was a lite knock and Staff P, Caregiver, walked in. Staff P did not knock on the door prior to unlocking and opening the door to enter R8's room.

Visitation

In an observation on 12/12/2023 at 5:32 AM, on the entry door to the south side of the facility was a sign posted on the door that showed, "families as a reminder, we are still not allowing family members in the dining room with the residents during mealtimes. We will let you know as soon as this changes. We appreciate your understanding.
Thank you."

In an observation on 12/12/2023 at 6:06 AM, on the entry door to the north side of the facility was a sign posted on the door that showed, "families as a reminder, we are still not allowing family members in the dining room with the residents during mealtimes. We will let you know as soon as this changes. We appreciate your understanding. Thank you."

In an interview on 12/19/2023 at 12:47 PM, Collateral Contact 1 (CC1), Daughter of R7, stated they were turned away to visit with R7 when it was mealtime. CC1 stated they were told they could not sit with R7 when they were eating and had to wait in the hallway until R7 was done.

In an interview on 01/08/2024 at 12:37 PM, Staff A, Executive Director, stated families are allowed to visit. Staff A stated that family are not allowed to eat in the dining room with the resident as there was not enough seating. Staff A stated they would not turn a residents family member away if they came to visit during mealtimes.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/24/24 .

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to have a communication system

available for 3 of 3 sampled residents (Resident 8 [R8], Resident 6 [R6], and Resident 11 [R11]) in their living area of their apartment to call for staff if they required assistance. This failure resulted in all three residents not having a means to summon on-duty staff, and placed the residents at risk for a delay of care and assistance, and unmet care needs.

Findings included...

R8

Record review of R8's face sheet, showed R8 moved into the facility on [redacted]/2023.

Record review of R8's "Master Assessment", dated [redacted]/2023, under the section titled, "safety and evacuation", showed R8 was independent with the call system operation.

Record review of R8's Service Plan Agreement (facility's version of the negotiated service agreement), dated 09/20/2023, showed R8 was able to communicate and make their needs known. Under the section, "call light use", showed R8 understood the purpose and the use of the call light system. R8 was able to notify staff with the call light if they needed to.

In an observation and interview on 12/13/2023 at 9:54 AM, inside the apartment in the living area of R8's room, R8 sat in their reclining chair watching television. In the living room area around R8's reclining chair was observed to not have a call light or pull cord available for R8 to use to call for assistance from staff. R8 stated they walk and use the pull cord in bathroom if they needed staff assistance. R8 stated there was not a call light or pull cord to use if they were unable to walk to the bathroom to call for assistance. When R8 was asked how they would call for assistance if they were unable to get up from their recliner, R8 stated "I don't know, something I did not consider."

R6

Record review of R6's face sheet, undated, showed R6 admitted to the facility on [redacted]/2023.

Record review of R6's "Master Assessment", dated 11/30/2023, showed R6 was independent with the call system operations. R6 was able to communicate and make their needs known.

Record review of R6's, Service Plan Agreement, dated [redacted]/2023, showed R6 was independent with the use of a call light. R6 was oriented to person, place, and situation.
R6 was able to make their needs known.

In an observation and interview on 12/13/2023 at 9:52 AM, in R6's apartment, R6 was sitting in their chair. There was no call light or pull cord observed in the living area that R6 was sitting in for use. R6 stated there was a call button in the bedroom that had a string they could use, but not in the living area.

R11

Record review of R11's Face Sheet, showed R11 moved into the facility on [redacted]/2022.

Record review of R11's "Master Assessment", dated 10/12/2023, under the section "safety and evacuation", showed R11 had some difficulty using the call system and needs were met by the service plan. R11 was able to communicate and make their needs known.

Record review of R11's Service Plan Agreement, dated 10/12/2023, showed R11 was oriented to self and location. R11 could speak clearly and could communicate their needs. Under the section titled "safety check", showed there was no documentation about R11's capability to use the call system. Staff were to ensure R11 had a fall mat next to their bed and an IAlert bed alarm. Staff were to provide frequent safety checks related to R11's history of falls and high risk for further falls. R11 prefered to sleep in their chair rather than her bed.

In an observation and interview on 12/13/2023 at 10:37 AM, inside R11's room, R11 was sitting in their chair. There was no call light system available for use around R11's chair. R11 stated that they enjoyed sitting in their chair this time of the year to watch the hallmark movies. R11 stated they spent most of the time in their chair rather than their bed. R11 stated the call light system was beside their bed and not accessible from their chair. R11 stated the call light cord was "not in a very good spot".

In an interview on 12/13/2023 at 1:05 PM, Staff E, Medication Technician, stated R11 sat in their chair most of the time. Staff E stated R11 had bad days when R11 was unable to get up out of their chair. R11 would then scream out for help.

In an interview and observation on 12/14/2023 at 5:13 PM, Staff A, Executive Director, was observed to look for a call light system in R6's living room area of their apartment. Staff A stated that there was no call light system for use in the living room area of R6's room. Staff A stated R8's living room area of their apartment did not have a call light system for use in the area.

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) — Date: 2/1/24

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a 30-day assessment for 1 of 3 newly admitted residents (Resident 8 [R8]). This failure placed R8 at risk of unmet care needs and staff being uneducated to R8's needed care and services.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreement", undated, showed the initial resident service plan (facilities version of was based on discussions with the resident and the information gathered by the qualified assessor prior to admission. The negotiated service agreement would be completed within 30 days of the resident moving into the facility. The negotiated service agreement would be developed on building on the resident's strength and using the preadmission assessment, resident service plan, and the full assessment information.

Record review of R8's face sheet, showed R8 moved into the facility on [redacted]/2023.

Record review of R8's "Master Assessment", dated [redacted]/2023, under the section titled, "safety and evacuation", showed R8 was independent with the call system operation.

Record review of R8's Service Plan Agreement, dated 09/20/2023, showed all the effective dates for the service types that were on the service plan had a date of 09/15/2023 and 09/18/2023. The service plan was signed by the R8's daughter on 09/20/2023.

On 12/13/2023 at 9:35 AM, the Department requested R8's 30-day service plan for review.

On 12/14/2023 at 11:50 AM, the Department requested R8's 30-day service plan for review. The department received R8's Service Plan Agreement dated 12/14/2023.

In an interview on 12/14/2023 at 4:15 PM, Staff A, Executive Director, stated the Service Agreement Plan dated 12/14/2023 was the 30-day assessment for R8. Staff A stated the date on the service agreement plan is the day that it was printed not when it was completed. Staff A pulled up R8's service plans that had been done on the facility's computer system. The system showed R8 had only one completed service plan agreement that was dated 09/20/2023. There were no other service plan agreements that had been completed since R8 admitted to the facility. Staff A showed that the 30-day assessment was completed on 10/04/2023, but no 30-day service plan agreement had been completed.

Plan/Attestation Statement

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

Lavaya Law — Administrator (or Representative)

2/1/24 — Date

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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of food, failed to ensure proper hand hygiene was performed with food preparation, and failed to ensure food preparation and storage areas were cleaned and maintained for 1 of 1 kitchen reviewed. The facility also failed to ensure staff received and maintained their food handlers' cards for 3 of 7 Staff reviewed (Staff A, Staff H, and Staff I). These failures placed 81 of 81 residents at risk for potential food borne illness and receiving food prepared by unqualified staff.

Findings included...

WAC 246-217-015 (1)
"(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."
WAC 246-217-025 (1)(8)(9)
"(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee.
(8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials."

WAC 246-217-035 (1) (5)(c)
"(1) All initial cards are valid for two years from the date of issuance.
(5) The card shall be approximately three inches by five inches in size and contain the following information: (c) Printed (or typed written) name and signature of the food service worker

WAC 246-215-03610
"Labeling—Food labels (FDA Food Code 3-602.11). (1) FOOD PACKAGED in a FOOD ESTABLISHMENT must be labeled as specified in LAW, including chapters 69.04 and 15.130 RCW; 21 C.F.R. 101 - Food Labeling; and 9 C.F.R. 317 - Labeling, Marking Devices, and Containers. (2) Label information must include: (a) The common name of the FOOD or, absent a common name, an adequately descriptive identity statement; (b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD; (c) An accurate declaration of the quantity of contents; (d) The name and place of business of the manufacturer, packer, or distributor; (e) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or unusual name of the respective ingredient; (3) Bulk FOOD that is available for CONSUMER self-dispensing must be prominently labeled with the following information in plain view of the CONSUMER: (a) The manufacturer's or processor's label that was provided with the FOOD; or (b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section."

WAC 246-215-03300 "Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305."
WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."

Storage and Labeling

In an observation on 12/12/2023 at 7:00 AM, the dry storage area of the kitchen was observed with boxes of instant food thickener, foam plates, foam cups, and a box of large cans of pinto beans were stored on the ground. There was dirt and debris observed on the floor between the racks and the boxes on the floor of the dry storage. There was an open bag of walnut halves and pieces observed to be open, loosing wrapped with plastic wrap with no date or label. In the corner of the dry storage by the door, was a 50 pound bag of Quaker Oats oatmeal sitting on the ground.

In an observation on 12/12/2023 at 7:04 AM, the walk in refrigerator was observed to have half a tomato wrapped in plastic wrap with no label or date. The tomato was noted to feel soggy and squishy when touched. A large chunk of white cheese was wrapped in plastic wrap with no label or date. Half an onion wrapped in plastic wrap with no date or label was sitting on a shelf. A cup of yellow mustard was observed to have spilled onto the floor between the racks in the walk in refrigerator, along with dirt and debris.

In an observation on 12/12/2023 at 7:06 AM, on the outside door of the walk in refrigerator, was a temperature log with no month or year noted. Days 1 through 12, and 17 through 31 were blank with no recorded temperatures. There was a second log, for the walk in Freezer, dated August with no year, and the form was completely blank with no documented temperatures.

In an observation on 12/12/2023 at 7:08 AM, the walk in freezer was observed to have boxes of pork sausage patties on the floor. The floor was noted to have dirt , frozen French fries, and debris between the boxes and under the shelves.

In an observation on 12/12/2023 at 7:12 AM, there was an open half gallon jug of orange juice, with a manufacturers expiration date of 11/21/2023.

In an observation on 12/12/2023 at 12:15 PM, there were three full sized hams in a metal bowls thawing above ready to eat bread. Above the hams, there were two full size roasts observed to be thawing above ready to eat dessert cups.

In an interview on 12/12/2023 at 12:31 PM, Staff O, Culinary Services Director, stated the walk-in refrigerator and freezer temperature logs were not being completed, but should have been. Staff O stated the hams and roasts should not be thawing above ready to eat foods.

Hand Hygiene

In an observation on 12/12/2023 at 12:07 PM, Staff J, Cook, was observed to be plating food for the lunch meal. Staff J was observed to grab a plate, reach into the container with meat loaf patties, grab a meat loaf patty with his gloved hand and place it on the plate. It was noted there was a pair of tongs sitting next to the container of cooked meat loaf patties. Staff J then walked away from the plate, across the kitchen, grabbed a bag of bread, opened the bag and reached in with his gloved hand that had just touched the meat loaf patty. Staff J then walked back to the plate, and placed the bread onto the plate with the meat loaf patty. Staff J continued to plate meat loaf patties with his gloved hands, and then walk over to the bread and grab slices of bread, and place on the plates, then continue to grab more plates and place the meat loaf patties on the plates with the same gloved hands. At 12:11 PM, Staff J was observed to change his gloves. He did not perform hand hygiene. At 12:12 PM, Staff J was observed to continue to grab meat loaf patties and place them on plates for residents with his gloved hands.

In an interview on 12/12/2023 at 12:36 PM, Staff O stated he observed Staff J grabbing food with his gloved hands as well. Staff O stated Staff J should not be grabbing food with gloved hands and should use the tongs provided. Staff O stated Staff J should have performed hand hygiene between tasks and glove changes.

Food Handlers

Record review of Staff A's, Executive Director, personnel file showed a hire date of 11/16/2020. There was no food handlers card available for review for Staff A.

Record review of Staff H's, Dietary Aide, personnel file showed a hire date of 07/07/2023. Review of Staff H's food handler card showed it expired on 12/02/2023.

Record review of Staff I's, Caregiver, personnel file showed a hire date of 07/14/2020. Review of Staff I's food handler card showed it expired on 02/07/2023.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2630 Reporting abuse and neglect.

(2) The assisted living facility must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to have the required state agency and state ombudsman's contact information posted within the facility for 81 of 81 residents, staff members, and visitors for review. This placed all 81 residents, visitors, and staff members at risk of not having the contact information to report to the Department of any abuse, neglect, or violation of the resident's rights.

Findings included...

"RCW 70.129.030 Notice of rights and services—Admission of individuals. (b) A posting of names, addresses, and telephone numbers of the state survey and certification agency, the state licensure office, the state ombuds program, and the protection and advocacy systems; and (c) A statement that the resident may file a complaint with the appropriate state licensing agency concerning alleged resident abuse, neglect, and misappropriation of resident property in the facility."

In an observation on 12/12/2023 at 5:30 AM, of the lobby area of the facility showed there were no posted information about the Department's hotline phone number and ombudsman's contact information for review.

In an observation on 12/12/2023 at 6:05 AM, general tour of the south side of the facility showed there were no posted information about the Department's hotline phone number and ombudsman's contact information for review.

In an observation on 12/12/2023 at 6:55 AM, general tour of the north side of the facility showed there were no posted information about the Department's hotline phone number and ombudsman's contact information for review.

In an interview on 12/12/2023 at 7:14 AM, Staff Q, Medication Technician, stated there were no posters of the Departments and the state ombudsman's contact information

posted within the facility for review that they have seen.

In an observation and interview on 12/14/2023 at 5:15 PM, Staff A, Executive Director, walked on the north side of the facility and was unable to show the Department the ombudsman's and the Departments contact information for the residents, public, and visitors to access for review. Staff A stated the information was posted in the employee breakrooms and not in the hallways of the facility

Plan/Attestation Statement

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Lawyer Law — Administrator (or Representative)

2/1/24 — Date

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure resulted in all residents and visitors being without access to and being uninformed of the facility's inspections results.

Findings included...

In an observation on 12/12/2023 at 5:30 AM, just inside the entrance of the facility in the lobby there were no posted signs for the public and visitors to know where to view the inspection binder. Inside the top drawer of the table near the south side doors underneath papers and pamphlets was a binder that was titled "survey binder". Inside the binder was the last inspection dated 05/28/2019. The binder did not have any complaint inspections that resulted in citations available to review.

Record review of the Department records showed the facility had received numerous citations and inspection reports since the last annual full inspection on 05/28/2019.

In an interview on 12/13/2023 at 8:13 AM, Staff A, Executive Director, stated there was no posted sign to indicate where the inspection binder was located for the residents, visitors, and public to view. Staff A state if anyone wanted to review the inspection binder content they were to ask. Staff A stated they were responsible to update the inspection binder with all inspections.

Plan/Attestation Statement

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Lawyer Law — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 4 sampled staff (Staff A, Staff I, and Staff J) had submitted a new Washington State (WA) name and date of birth background check every two years. This failure placed 81 of 81 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of the facility's policy, "background checks", undated, showed "to safeguard all resident in our community each employee will have a completed background check in accordance with state regulations."

Record review of the facility's provided undated and untitled document with a list of

employees showed Staff A, Executive Director, was hired at the facility on 11/07/2020 and first day of employment was on 11/16/2020.

Record review of Staff A's WA state name and date of birth background check upon hire was dated 11/10/2020, that expired on 11/10/2022.

Record review of Staff A's most updated WA state name and date of birth background check was dated 01/24/2023. The background check was completed 75 days after the prior background check expired.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff I, Caregiver, was hired at the facility on 07/14/2020.

Record review of Staff I's WA state name and date of birth background check upon hire was dated 06/25/2020, that expired on 06/25/2022.

Record review of Staff I's most updated WA state name and date of birth background check was dated 01/23/2023. The background check was completed 213 days after the prior background check expired.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff J, Cook, was hired at the facility on 05/04/2021.

Record review of Staff J's WA state name and date of birth background check upon hire was dated 05/30/2021 that expired on 05/30/2023.

Record review of Staff J's most updated WA state name and date of birth background check was dated 06/15/2023. The background check was completed 16 days after the prior background check expired.

In an interview on 12/14/2023 at 3:27 PM, Staff R, Human Resources Assistant, stated they audit the background checks and ensure that all employees have a WA state name and date of birth background check completed every two years.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a character, competence, and suitability for 5 of 5 staff members (Staff A, Staff I, Staff J, Staff F, and Staff D) before they were determined they were cleared to work with vulnerable adults. This placed 81 of 81 residents at risk for potentially being cared for by an unauthorized staff member.

Findings included...

"WAC 388-113-0060 How and when must a character, competence, and suitability [CCS] determination be conducted by the department or an authorized entity? (1) The department or an authorized entity must conduct a character, competence, and suitability determination of an employee, prospective employee, or other individual who is required to undergo a background check when the applicant has received a "review required" result as defined in WAC 388-113-0101(b). (3) If an applicant is required to have a character, competence, and suitability determination under this section, the applicant may not have unsupervised access to minors or vulnerable adults unless the character, competence, and suitability determination has: (a) Been completed and documented in writing. applicant may have unsupervised access to minors or vulnerable adults."

Record review of the facility's policy, "background checks", undated, showed "to safeguard all resident in our community each employee will have a completed background check in accordance with state regulations."

Record review of the facility's provided undated and untitled document with a list of employees showed Staff I, Caregiver, was hired and started employment at the facility on 07/14/2020. Record review of Staff I's 2 year WA state name and date of birth background check was dated 01/23/2023.

Record review of Staff I's CCS showed it was reviewed, completed, and signed on 02/02/2023. That was 10 days after results were released to the facility.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff J, Cook, was hired at the facility on 04/30/2021 and first day of employment on 05/04/2021.

Record review of Staff J's 2 year WA state name and date of birth background check was dated 06/15/2023.

Record review of Staff J's CCS showed it was reviewed, completed, and signed on 09/23/2023. That was 106 days after results were released to the facility.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff A, Executive Director, was hired at the facility on 11/07/2020 and first day of employment on 11/16/2020.

Record review of Staff A's every 2 year WA state name and date of birth background check was dated 01/24/2023.

Record review of Staff A's CCS showed it was reviewed, completed, and signed on 02/02/2023. That was 9 days after results were released to the facility.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff F, Medication Technician, was hired at the facility on 05/29/2023 and first day of employment on 06/02/2023.

Record review of Staff F's every WA state name and date of birth background check was dated 05/25/2023.

Record review of Staff F's CCS showed it was reviewed, completed, and signed on0 6/08/2023. That was 8 days after results were released to the facility.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff D, Medication Technician, was hired at the facility on 04/12/2022 and first day of employment on 04/17/2022.

Record review of Staff F's WA state name and date of birth fingerprint background check was dated 04/13/2023.

Record review of Staff D's CCS showed it was reviewed, completed, and signed on 04/12/2022. There was no updated CCS that was completed for the chargers that were resulted on the WA state name and date of birth fingerprint background check dated 04/13/2023 for review.

In an interview on 12/14/2023 at 3:27 PM, Staff R, Human Resources Assistant, stated they fill out a CCS form and meet with the employee to discuss and review the results of the background check and ensure they were approved to be employed at the facility. Staff R stated they complete a CCS for any new background check that was completed.

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) — Date: 2/1/24

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 4 of 7 sampled staff members (Staff A, Staff F, Staff G, and Staff I) were screened for tuberculosis (TB, a communicable disease) with the required two set skin testing. This failure placed all 81 of 81 residents and staff at risk of TB infection.

Findings included...

Record review of the Centers for Disease Control and Prevention web site article titled, "TB Screening and Testing of Health Care Personnel", dated 08/30/2022, under the section, "baseline testing: Two-step testing", showed "if the Mantoux tuberculin skin test (TST) is used to test health care personnel upon hire (preplacement), two-step testing should be used. This is because some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection". The second TST test was to be administered one to three weeks after the first test.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the facility's policy, "TB testing", undated, showed all staff must have a baseline two-step skin test initiated within three days of being hired unless the staff person has a documented history of a negative results from a previous two-step or there was a documented negative result from a one-step skin testing in the previous twelve months. The skin tests must be given no less than one or no more than three weeks apart and read between forty-eight and seventy-two hours following administration.

Record review of Staff A's, Executive Director, personnel file showed they were hired at the

facility on 11/07/2020.

Record review of Staff A's, "Employee Tuberculosis Screening", dated 01/22/2021, showed Staff A received their first step on 01/22/2021. Staff A's second step skin test was completed on 02/10/2023. The second step was read on 09/13/2021. The second step skin test was read more than 72 hours when the first step was administered to Staff A.

Record review of Staff F's, Medication Technician, employee file showed they were hired at the facility on 05/29/2023.

Record review of Staff F's employee file showed Staff F was administered their first TB skin test on 08/12/2023. The first step was administered 72 days after the required time. Staff F's second step skin test was administered on 09/04/2023. The second step skin test was completed more than 3 weeks after the first skin test administration.

Record review of Staff G's, Caregiver, employee file showed they were hired at the facility on 09/01/2023.

Record review of Staff G's employee file showed Staff G was administered their first TB skin test on 04/07/2022. There was no second step administration record for Staff G for review. There were no prior TB skin testing results in Staff G's employee file for review that would exempt Staff G received a two-step TB skin test.

Record review of Staff I's, Caregiver, employee file showed they were hired at the facility on 07/14/2020.

Record review of Staff I's employee file showed Staff I was administered their first TB skin test on 07/14/2020. Staff I's second step skin test was administered on 08/08/2020. The second step skin test was completed more than 3 weeks after the first skin test administration.

In an interview on 01/08/2023 at 12:27 PM, Staff A, Executive Director, stated the nurses of the facility were responsible to administer employees TB testing as required. Staff A stated the licensed nurses keep track when the tests were to be read and when the second step was to be administered.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24.

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

Lawnya Hall — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation interviews , and record review, the facility failed to ensure the facility was maintained in a safe, sanitary, and in good repair for 1 of 1 facility reviewed. These failures placed 81 of 81 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Review of the facility policy, titled, "Safe Storage and Handling of Supplies and Equipment", undated, showed the facility would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

In an observation on 12/12/2023 at 6:01 AM, on the floor by the south dining room double doors and the main door to the south side of the facility was a here was a 12-inch-long dried sticky substance.

In an observation on 12/12/2023 at 6:26 AM, on the north side of the facility inside the bathroom NB4 had multiple white particles scattered all over the floor. There was brown substance on the toilet seat and inside the white toilet bowl. The floor had a sticky substance that made your shoe's make a tacky noise when walked on the floor.

In an observation on 12/12/2023 at 6:27 AM, the fire extinguisher box outside room N30 (accessible to residents) had a cracked plastic covering exposing sharp edges.

In an observation 12/12/2023 at 6:30 AM, on the north side of the facility inside the bathroom NB5 was a white shower bench inside the shower stall. There were brown smears and stains in the middle of the white shower bench seat., that resembled feces.

In an observation and interview on 12/12/2023 at 6:45 AM, in the north side dining room closest to the kitchen under the resident dining tables was a panel of the ceiling tile was missing. There was a hole in the ceiling's drywall. The drywall was noted to be a darker color black and had dried dark lines that resembled water lines. Underneath
the hole was a white blanket with a beige trash can with an empty trash bag. Staff Q, Medication Technician, stated the ceiling has been leaking for a while. Staff Q stated when it rained the water would drip onto the ground. Staff Q stated that is why the white blanket and the trash can was under the hole to help contain the water that dripped. There were three dining room tables that were placed around the trash can. Staff Q stated the residents sat at the tables for meals.

In an interview on 12/13/2023 at 3:13 PM, Staff L, Maintenance Supervisor, stated the facility was aware of the hole in the north unit dining room ceiling and that they had

contacted the roofing company. Staff L stated there was a bucket under the hole in the ceiling because due to water leaking through the hole.

Garbage

In an observation on 12/12/2023 at 7:57 AM, on the wooden ramp by the dumpster outside behind the facility, were two tied up bags of trash. There were multiple blue disposable gloves on the ground and other various items on the ground around the dumpster. The dumpster lid was open and there were multiple bags of trash that were overflowing out of the dumpster.

In an observation on 12/12/2023 at 8:02 AM, in the back hallway of the facility was a blue round trash can. Inside the trash can were disposed surgical masks and blue disposable gloves that were inside out. There was no trash can liner inside the trash can.

In an interview on 12/12/2023 at 9:52 AM, Staff K, Maintenance Assistant, stated the facility's dumpster was emptied by the trash company every Monday and Friday. Staff K stated due to cars that were parked by the dumpster the trash company was unable to empty the dumpster on Monday 12/11/2023.

In an interview and observation on 12/13/2023 at 3:13 PM, there was trash and debris observed outside the back door of the facility leading to the garbage dumpster. In the dumpster area, there was a broken toilet against the wall, a broken mini fridge, numerous cans of paint with substances inside, and other various trash and debris. There was an empty propane tank sitting against the half wall by the dumpster, on the other side of the wall was the facility staff smoking area. There was building siding material and other debris around the garbage dumpster. Staff L, Maintenance Supervisor, stated he was unsure how long the paint had been sitting by the dumpster, but stated it had been awhile. Staff L stated the broken toilet, mini fridge, and empty propane tank had been sitting by the dumpster for about 2 to 3 months.

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)~~ — Date: 2/1/24

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(1) Maintain a systematic and secure method of identifying and filing resident records for easy access;

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records, maintain records for easy access, and provide the department with access to resident records for 2 of 2 units reviewed (North and South Units). These failures placed 81 of 81 residents at risk for exposure of confidential records and resulted in delays of information to authorized representatives of the Department.

Findings included...

In an observation on 12/12/2023 at 5:35 AM, there were a stack of papers on a table in the hallway accessible to all by the medication room on the south wing of the building. The paper was titled, "6 Way Run Sheet", and contained information about all 41 residents residing on the South side of the facility. The information included residents first and last names, toileting status such as "I wear a pull up- toilet before/after meals", bed alarm status, fall matt status, caregiver gender preferences, room numbers, and various other resident care needs. There were multiple copies of the form on the table.

In an observation on 12/14/2023 at 12:46 PM, the medication cart in the North dining room was parked with the laptop open to resident information. Resident 15's information was open on the screen. Staff D, Medication Technician, was observed across the dining room with their back to the cart providing a resident with medication. Staff D returned to the medication cart, and clicked on a new resident on the screen of the computer. At 12:47 PM, Staff D was observed to walk to the middle of the dining room, with their back to the cart, to provide a resident with medications. The computer screen remained open and visible to Resident 16 information. Throughout the observation residents were noted walking into the dining room to be seated, walking past the open computer screen on the medication cart.

In an interview on 01/11/2024 at 11:06 AM, Staff A, Executive Director, stated if the medication technician walks away from the medication cart computer, they were to secure it so no resident identified information was visible.

Plan/Attestation Statement

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

Laundy Klau
Administrator (or Representative)

2/1/24
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(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 observation, interviews, and record review, the facility failed to implement infection control practices by staff not performing hand hygiene and dragging soiled linen and trash bags on the ground through the facility for 3 of 3 areas (north unit, south unit, and kitchen) reviewed. These failures placed 81 of 81 residents at risk for cross contamination and infection when care and services were provided and when food was prepared by the facility staff.

Findings included...

Record review of the facility's policy, "Handwashing", undated, showed "the purpose of good handwashing is to be the front-line protection of spread of infections. Handwashing is the single most important measure for preventing the spread of infection and disease. All staff will be responsible for carrying out the hand washing policy." Staff were to wash their hands after handling soiled laundry or items with body fluids and housekeeping tasks, before handling medication, before and after helping residents with personal care tasks of daily living, before handling of any food, whenever a person changes from a doing a "dirty" task to a "clean" task, and whenever hands are obviously soiled. "The use of gloves does not replace hand washing."

Record review of the Centers of Disease Control and Prevention (CDC) web site article titled, "hand hygiene in healthcare settings", dated 01/30/2020, showed "the Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. Health care facilities should require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. Ensure that supplies necessary

for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands."

In an observation and interview on 12/12/2023 at 5:37 AM, in the south side medication and charting room, Staff F, Medication Technician, reviewed the medication administration record (MAR) on the computer. Staff F went to the medication cart and pulled Resident 2's medication levothyroxine (a prescribed medication to help replace the thyroid hormone) bubble pack. Staff F popped the medication out of the bubble pack into the medication cup. Staff F crushed the pill and mixed with chocolate pudding. Staff was not observed to wash her hands or use hand sanitizer. Staff F walked to R2's apartment room. Staff F pulled their keys out and unlocked R2's bedroom door. Staff F administered R2 the mixed medication with pudding. Staff F left R2's room and returned to the medication/charting room. Staff F signed out the medication on the computer on R2's MAR. Staff F then pulled up Resident 3's MAR. Staff F returned to the medication cart and pulled R3's bubble pack and popped the medication into the medication cup. Staff F then closed the medication/charting room left to go to R3's room. Staff F was not observed to wash their hands or use hand sanitizer prior to popping R3's medication out into the medication cup or before leaving the medication/charting room. Staff F entered R3's room. R3 was lying in bed and noted to be sleeping. Staff F touched R3's arm and attempted to wake R3 up to take their medications. R3 did not want to take the medication. Staff F left R3's room and returned to the medication/charting room and used the computer to sign out the medication they administered. Staff F stated they were to wash their hands with any change in task. Staff F stated they used the hand sanitizer that was on top of the medication cart. Staff F did not have any hand sanitizer with them or observed to use the hand sanitizer that was on the medication cart that Staff F picked up and showed.

In an observation on 12/12/2023 at 6:31 AM, just outside of the north side dining room, there was a door with a keypad. A dietary staff member was in the dining room passing out clean utensils out on the table with blue disposable gloves on each hand. The unknown staff member came over to the door and typed in the code to the keypad with their gloved hand. The staff member then left and returned to pass out the clean utensils with the same gloves without changing them or washing their hands after touching the keypad.

In an observation and interview on 12/12/2023 at 6:21 AM, Staff X, Caregiver, was observed to exit a resident room on the north side hallway with a clear bag of soiled clothing items. Staff X walked down the hallway into the medication room and leaned against the door frame while still holding the bag of soiled clothing in her hands. Staff X then walked over to the table outside of the medication room, and began flipping through the shower book, while the bag of soiled clothing remained in her hands. Staff X was then observed to walk down the hallway, running her hands along the railing in the hallway, with the bag of soiled items in her hands. Staff X was observed to pick something up off the floor and dispose of it in a nearby trashcan. Staff X then reached into her pocket, removed the key to open the door to the closet where Staff X dropped off the bag of soiled clothing. Staff X then left the room and continued to walk down the hallway. Staff X was not observed to perform hand hygiene at any point since exiting the resident's room with the soiled items and after dropping off the soiled items. Staff X was asked when they should do hand hygiene, and they stated before and after each task. Staff X stated they had hand sanitizer they could use or they could wash their hands in the bathroom.

In an observation and interview on 12/13/2023 at 9:49 AM, Staff M, Caregiver, was observed dragging a large clear bag of soiled laundry on the floor down the north side hallway. Staff M was observed to drag, on the carpeted floor, the large bag of soiled laundry down the length of the hallway and around the corner into the locked room for soiled items. Staff M was observed to dispose of the items into the room, turn around and begin walking down the hallway. Staff M did not perform hand hygiene. When asked about handling soiled laundry and hand hygiene, Staff M stated they put on gloves, put the items in a bag, and put it in the soiled laundry bin. Staff M stated she had hand sanitizer in her pocket to perform hand hygiene, pulled the bottle out to show, and then put it back in her pocket. Staff M did not perform hand hygiene.

In an observation on 12/12/2023 at 12:07 PM, inside the kitchen at the steam table, Staff J, Cook, was wearing clear disposable gloves while plating ready to eat food. Staff J walked away from the steam table and grabbed a serving utensil from a bin on a different counter. Staff J returned to the steam table and picked up a piece of ready to eat meatloaf and placed it on a plate. Staff J then touched their apron with their gloved hands, walked away from the steam table, returned to the steam table with two pieces of ready to eat bread. Staff J cut the bread in half and placed it on a plate for a resident. Staff J was not observed to wash their hands or change their gloves after they had changed task or touched their apron. At 12:11 PM, Staff J was observed to remove their disposable gloves, and put on a new pair. Staff J was not observed to wash their hands after removing the prior pair of disposable gloves.

In an observation on 12/13/2023 at 10 AM, inside R8's apartment, Staff P, Caregiver, came into R8's room. Staff P pulled out a pair of disposable gloves from their pants pocket. Staff P was not observed to wash their hands or use hand sanitizer prior to putting gloves on. Staff P entered R8's bedroom area and made the bed. Staff P approached R8's spouse, touched their walker, and helped the spouse stand up with the same disposable gloves on. Staff P walked to the bathroom with the spouse and shut the bathroom door. Staff P assisted the spouse with toileting needs all with the same disposable gloves that they put on first entering the room. Staff P was not observed to change their gloves, wash their hands, or use hand sanitizer during the entire observation and change in tasks.

In an interview on 12/13/2023 at 5:30 PM, Staff A, Executive Director, stated all staff were to have hand sanitizer with them. Staff A stated all staff were to wash their hands with any change in activity or task, removal of gloves, or any if they are soiled. Staff A stated they should be carrying dirty linen and trash bags to the soiled linen room not dragging them on the ground.

This is a recurring deficiency previously cited on 01/05/2023 and 04/11/2023.

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) — Date: 2/1/24

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to have Registered Nurse (RN) Delegation services and documentation in place for 3 of 3 sampled residents (Resident 7 [R7], Resident 11 [R11], and Resident 5 [R5]). This failure placed all residents receiving RN delegated services at risk for receiving care and services by untrained staff.

Findings included...

"RCW 18.88B.070 Nurse delegated tasks. (3) The home care aide is accountable for his or her own individual actions in the delegation process. Home care aides accurately following written delegation instructions from a registered nurse are immune from liability regarding the performance of the delegated duties".

"WAC 246-840-910 Purpose. This rule defines a consistent standard of nursing care with the delegation of nursing tasks to nursing assistants or home care aides. The registered nurse delegator makes independent professional decisions of the delegation of a nursing task. A licensed registered nurse may delegate specific nursing care tasks to nursing assistants or home care aides meeting certain requirements and providing care to individuals in a community-based care setting defined by RCW 18.79.260 (3)(e)(i) and to individuals in an in-home care setting defined by RCW 18.79.260 (3)(e)(ii). Before delegating a task, the registered nurse delegator determines that specific criteria are met and the patient is in a stable and predictable condition. Registered nurses delegating tasks are accountable to the Washington state nursing care quality assurance commission. The registered nurse delegator, home care aide and nursing assistant are each accountable for their own individual actions in the delegation process. No person may coerce a registered nurse into compromising patient safety by requiring the registered nurse to delegate. Registered nurse delegators shall not delegate the following care tasks: (1) Administration of medications by injection (by intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) with the exception of insulin injections".

WAC 246-840-920 Definitions. (7) "Indirect supervision" means the registered nurse delegator is not on the premises. The registered nurse delegator previously provided written instructions for the care and treatment of the patient. The registered nurse delegator documents in the patient record the instruction to the nursing assistant or home care aide, observation of the delegated task, and confirmation of the nursing assistant's or home care aide's understanding the directions.

WAC 246-840-930 Criteria for delegation. (1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. ASSESS (3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition. (4) Determine the task to be delegated is within the delegating nurse's area of responsibility. (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or un[1]expected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent. (13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient. IMPLEMENT (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care. (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide,

including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

Record review of the facility's policy titled, "Medication Services", undated, showed "medication administration means a resident is not able to physically able to ingest or apply a medication independently or with assistance, so must have the medication administered by a person legally authorized to do so. If the resident cannot safely self-administer or self-administer with assistance and/or cannot indicate awareness that she or he is taking a medication, then the medication must be administered to the resident by a person legally authorized to do so." Under the section titled "medication administration", showed "residents that cannot indicate understanding that they are taking medications and/or do not have the ability to place the medications in their eyes, ears, or skin will receive medication administration services".

Record review of the facility's policy, "Delegation of Nursing Tasks", undated showed the registered nurse (RN) delegating the task retains the responsibility and accountability for the nursing care of the resident. The RN was responsible for evaluating the nursing needs of the residents, and the ability of the current staff to perform these tasks within the realm of the nurse delegation. Delegation would be in accordance with current nurse delegation regulations, boarding home regulations, and the nurse practice act of WA state.

Record review of the Department of Social and Health Services document titled, "Community Nure Delegation Orientation 2023", undated, under the section titled, "Planning", showed delegation was specific and focused to the client and their condition. A clear description of nursing task with step-by-step instructions, expected outcomes of the delegated nursing task, possible side effects of the medications prescribed, and how to document the nursing tasks as complete or omitted. Under the section titled "what is medication administration", showed "when a client is not functionally able and/or not cognitively aware they are receiving medications, the LTCW [long term care worker] is authorized to do so with delegation of the medication". Under the section titled, "nursing task sheet" showed the RN delegator was to be specific when giving examples of side effects and steps to perform tasks. There was to be a task sheet for each individual task, must have clear description of the procedure or steps to follow to perform the task, and instruct on how to document tasks in patient's record. The documentation must be client specific and include predictable outcomes of the nursing tasks and how to effectively deal with them, how to observe and report potential side effects or unexpected outcomes including when to notify the RN, primary care provider. The RN and the primary care provider contact information must be provided. Under the section titled, "nursing visit form", showed the form was used for assessment, supervisory 90-day visits, change of condition evaluations, change in a delegated task, delegation to a new LTCW or new task, and was essentially used as the RN delegators progress note. All delegation forms must be left where residents reside for compliance with the rules.

Record review of the Department of Social and Health Services document 13-678B titled,

"Instructions for Completing Nurse Delegation: Assumption of Delegation", dated 04/2013, showed all fields were required unless indicated optional. Under the section "reason/dates for assuming delegation", showed the RN delegator was to enter a reason other RN delegator rescinded and the day you assume responsibility for the delegation.

Record review of the Department of Social and Health Services document 13-678 titled, "Instructions for Completing Nurse Delegation: Instructions for Nursing Task", dated 09/2021, showed all fields were required unless indicated optional. Delegated task and expected outcome, showed the RN delegator was to enter the name of the task and what outcome was anticipated. Separate task sheet is required for each task. Steps to perform the tasks were to be written in simple language with individualized detail. Individualized side effects or unexpected outcomes were to be listed for when to report to the RN delegator. The health care providers name and telephone number were to be listed. Individualized side effects and unexpected outcome were to be listed for when to report to the health care provider. A list of signs and symptoms were to be listed for when to call 9-1-1 services. The RN delegated was to sign and date their signature.

Record review of the Department of Social and Health Services document 14-484 titled, "Instructions for Completing Nurse Delegation: Nursing Visit", dated 04/2013, showed all fields were required unless indicated optional. For the section "client requires nurse delegation for these delegated tasks" showed all tasks that the RN delegator was delegating were to be listed and a reason why the client needed to have tasks delegated documented. For the section Caregiver Training Competency showed the names of the caregivers being evaluated at that visit were to be listed. The RN delegator was to sign and date their signature on the form.

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selections" undated, showed there were 10 residents that were identified to have RN delegated services.

R7

Record review of R7's face sheet showed R7 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R7's "Master Assessment", dated 10/26/2023, showed R7 recently had a decline in cognitive condition required hospice services. Under the section titled "medication assistance" showed the facility was to assist R7 with all medication management. R7 were prescribed medication to be taken orally on the skin, and eye drops.

Record review of R7's "home health/hospice visit report", dated 11/09/2023, showed R7's ferrous sulfate (supplement vitamin to help build iron in the body), folic acid (supplement vitamin to help low blood count), magnesium oxide (vitamin to increase magnesium levels), Pradaxa (medication to help thin the blood), rosuvastatin (medication to help reduce cholesterol levels), and vitamin B12 (vitamin to replace B12 in body) were discontinued. R7's carvedilol (medication to help lower high blood pressure) was decreased down to take

only once a day for 4 days and then discontinued with the stop date on 11/12/2023.

Record review of R7's, untitled document, dated 11/29/2023, showed R7 had experienced vaginal pain, swelling, and bleeding. R7's physician ordered a new prescribed medication lidocaine oropharyngeal viscous to apply two times daily and as needed.

Record review of R7's "Nurse Delegation: Assumption of Delegation", dated 10/27/2023, showed the form was electronically signed and dated by Staff W, on 10/27/2023. In the section titled "Reason/dates for assuming delegation", showed on 10/27/2023, assumption of delegation for new delegating RN, on 10/17/2023 new delegating RN, and on 06/28/2023 resident has a change in condition and now requires delegation was documented for review. There was no reason documented why a new RN assuming delegation for review.

Record review of R7's "Nurse Delegation: Instructions for Nursing Task", dated 10/27/2023, showed R7 required delegated task for medications and treatments. Under the section titled, "list specific medications, dosages, and frequency of medications delegated on this date", showed R7s medications that included some but not all, carvedilol to be taken two times daily, folic acid, ferrous sulfate, magnesium oxide, Pradaxa, rosuvastatin, Orencia injection, aspercreme lotion, timolo maleate eye drops, preparation H gel, and multiple oral medication listed on the one nursing task form. Under the section titled, "steps to perform the task", showed "administer medications per the 5 rights of medication administration. Perform 3 safety checks prior to administration. Wear gloves when administering topical and eye drops. Wash hands/use sanitizer between care". Under the section titled, "health care provider name", showed there was no name of R7's healthcare provider documented. Under the section titled, "what to report to 9-1-1", showed "per policy, per PCP [primary care provider], per POA [power of attorney]". Under the section titled, "what to report to the health care provider", showed adverse effects and need for evaluation by PCP. There were no specific adverse effects listed for R7 specific medication.

Record review of R7's "Nurse Delegation: Nursing Visit", undated, showed a new delegating RN was evaluating. The form showed R7 required nurse delegation for tasks "medication administration and treatment management". There were no specific tasks listed. The form was unsigned and undated by the RN Delegator. There was no documentation on the nursing visit form to show what RN delegator completed the visit for R7's delegation. There were no other nurse delegation visit forms for R7 that showed and reflected the medication changes written on 11/09/2023 for review.

R11

Record review of R11's face sheet showed R11 moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R11's untitled document, dated 11/13/2023, showed R11's Humulin NPH was changed. R11 was to receive 45 units of insulin every morning and 27 units every evening per the physician.

Record review of R11's MAR, dated 12/01/2023 through 12/31/2023, R11's current physician order for Humulin NPH (long-acting insulin) showed for R11 to have 27 units injected every evening and 45 units injected every morning.

Record review of R11's "Nurse Delegation: Assumption of Delegation", dated 10/27/2023, showed the form was electronically signed and dated by Staff W, on 10/27/2023. In the section titled "Reason/dates for assuming delegation", showed on 10/27/2023, assumption of delegation for new delegating RN and on 10/16/2023 new delegating RN. There was no reason documented why a new RN assuming delegation for review.

Record review of R11's "Nurse Delegation: Instructions for Nursing Task", dated 10/27/2023, showed R711 required nurse delegated task for blood glucose (test that shows how much sugar is in the blood) and administering insulin per the primary care physician (PCP) orders on one nursing task form. There was no expected outcome documented for the nurse delegated tasks. Under the section titled, "list specific medications, dosages, and frequency of medications delegated on this date", showed R11's nightly blood sugar check with the direction to call the PCP if R11's blood sugar was less than 110 or greater than 260, Humulin N (long-acting insulin to help prevent blood sugars from being to high) 30 units every evening, and Humulin N 42 units every morning. The dose of the insulin to inject did not reflect the most updated physician order or MAR for R11. Under the section "what to report to the RN Delegator", showed any and all medication errors, side effects, and changes to delegated medications. There were no listed specific side effects related to R11's insulin that were documented for the medication technicians for review. The second page of the nursing task form was dated 10/27/2023 but was unsigned by the RN delegator. There were no other nursing task forms provided for R11 that reflected the change in R11's insulin doses that were ordered by the physician.

Record review of R11's "Nurse Delegation: Nursing Visit", undated, showed the visit was completed because of the new delegating RN. The form showed R11 required nurse delegation for tasks "capillary [superficial access to blood] blood glucose checks, insulin administration". The form was unsigned and undated by the RN Delegator. There was no documentation on the nursing visit form to show what RN delegator completed the visit for R11's delegation. There were no other nursing visit forms for R11's delegated services provided by the facility for the Department for review.

In an observation and interview on 12/13/2023 at 11:06 AM, R11's Lispro (short acting insulin) insulin pen was noted to have been dated open on 11/14/2023. Staff E stated they were not aware how long an insulin pen was good for once it had been opened. At 11:09 AM, Staff E stated they had asked the nurse and stated an insulin expires after 28 days of being opened. Staff E stated the Lispro insulin pen was expired and that they had administered that insulin to R11 that day, 12/13/2023.

R5

Record review of R5's face sheet, undated, showed R5 re-admitted to the facility on [redacted]/2023 with diagnoses to include [redacted].

Record review of R5's Service Plan Agreement, dated 10/09/2023, showed R5 spoke in word salad (words and phrases out of order or context), and to have short- and long-term memory loss. Received medication set-up. The service plan showed, "[R5] requires medication administration by staff. She can swallow medications whole without any

difficulty at this time. [R5's] medications will be set up for administration in accord with the physician's medication/treatment orders. Community to provide medication set-up services to support safe and effective medications administration practices."

Record review of R5's "Master Assessment", dated 11/13/2023, showed R5 had short term and long-term memory impairment. R5 was noted to be unable to use a call system and their needs were met by the service plan. R5 was noted to need community assistance with all medication management. R5 received oral medications and was noted to have no eye or ear drops.

Record review of a provider fax for R5, dated 09/06/2023, showed R5 was started on a prenatal vitamin for a diagnosis of [redacted].

Record review of R5's physician's orders, dated 11/08/2023, showed, "May crush all medications together and mix with food/drink." R5 was prescribed medicated eye drops, two drops in both eyes four times a day, with an order date of 11/01/2023.

Record review of R5's MAR, dated November 2023, showed R5 received medicated eye drops on 11/03/2023 through 11/09/2023.

In an interview on 12/14/2023 at 12:32 PM, Staff E, Medication Technician, stated that R5 received medicated eye drops for a period and that staff were the ones to administer the eye drops into R5's eyes as R5 was unable to do it herself. Staff E stated that R5 sometimes took her medications whole, other times they had to be spoon feed medications into her mouth as she would not know what to do with the medications, and other times the medications had to be crushed. When asked if Staff E was nurse delegated for R5, Staff E stated she was not, but was not sure how the facility did their nurse delegation process.

In an interview on 12/14/2023 at 3:59 PM, Staff C, Licensed Practical Nurse, was asked if R5 should have her medications delegated, and Staff C did not provide a response. Staff C did confirm R5 received crushed medications.

Record review on 12/12/2023 at 11:30 AM, of the RN Delegation binder provided by Staff A, showed there were resident consent forms for RN delegation and some staff credential verification and certificate forms for review. There were no resident nurse visits, nursing assessments, or nurse delegated tasks forms for review for any residents.

On 12/12/2023 at 11:35 AM, Staff W, RN Delegator stated all resident nurse delegation forms were saved electronically. The facility denied the Department to access all the residents electronic nurse delegated forms. Staff W stated there were only seven residents that required nurse delegated services. The Department requested all the current delegated resident's documents and the last 90-day evaluations be sent for review.

On 12/12/2023 at 2:20 PM, the Department received RN delegation forms that were current for seven residents. There were no prior RN delegation form provided for review to evaluate dates of prior RN evaluations.

On 12/12/2023 at 2:23 PM, the Department requested from Staff A, all resident that were on RN delegated services, their 90 days prior nurse visits be provided to the Department for review. Staff A stated they would have Staff W and Staff T get those records for review.

In an observation 12/12/2023 at 5:37 AM, Staff F, Medication Technician, crushed R14's levothyroxine and mixed with chocolate pudding. Staff F mixed the medication with the pudding. Staff F came to R14's room and stated R14's name. Staff F then scooped the medication mixed pudding onto the spoon and spoon fed R14 the mixture. R14 did not say anything during the entire interaction with Staff F.

In an interview on 12/12/2023 at 11:35 AM, Staff W, stated they were the RN delegator for the facility. Staff W stated there were only seven residents that required nursing tasks to be RN delegated.

In an interview on 12/12/2023 at 6:57 AM, Staff Q, Medication Technician, stated the facility just got a new RN delegator Staff W. Staff Q stated they were unaware where Staff W's contact information was located.

In an interview on 12/12/2023 at 12:51 PM, Staff E, Medication Technician, stated they would look in the blue RN delegation binder, that was stored in the south resident care managers office, to review what residents required nurse delegated tasks. Staff E stated they were not aware or how to access any electronic RN delegation forms for delegated residents for review.

In an interview on 12/12/2023 at 1:21 PM, Staff Q stated they did not know where to look to see if a resident required any nursing tasks to be RN delegated. Staff Q stated they were not taught to look anywhere in the facility's electronic records.

In an interview on 12/14/2023 at 1:05 PM, Staff E stated any resident that received eye drops and blood sugar checks would be RN Delegated. Staff E stated R11 was RN Delegated for their insulin and blood sugar checks. Staff E stated they were unaware when to call the RN Delegator or where to find the RN delegators contact information.

In an interview on 01/08/2024 at 12:08 PM, Staff Z, RN Delegator (former), stated they delegated 15 to 20 residents for delegated tasks prior to last day of employment as the RN delegator for the facility on 10/16/2023. Staff Z stated the nurse delegation forms were not printed and in written form for medication technician's or other staff for review. Staff Z stated all delegation forms were electronic. Staff Z stated when they delegated a new medication technician they would add on to their prior nurse visit form and not update to reflect the date they made the visit.

In an interview on 01/08/2024 at 1:59 PM, Staff W stated they were delegating any resident that required insulin administration or blood sugar checks and was provide a list of residents that were previously delegated. Staff W stated any resident that required the medication technicians to crush their oral medications and administer eye drops and the resident was unable to understand how to would require delegation for those tasks. Staff W stated the complete a new nurse visit form when a new medication technician was newly delegated. Staff W stated they had put all resident's medication that were delegated all on one task sheet as she was trained.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Administrator (or ~~Representative~~) — Date: 2/1/24

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(8) Medical and nursing services provided by the assisted living facility for a resident, including:

(a) A record of providing medication assistance and medication administration, which contains:

(iii) The signature or initials of the person providing any medication assistance or administration; and

(b) A record of any nursing treatments, including the signature or initials of the person providing them.

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to have the licensed practical nurse document that they administered 1 of 1 resident's injection (Resident 7 [R7]) on the medication administration record (MAR). This failure placed the R7's record to not have the most accurate documentation for review.

Findings included...

"WAC 246-840-700 Standards of nursing conduct or practice. (3) The following standards apply to registered nurses and licensed practical nurses: (b) The registered nurse and licensed practical nurse shall document, on essential client records, the nursing care given and the client's response to that care".

Record review of the facility's document titled, "documentation", undated, showed "if it was not documented, it did not happen."

Record review of R7's face sheet showed R7 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted]

[redacted]

Record review of R7's MAR, dated 11/01/2023 through 11/30/2023, showed R7 had an order for Orencia injection (prescribed medicated injection to help treat the symptoms from rheumatoid arthritis) administered weekly. Review of the administration on 11/03/2023, 11/10/2023, 11/17/2023, and 11/24/2023, showed Staff U, Medication Technician, was documented to have administered the medication on those dates. There was no documentation of the site of administration the injection was administered at on R7.

Record review of R7's MAR, dated 12/01/2023 through 12/13/2023, showed R7's Orencia injection was administered on 12/01/2023 by Staff U, and on 12/08/2023, Staff V, Medication Technician. There was no documentation that showed a licensed nurse had administered the medication.

Record review of R7's progress note dated 11/03/2023 at 3:46 PM, documented by Staff C, showed "Orencia injection 125 mg/ml [milligrams per milliliter] left upper abdomen". The progress noted only showed the location of where the injection was administered. The note did not indicate that the injection was administered by Staff C.

Record review of R7's progress note dated 11/10/2023 at 5:59 PM, documented by Staff C, showed "Orencia injection 125 mg/ml [milligrams per milliliter] right upper abdomen". The progress noted only showed the location of where the injection was administered. The note did not indicate that the injection was administered by Staff C.

Record review of R7's progress note dated 11/17/2023 at 4:26 PM, documented by Staff C, showed "Orencia injection 125 mg/ml [milligrams per milliliter] right lower abdomen". The progress noted only showed the location of where the injection was administered. The note did not indicate that the injection was administered by Staff C.

Record review of R7's progress note dated 11/24/2023 at 4:24 PM, documented by Staff C, showed "Orencia injection 125 mg/ml [milligrams per milliliter] left lower abdomen". The progress noted only showed the location of where the injection was administered. The note did not indicate that the injection was administered by Staff C.

Record review of R7's progress note dated 12/01/2023 at 4:17 PM, documented by Staff C, showed "Orencia injection 125 mg/ml [milligrams per milliliter] left upper abdomen". The progress noted only showed the location of where the injection was administered. The note did not indicate that the injection was administered by Staff C.

Record review of R7's progress note dated 12/08/2023 at 3:38 PM, documented by Staff C, showed "Orencia injection 125 mg/ml [milligrams per milliliter] left lower abdomen". The progress noted only showed the location of where the injection was administered. The note did not indicate that the injection was administered by Staff C.

In an interview and observation on 12/14/2023 at 3:14 PM, Staff E, Medication Technician, pulled up R7's MAR on their computer for review. The MAR showed R7's Orencia injection was administered by Staff C, Licensed Practical Nurse, on 10/13/2023 and 10/27/2023 that was documented in the comment section. Staff E stated the nurse administers the injection, but then the medication technician will document the administration on the MAR and then write that the LPN administered it. Review of the notes for November and December 2023 showed there were no other documented comments for the four

administrations of the Orencia injection in November 2023 and the two administrations for December 2023 that showed an LPN administered the injection.

In an interview on 12/14/2023 at 3:23 PM, Staff C stated they administer the Orencia injection to R7. Staff C stated they notify the medication technician after they administer the injection so they could document the injection on the MAR. Staff C stated they do not sign the injection out on the MAR themselves. Staff C stated they make a progress note in R7's progress notes, that they administered the injection. Staff C stated they did not know how to sign a medication out on the MAR. Staff C stated they should be signing on the MAR for the administration of the injection for R7 and not the medication technicians.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24.

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

Lawrence Lau — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have the residents service plan agreement (facility's version of the negotiated service plan) updated with the most accurate information for 5 of 5 residents (Resident 13 [R13], Resident 10 [R10], Resident 9 [R9], Resident 11 [R11], and Resident 5 [R5]). This failure placed all 4 residents to have unmet care needs and care staff uneducated and unable to provide the care and

services that the residents required.

Findings included...

Record review of the facility's policy, "Negotiated Service Agreements", undated, showed agreements would be based on the resident's assessed needs and would be developed with the input, participation, and agreement of the resident, responsible parties, case manager, community staff and others as appropriate and to the extent possible. The negotiated service plan would be updated to be consistent with the residents needs and when there has been an observed change in resident's physical, mental, or emotional function. The negotiated service plan would address all reasonable risk and how those risk would be managed. The negotiated service plan would be updated when it no longer addressed the residents needs and/or preferences.

R13

Record review of R13's face sheet showed R13 moved into the facility on [redacted]/2023.

Record review of R13's progress note, dated 09/10/2023 at 4:13 PM, showed R13 attempted to brush their teeth with a razor that had toothpaste on it. The caregiver removed all razors with blades from R13's room.

Record review of R13's Master Assessment (nurses assessment), dated 08/30/2023, showed R13 required one-person physical assistance with grooming that included shaving. Facility staff were to use an electric razor and not to shave with safety razors. R13' fall risk evaluation showed R13 was a high fall risk. R13 had a history of falling out of bed. R13's nightstand was removed from their room and R13's bed was moved against the wall. R13 required medication assistance for oral medications.

Record review of R13's Service Plan Agreement (facility's version of negotiated service plan), dated 10/01/2023, showed R13 was able to speak clearly with some word salad. For grooming services R13 was able to brush teeth independently with reminder. R13 required physical assistance with shaving. The service plan did not indicate the R13 was not to use safety razors for shaving and only an electric razor as indicated on the nursing assessment. The service plan did not show that R13 had a history of attempting to brush their teeth with a razor and that razors were not to be stored in R13's room. R13 was shown to be a low fall risk. There was no documentation that R13's had history of falls and recently R13's bed was moved up against the wall related to them falling out of bed at night. The service plan showed R13 required medication administration by the facility staff. This was not that same as the nurse's assessment.

In an interview on 12/13/2023 at 11 AM, Staff D, Medication Technician, stated R13's typically tired all day.

R10

Record review of R10's face sheet showed R10 moved into the facility on [redacted]/2023.

Record review of R10's, Master Assessment, dated [redacted]/2023, showed R10's medical history included a history of non-injury falls. R10's fall risk evaluation under history of falls, showed "n/a [not applicable]".

Record review of R10's Service Plan Agreement, dated 11/28/2023, showed R10 has a history of non-injury falls and required safety checks. There were no other fall interventions in place to help reduce the risk of falls for R10.

Record review of R10's progress note, dated 11/29/2023 at 9:53 AM, showed R10 was found on the ground in their room.

Record review of R10's progress note, dated 11/30/2023 at 4:08 PM, showed R10 was found lying on their back with legs extended out in their room. R10 reported they fell.

R9

Record review of R9's face sheet showed R9 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R9's Master Assessment, dated 09/06/2023, was R9's pre-admission assessment for evaluation for possible facility placement. The assessment showed R9 had slipped in the shower two months prior. Under the section titled, "fall risk evaluation", for the question of history of falls, showed there was nothing marked for the R9's slip in the shower two months prior. R9 required verbal and set up assistance with their TED hose

Record review of R9's progress note dated 09/19/2023 at 11:11 AM, showed caregivers reported that R9 was incontinent of urine and urinated on the bathroom floor. R9's spouse was called at 1:53 PM, for a request that briefs were brought in for R9 to use at night.

Record review of R9's progress note, dated 09/20/2023 at 8:34 AM, showed R9 was mainly incontinent of urine at night and required the use of briefs.

Record review of R9's progress note, dated 10/19/2023 at 8:10 PM, showed R9 grabbed the caregiver's buttocks very tightly. The caregiver told R9 that was inappropriate and R9 smiled at the caregiver.

Record review of R9's Master Assessment, dated 10/12/2023, under the section, medical history, showed R9 had a slipped during a shower two months prior. R9 required verbal and standby assisting with putting on and taking off their TED hose (tight socks that compress the legs to help blood and fluid flow). R9's fall risk evaluation section showed "n/a" for history of falls.

Record review of R9's Service Plan Agreement, dated 10/31/2023, showed R9 required safety checks during each shift as R9 adjusted to new placement to the facility. R9's service plan did not indicate that R9 required assistance from the staff to help put on and take of their TED hose. The service plan did not show that R9 had a fall two months prior or that R9 was a fall risk. R9 required one person assistance as they were incontinent of urine. There was no documentation that showed R9 was incontinent of urine at night and required to use disposable undergarments. R9 had a history of delusions about the government or people after them. There was no documentation that R9 had a history of in appropriately touching caregivers during care.

R11

Record review of R11's face sheet showed R11 moved into the facility on [redacted]/2022, with

multiple medical diagnoses that included [redacted], and [redacted].

Record review of R11's MAR, dated 12/01/2023 through 12/13/2023, showed R11 required their blood sugar checked four times daily and insulin administered from two to four times daily.

Review of R11's Master Assessment, dated 10/12/2023, showed R11 was on a low concentrated sweets diet. R9 required insulin administration and fasting blood sugar checks two times daily. R9 had a history of multiple falls from rolling off of the couch or bed while sleeping. R9's required frequent safety checks and apartment to be checked for safety hazards were in place to help reduce R9's risk of falls. R11 had a history of a skin rash and no other skin care needs.

Record review of R11's Service Plan Agreement, dated 10/12/2023, showed R11 was independent with all eating. There was nothing document that showed R11 was non complaint with eating on a low concentrated sweets diet and interventions in place for the caregivers to follow if observed R11 to make poor diet choices. Under the section titled, diabetes mellitus, showed R9 required insulin administration by the medication technicians two times daily and blood sugars. R9 preferred to sleep in their chair as it was uncomfortable to lay flat on their back. R9 had a history of falls at night that required R9 to use a fall mat next to their bed to help prevent injuries. There was nothing documented that R9's bed was up against the wall. There were no interventions in place when the resident slept in their recliner and past falls from their recliner.

Record review of R11's progress note, dated 09/11/2023 at 4:34 PM, showed R11 had a wound to be coccyx area that was open and required a dressing.

Record review of R11's progress note, dated 10/17/2023 at 6:33 AM, showed R11 was heard yelling for help, when caregivers found R11 on the floor in front of R11's recliner face down on the carpet.

Record review of R11's progress note, dated 10/23/2023 at 1:50 PM, showed R11 was heard calling. R11 was anxious when caregivers arrived. R11 was observed lying on the floor in front of their personal recliner.

In an interview on 12/14/2023 at 1 PM, Staff E, Medication Technician, stated R11 sat in their recliner chair most of the time when they were in their room. Staff E stated they do random safety checks to help prevent and reduce R11 from falling.

R5

Record review of R5's face sheet, undated, showed R5 re-admitted to the facility on [redacted]/2023 with diagnoses to include [redacted].

Record review of a provider fax for R5, dated 09/06/2023, showed R5 was started on a prenatal vitamin for a diagnosis of [redacted].

Review of R5's MAR, dated November 2023, showed R5 received medicated eye drops on 11/03/2023 through 11/09/2023.

Record review of R5's physician's orders, dated 11/08/2023, showed, "May crush all medications together and mix with food/drink." R5 was prescribed medicated eye drops, 2 drops in both eyes 4 times a day, with an order date of 11/01/2023.

Record review of R5's "Master Assessment", dated 11/13/2023, showed R5 had short term and long-term memory impairment. R5 was noted to be unable to use a call system and her needs were met by the service plan. R5 was noted to need community assistance with all medication management. R5 received oral medications and was noted to have no eye or ear drops.

Record review of R5's Service Plan Agreement, dated 10/09/2023, showed R5 spoke in word salad (words and phrases out of order or context), and to have short- and long-term memory loss. received medication set-up. The Service plan showed, "[R5] requires medication administration by staff. She can swallow medications whole without any difficulty at this time. [R5's] medications will be set up for administration in accord with the physician's medication/treatment orders. Community to provide medication set-up services to support safe and effective medications administration practices." The service plan did not indicate that R5's medication required to be crushed for administration and that R5 had a history of eating nonedible items with a diagnosis of [redacted].

In an interview on 12/14/2023 at 12:32 PM, Staff E, Medication Technician, stated that R5 received medicated eye drops for a period and that staff were the ones to administer the eye drops into R5's eyes as R5 was unable to do it herself. Staff E stated that R5 sometimes took her medications whole, other times they had to be spoon feed medications into her mouth as she would not know what to do with the medications, and other times the medications had to be crushed. When asked if Staff E was nurse delegated for R5, Staff E stated she was not, but was not sure how the facility did their nurse delegation process.

In an interview on 12/14/2023 at 3:59 PM, Staff C, Licensed Practical Nurse, was asked if R5 should have her medications delegated, and Staff C did not provide a response. Staff C did confirm R5 received crushed medications.

In an interview on 12/14/2023 at 1:13 PM, Staff B, Resident Care Manager/Licensed Practical Nurse, stated they placed every new resident on safety checks. Staff B stated if a resident had a history of slipping out of bed they would not be identified as a high fall risk. Staff B stated only care related services from the nursing assessment was transcribed to the residents service plan. Staff B stated they do not document on the service plan when a resident's bed was up against the wall. Staff B stated the beds position would be related to care services. Staff B stated they did put R10's bed up against the wall after they had a fall and got their feet tangled with the bed linens. Staff B stated R10 does not sleep at night and that increase R10's risk for falls.

In an interview on 12/14/2023 at 2: 16 PM, Staff B stated either Staff C, Licensed Practical Nurse, or themselves complete the resident assessment and then develop and update the resident's service plans. Staff B stated the service plan contents was to have all the care and services that the care staff needed to know to care for the resident. Staff B stated if a resident took their medications crushed, how they get their care provided with number of staff, any grooming needs or precautions, things to observed with the residents' skin and whom to report to that were some of the things that would be documented on the service plan. Staff B stated a bed up against the wall would be a care need that care staff would need to know.

In an interview on 12/14/2023 at 3:23 PM, Staff C, Licensed Practical Nurse, stated they do not add on the resident's service plan if one side of the resident's bed was up against the wall. Staff C stated they would put if a resident used a fall mat or any other device.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2720 Timing of disclosure.

(1) The assisted living facility must provide the disclosure form completed by the assisted living facility:

(a) In response to a request by a prospective resident or his or her representative, if any, for written information about the assisted living facility's services and capabilities; or

(b) At the time the assisted living facility provides an application for residency, an admission agreement or contract, if not previously received by the prospective resident or his or her representative, if any.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide a copy of the disclosure of services and have the family or residents representative sign that they received it for 4 of 9 sampled residents (Resident 8 [R8], Resident 5 [R5], Resident 6 [R6], and Resident 10 [R10]). This failure placed all 4 residents, resident representatives, and any visitor at the facility from having knowledge of what services the facility provided.

Findings included...

Record review of R10's face sheet, showed R6 moved into the facility on [redacted]/2023.

Record review of R10's,"Acknowledgement of Disclosure of Service", was signed and dated by the representative for R10 and the facility's representative on 12/13/2023.
There was no disclosure of services provided that was dated prior 12/13/2023 for review.

Record review of R5's face sheet, showed R6 moved into the facility on [redacted]9/2023.

Record review of R5's "Acknowledgement of Disclosure of Service", was signed and dated

by the power of attorney for R5 and the facility's representative on 12/13/2023.
There was no disclosure of services provided that was dated prior 12/13/2023 for review.

In an interview on 12/13/2023 at 2:31 PM, Staff S, Receptionist/Marketing Assistant, stated R10's disclosure of services was signed that day. Staff S stated the facility did not have a signed disclosure of services for the Department to review for R6 and R8. Staff S stated the facility was waiting for the family and/or resident representative to come into the facility to sign the document today 12/13/2023.

Record review of R6's face sheet, showed R6 moved into the facility on [redacted]/2023.
On 12/13/2023 at 3:13 PM, Staff S provided the Department a copy of R6's "Acknowledgement of Disclosure of Service", that was signed and dated by the representative for R6 and the facility's representative on 12/13/2023. There was no disclosure of services provided that was dated prior 12/13/2023 for review.

Record review of R8's face sheet, showed R8 moved into the facility on [redacted]/2023.

On 12/13/2023 at 3:45 PM, Staff S provided the Department a copy of R8's "Acknowledgement of Disclosure of Service", that was signed and dated by the representative for R8 and the facility's representative on 12/13/2023. There was no disclosure of services provided that was dated prior 12/13/2023 for review.

In an interview on 12/14/2023 at 9:13 AM, Collateral Contact 2 (CC2), Son and Power of Attorney for R8, stated the facility provided a list of disclosure of services to them to review a few days prior from today 12/14/2023. CC2 stated the facility requested that they signed a document that they received it on 12/13/2023. CC2 stated they had not been provided a disclosure of services upon R8's admission to the facility.

In an interview on 01/08/2024 at 12:27 PM, Staff A, Executive Director, stated Staff Y, Marketing Director, was responsible to ensure all potential and new residents and/or their responsible party sign that they have received the disclosure of services before they move in. Staff A stated then marketing assistant would review the resident file for all the required signatures needed and if there were any missing, Staff Y would be notified to obtain the signature.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have 1 of 1 resident's (Resident 10 [R10]) medication at the facility and available to be administered when the resident was experiencing behaviors. This failure placed the resident at risk for unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's policy "unavailable medications", undated showed "it is the policy of the community to provide medications to residents in a timeframe and in a manner that promotes health and welfare." When the resident and/or the responsible party was responsible to obtain the medications for the resident, the designated staff would contact the resident/responsible party and explain concerns regarding medications being unavailable. After talked with the resident/responsible party if the medications would not be available to the resident in the timeframe needed, the designated staff person would contact the prescriber of the medication and the incident would be documented in the resident's health file, and the administration would take proper steps to ensure that medications were delivered in a timely manner.

Record review of R10's face sheet showed R10 moved into the facility on [redacted]/2023.

Record review of R10's, Service Plan Agreement, dated [redacted]/2023, showed R10 the facility managed their medications. R10 received their medications from their own pharmacy. R10 was diabetic (bodies inability to regulate high blood sugar levels within the blood) but did not require medications or blood sugar checks. The service plan did not show that R10 had any history of behaviors for care staff to know of.

Record review of R10's "Master Assessment", dated [redacted]/2023, showed R10 had dementia (progressive brain disorder that effects one's ability to think, remember, and can affect one's ability to perform daily life tasks and activities). R10 required occasional redirection when disoriented to person, place or time. Staff were to collaborate with family that were heavily involved with physical and emotional needs. R10 used an outside pharmacy for their medication. The facility was to assist with all R10's medication management. Under the section titled, "nurse case management services", showed R10 was pleasant with a good sense of humor. R10 spoke clearly and was able to communicate their needs with some forgetfulness. R10 was recently admitted to the facility from home and could present with some challenges with adjustment away from spouse. There were no other documented behaviors for R10.

Record review of R10's Medication Administration Record, dated 12/01/2023 through 12/13/2023, showed R10 had an order for olanzepine (precribed medication to help treat mental health conditions or behaviors) 5 milligrams (mg) take one tablet every 12 hours as needed for agitation.

Record review of R10's "Receipt of Medication", dated [redacted]/2023, showed R10 did not have a supply of olanzepine that was delivered to the facility that day R10 admitted.

Record review of R10's progress note, dated 12/07/2023 at 3:20 PM, showed R10 experienced aggressive behaviors towards staff that required an olanzepine.

Record review of R10's progress note, dated 12/07/2023 at 3:20 PM, showed the facility contacted the power of attorney of R10 to order R10's olanzepine for the facility to have on hand. There were no other progress notes since admission on [redacted]/2023, that showed R10's responsible party was notified that R10 did not have this medication at the facility and available for administration as needed.

In an observation on 12/12/2023 at 6:50 AM, in the north medication cart, R10 had seven bottles of prescribed medications. There was not a bottled of olanzepine supply for R10 in the medication cart.

In an interview on 12/14/23 at 1:48 PM, Staff D, Medication Technician, stated R10 did not have a supply of olanzepine from the facility in their name. Staff D stated R10 received their medications from an outside pharmacy and R10's responsible party were to bring them to the facility. Staff D stated as of 12/14/2023 R10 olanzepine was still not at the facility and available for administration if needed.

In an interview on 12/14/2023 at 2:16 PM, Staff B, Resident Care Manager/Licensed Practical Nurse, stated R10 did not have a supply of olanzepine prescribed in their name available at the facility for use.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Lawrence Lau — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-2220 Prescribed medication authorizations.

(1) Before the assisted living facility may provide medication assistance or medication administration to a resident for prescribed medications, the assisted living facility must have one of the following:

(a) A prescription label completed by a licensed pharmacy;

(2) The documentation required above in subsection (1) of this section must include the following information:

(a) The name of the resident;

(b) The name of the medication;

(c) The dosage and dosage frequency of the medication; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to administer medications as they were ordered by the prescribed physician for 2 of 2 residents (Resident 10 [R10] and Resident 11 [R11]. This failure placed the residents at risk for medical complications and unmet care needs.

Findings included...

RCW 69.41.050 Labeling requirements—Penalty. (1) To every box, bottle, jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of patient and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he or she determines that his or her patient should not have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with federal law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient.

Record review of the National Library of Medicine website article titled, Nursing Rights of Medication Administration, dated 09/04/2023, showed "it is standard during
nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. These 'rights' came into being during an era in medicine in which the precedent was that an error committed by a provider was that provider's sole responsibility and patients did not have as much involvement in their own care." The five traditional rights included the right patient, right drug, right route, right time, and right dose.

R10

Record review of R10's face sheet showed R10 moved into the facility on [redacted]/2023.

Record review of R10's, Service Plan Agreement, dated [redacted]/2023, showed R10 the facility managed their medications. R10 received their medications from their own pharmacy. R10 was diabetic (bodies inability to regulate high blood sugar levels within the blood) but did not require medications or blood sugar checks. The service plan did not show that R10 had any history of behaviors for care staff to know of.

Record review of R10's "Master Assessment", dated [redacted]/2023, showed R10 had dementia (progressive brain disorder that effects one's ability to think, remember, and can affect one's ability to perform daily life tasks and activities). R10 required occasional redirection when disoriented to person, place or time. Staff were to collaborate with family that were heavily involved with physical and emotional needs. R10 used an outside pharmacy for their medication. The facility was to assist with all R10's medication management. Under the section titled, "nurse case management services", showed R10 was

pleasant with a good sense of humor. R10 spoke clearly and was able to communicate their needs with some forgetfulness. R10 was recently admitted to the facility from home and could present with some challenges with adjustment away from spouse. There were no other documented behaviors for R10.

Record review of R10's Medication Administration Record (MAR), dated 12/01/2023 through 12/13/2023, showed R10 had an order for olanzepine 5 milligrams (mg) take one tablet every 12 hours as needed for agitation. R10 was administered a dose of olanzepine on 12/07/2023 at 12:23 PM.

Record review of R10's "Receipt of Medication", dated [redacted]/2023, showed R10 did not have a supply of olanzepine that was delivered to the facility the day R10 admitted on [redacted]/2023.

In an observation on 12/12/2023 at 6:50 AM, in the north medication cart, R10 had seven bottles of prescribed medications. There was no bottled supply of olanzepine (prescribed medication to help treat mental health and behaviors) for R10 in the medication cart.

Record review of R10's progress note, dated 12/07/2023 at 3:20 PM, showed R10 experienced aggressive behaviors towards staff that required an olanzepine. R10 that morning had not come to the dining room for breakfast and slept.

Record review of R10's progress note, dated 12/07/2023 at 3:20 PM, showed the facility contacted the power of attorney of R10 to order R10's olanzepine for the facility to have on hand.

In an interview on 12/12/2023 at 5:45 AM, Staff F, Medication Technician, stated they were not allowed to administer another resident's medication and administer it to another resident. Staff F stated the medication had to be prescribed to the resident for the medication technician to administer the medication.

In an interview on 12/14/2023 at 1 PM, Staff E, Medication Technician, stated they could not administer medication from another resident to administer to a resident that did not have a supply in their name.

In an interview on 12/14/2023 at 1:48 PM, Staff D, Medication Technician, stated they did not have R10's olanzepine to administer. Staff D stated they administered another residents supply of olanzepine to R10. Staff D stated the other resident that had the olanzepine supply, no longer resided at the facility. Staff D was unable to show the Department the medication that Staff D used to administer to R10.

In an interview on 12/14/2023 at 2:16 PM, Staff B, Resident Care Manager/Licensed Practical Nurse, stated they were aware that Staff D administered another resident's supply of onlanzepine to R10. Staff B stated they gave Staff D permission to use a dose of Resident 9's supply of olanzepine.

In an interview on 12/14/2023 at 3:14 PM, Staff A, Executive Director, stated the medication technician's and the nurses were only to administer medications that were prescribed and labeled by the pharmacy in the resident's name. The medication technician's and the nurses were not allowed to administer a resident's medication to another resident if the medication supply was not available for the intended resident.

R11

Record review of R11's, MAR's, dated 09/01/2023 through 12/13/2023, showed R11 had an order for acetaminophen (APAP) 325mg take two tablets by mouth four times daily as needed for pain. R11 had been administer the APAP routinely four times daily except for the times they were out of the facility every day.

Record review of R11's, Cycle Review Worksheet, dated 06/14/2023, from the local pharmacy that R11 used, showed on 06/14/2023 the order acetaminophen 325mg tablets take two tablets four times daily was handwritten. There was a typed note dated 06/18/2023, showed "the order we have on file for the APAP [acetaminophen] is a PRN [as needed] order and will not be included in the cycle. Please request when needed."

In an interview and observation on 12/14/2023 at 1 PM, Staff C, Licensed Practical Nurse, read R11's APAP order on the electronic MAR on the computer. Staff C stated the order was an as needed medication and would be administered upon request. Staff C stated that was the current order the medication technicians were to administer. The order on the electronic record showed the APAP order was started on 01/31/2023. Staff C was unaware as to why R11 was administered the APAP four times a day routinely.

In an interview on 12/14/2023 at 3:23 PM, Staff C stated the current order that the pharmacy had on filed for R11's APAP was to only be administered as needed dated from 06/18/2023. Staff C stated the pharmacy was going to correct the MAR to reflect the as needed order.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Laumya Rai — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to dispose of medications for residents that no longer resided at the facility for 1 of 1 medication/charting rooms observed. The facility failed to ensure residents medications orders were followed as prescribed for 2 of 2 sampled residents (Resident 6 [R6], and Resident 10 [R10]) per the physicians prescribed orders and parameters. The facility failed to ensure 1 of 1 residents (Resident 11 [R11]) insulin was not administered after it was expired. The facility failed to ensure 2 of 2 residents (Resident 10 [R10] and Resident 9 [R9]) medications were only administered to themselves as labeled per the prescribed physician and pharmacy. These failures contributed to R10 experiencing side effects to receiving non prescribed medications and being hospitalized, and placed all residents at risk for improper handling, disposal, storage, and administration of medications and placed residents at risk for harm, medication errors, and misuse of medication.

Findings included...

Record review of the facility's policy, "disposal of medications', undated, showed "it is the policy of the community to ensure that all residents medications are disposed of in such a way as it cost saving and efficient for the resident, and within the boarding home and pharmacy regulations". The facility was to dispose medications when a medication was expired or outdated, medication was discontinued, medication that was left after a resident moved out of the facility or had passed away. Medications that were expired or left at the facility, were to be destroyed by a licensed nurse or administrator and witnessed by another employee. If a resident leaves a community and the medications were declined to be taken by the responsible party or family, the medications would be retained and disposed of after 30 days or at the time of the expiration which every was sooner. Disposal would be documented in the residents record on and on the community disposal sheet and co-signed by two staff members, one of which is a licensed staff or the administrator. All expired, outdated, or discontinued medications shall be removed from the boarding home premises within 90 days of discontinuation of use.

Record review of the American Diabetes Association website article, "Diabetes Disaster Response Coalition, Safe Storage of Insulin", undated showed "people with diabetes who use it, insulin is a vital need. It's important to store insulin as directed so that it remains usable by those who need it. Follow these tips to ensure effective insulin storage." Under the section titled "know its expiration date", showed "insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days and continue to work".

"RCW 69.41.050 Labeling requirements—Penalty. (1) To every box, bottle, jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete

directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of patient and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he or she determines that his or her patient should not have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with federal law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient.

Record review of the National Library of Medicine website article titled, Nursing Rights of Medication Administration, dated 09/04/2023, showed "it is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. These 'rights' came into being during an era in medicine in which the precedent was that an error committed by a provider was that provider's sole responsibility and patients did not have as much involvement in their own care." The five traditional rights included the right patient, right drug, right route, right time, and right dose".

Administering Resident Prescribed Medications

Record review of R10's face sheet showed R10 moved into the facility on [redacted]/2023.

Record review of R10's "Master Assessment", dated [redacted]/2023, showed R10 had dementia (progressive brain disorder that effects one's ability to think, remember, and can affect one's ability to perform daily life tasks and activities). R10 required occasional redirection when disoriented to person, place or time. Staff were to collaborate with family that were heavily involved with physical and emotional needs. R10 used an outside pharmacy for their medication. The facility was to assist with all R10's medication management. Under the section titled, "nurse case management services", showed R10 was pleasant with a good sense of humor. R10 spoke clearly and was able to communicate their needs with some forgetfulness. R10 was recently admitted to the facility from home and could present with some challenges with adjustment away from spouse. There were no other documented behaviors for R10.

Record review of R10's, Service Plan Agreement, dated [redacted]/2023, showed R10 the facility managed their medications. R10 received their medications from their own pharmacy.

Record review of R10's Medication Administration Record, dated 12/01/2023 through 12/13/2023, showed R10 had an order for Olanzepine (prescribed medication to help treat mental illness and/or behaviors) 5 milligrams (mg) take one tablet every 12 hours as needed for agitation. On 12/07/2023 at 12:23 PM, R10 was administered a dose of Olanzepine for aggression.

Record review of R10's "Receipt of Medication", dated [redacted]/2023, showed R10 did not have a supply of Olanzepine that was delivered to the facility the day R10 admitted on [redacted]/2023.

Record review of R10's progress note, dated 12/07/2023 at 3:20 PM, showed R10 experienced aggressive behaviors towards staff that required an Olanzepine. R10 that morning had not come to the dining room for breakfast and slept.

Record review of R10's progress note, dated 12/07/2023 at 3:20 PM, showed the facility contacted the power of attorney of R10 to order R10's Olanzepine for the facility to have on hand.

In an interview on 12/14/2023 at 1:48 PM, Staff D, Medication Technician, stated they did not have R10's Olanzepine to administer. Staff D stated they administered another resident's olanzapine supply to R10. Staff D stated the other resident no longer resided at the facility. Staff D stated they were unable to remember who the other resident was that they used the olanzapine from. Staff D stated the other residents supply of Olanzepine was in a bin waiting to be destroyed. Staff D was unable to show the Department the other residents supply of olanzapine as it had been destroyed since the administration to R10 and unable to show the Department the medication used. Staff D was unable to provide the name of the prior resident that the Olanzepine was prescribed for. Staff D stated Staff B, Resident Care Manager/Licensed Practical Nurse, gave them permission to use the prior residents Olanzepine for R10 to treat their behavior.

In an interview on 12/14/2023 at 2:16 PM, Staff B stated Staff D had come to her about R10 not having their medication Olanzepine available to administer when R10 was having behaviors on 12/07/2023. Staff B stated they gave Staff D permission to use R9's dose of Olanzepine. Staff B stated Staff D told them that the dose was the correct amount. Staff B stated they did not verify the medication was correct dose as R10's prescribed order. Staff B stated Staff D was only given permission to administer that one dose of R9's medication to R10. Staff B stated R9 had not used their as needed supply of Olanzepine since September 2023.

Record review of R9's medication bubble pack for Olanzepine tablet 10 mg, fill date 09/18/2023, showed there were two half tablets missing from bubble number 29 and bubble number 28. The half tablet in bubble 30 had been popped out then replaced and taped shut.

Record review of R9's MAR's dated 09/16/2023 through 12/13/2023 showed R9 had not experienced any agitation and showed R9 had not been administered their as needed Olanzepine.

Record review of R10's progress note, dated 12/08/2023 at 10:44 AM, was a late chart note for 12/07/2023, showed R10 at the beginning of the shift was in a deep sleep and care staff had a difficult time waking R10 up. R10 had gotten up and was noted to slur their words, unable to form sentences, and had a hard time keeping themselves upright and leaned to the side. At 8:30 PM, emergency medical services evaluated and transported R10 to the hospital for further evaluation.

Disposal of medications

Record review of the facility's, untitled document, dated 12/12/2023, showed a list of residents that moved into and out of the facility in the last three months. Review of the document showed R12 passed away on [redacted]/2023.

In an observation and interview on 12/12/2023 at 6:57 AM, in the north medication/charting room were five plastic bins full of cards with bubbles filled with medications for multiple residents. Staff F, Medication Technician, stated the medications were either expired, medication that were discontinued, or resident that no longer resided at the facility. Staff Q stated the resident care manager was to destroy the medications.

Staff Q stated the medications typically just stack up in the medication room. Observation of one of the bins showed there were multiple cards of prescribed medications labeled with R12's name. There were medication bubble pack cards for R13.

Record review of an email sent to the Department on 01/02/2024 at 9:13 AM, by Staff A, Executive Director, showed Collateral Contact 3 (CC3), Resident at another facility, showed they never resided at the facility.

In an interview on 12/14/2023 at 1:13 PM, Staff B, Licensed Practical Nurse/Resident Care Manager, stated medications that were discontinued, expired, or the resident had passed away were to be destroyed and mixed with cat litter. Staff B stated a licensed nurse and a medication technician were to destroy the medication expect for narcotics (medications that are regulated and need to be accounted for). Staff B stated the medications were to be destroyed when it was necessary. Staff B stated they were aware there were multiple medications that had been expired, discontinued, or resident no longer resided at the facility that needed to be destroyed in the north medication/charting room.

Expired medication administration

In an observation and interview on 12/13/2023 at 11:06 AM, R11's Lispro insulin pen was noted to have been dated open on 11/14/2023. Staff E stated they were not aware how long an insulin pen was good for once it had been opened. At 11:09 AM, Staff E stated they had asked the nurse and stated an insulin expires after 28 days of being opened. Staff E stated the Lispro insulin pen was expired and that they had administered that insulin to R11 that day, 12/13/2023.

Medication Parameters

R6

Record review of R6's face sheet, undated, showed R6 admitted to the facility on [redacted]/2023 with diagnoses to include [redacted], and [redacted].

Record review of R6's "Master Assessment", dated 11/30/2023, showed R6 was to receive assistance with all medication management from the facility.

Record review of R6's Service Plan Agreement (facility's version of the Negotiated Service Agreement), dated 12/01/2023, showed R6 received medication management. R6 had oral medication, eye drops, and topical cream that were prescribed and administered to them.

Record review of R6's, Medication Administration Record (MAR), dated December 2023, showed R6 was prescribed Amlodipine (prescribed medication to help lower high blood pressure) tab by mouth for hypertension. The instructions informed staff to hold the medication if the systolic blood pressure ((SBP) top number of the blood pressure reading) was less than 100 or if the diastolic (bottom number of the blood pressure reading) was less than 60. Staff were to notify the physician if the medication was held more than 3 times in a 7-day period. The instructions continued with, "IF RESIDENT'S SBP IS GREATER THAN 165 ADMINISTRER PRN [as needed] HYDRALAZINE." The MAR showed that the staff were to record R6's blood pressure results on the mar in the AM and the PM. For

12/01/2023 through 12/09/2023 the section to record R6's blood pressures were blank, and the medication was noted as given daily. On 12/13/2023 R6's blood pressure results were 110 systolic over 45 diastolic blood pressure, and R6 received the medication even though R6's blood pressure was out of parameters.

R10

Record review of R10's face sheet showed R10 moved into the facility on [redacted]/2023.

Record review of R10's "Master Assessment", dated [redacted]/2023, showed R10 had dementia (progressive brain disorder that effects one's ability to think, remember, and can affect one's ability to perform daily life tasks and activities). R10 required occasional redirection when disoriented to person, place or time. Facility was to assist with all medication management. Under the section titled "health monitoring", showed R10 did not required vital sign monitoring needs.

Record review of R10's, Service Plan Agreement, dated [redacted]/2023, showed the facility managed R10's medications. R10 received their medications from their own pharmacy.

Record review of R10's MAR, dated 12/01/2023 through 12/13/2023, showed R10 had an order for lisinopril (prescribed medication to help lower high blood pressure) take one tablet every morning hold for systolic (top number of the blood pressure reading) less than 100 or diastolic (bottom number of the blood pressure) blood pressure less than 60. Review of the administrations showed on 12/04/2023 through 12/09/2023 there was no documented blood pressure reading for the administered medication.

In an interview on 12/22/2023 at 1:58 PM, Staff T, Regional Support Specialist/Licensed Practical Nurse, stated if there was a specific parameter on the medication order, the parameter should be followed as it was listed.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24.

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician for 1 of 1 sampled residents (Resident 11 [R11]) when their blood sugar reading was out of parameter per the physician medication order.

Findings included...

R11

Record review of R11's face sheet showed R11 moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R11's Service Plan Agreement, dated 10/12/2023, showed R11's blood sugar checks were administered by the medication technicians. R11's medication would be set up for administration in accord with the physician's medication/treatment orders.

Record review of R11's MAR, dated 11/01/2023 through 11/30/2023, showed R11 had an order for their blood sugar to be checked every night. The primary care physician (PCP) was to be notified if R11's blood sugar was less than 110 or greater than 260. R11's blood sugars were outside of those parameters 7 of 29 administered times.

On 12/22/2023 at 2:47 PM, the Department was sent by the facility, all of R11's physician notifications about the out of parameter blood sugars for November 2023.

Record review of R11's untitled document, dated 11/11/2023, showed the physician was notified about R11's out of range blood sugar readings for dates 11/01/2023, 11/02/2023, 11/07/2023, and 11/08/2023.

As of 12/22/2023 at 5 PM, the Department had not received any further physician notifications for R11's out of parameter blood sugar readings for dates 11/14/2023, 11/25/2023, and 11/30/2023. The Department was unable to review the residents electronic record for any further physician notifications as access was not provided.

In an interview on 12/22/2023 at 1:58 PM, Staff T, Regional Support Specialist/Licensed Practical Nurse, stated if there was a specific parameter on the medication order, the parameter should be followed as it was listed. Staff T stated the facility will input own parameter for medications. Staff T stated the parameters for R11's blood sugars were not provided by the physician. Staff T stated the physician needed to be contacted for parameter clarification for R11's blood sugars.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24.

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

Administrator (or Representative) — Date: 2/1/24

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain safe water temperatures on 2 of 2 units (North unit and South Unit) reviewed. This failure placed residents, visitors, and staff at risk of injury from unsafe water temperatures.

Findings included...

In an observation on 12/13/2023 at 10:15 AM, resident Room N23A, located on the north side unit, bathroom sink hot water temperature measured at 127.5 degrees Fahrenheit (F).

In an observation on 12/13/2023 at 10:31 AM, resident Room N10, located on the north side unit, bathroom sink hot water temperature measured at 129.9 degrees F.

In an observation on 12/13/2023 at 10:36 AM, resident room S2, located on the south side unit, bathroom sink hot water temperature measured at 121 degrees F.

In an observation on 12/13/2023 at 10:43 AM, resident Room N21B, located on the north side unit, bathroom sink hot water temperature measured at 121.5 degrees F.

In an interview on 12/13/2023 at 11:33 AM, Staff L, Maintenance Manager, stated they did not have a thermometer to check hot water temperatures. Staff L stated they would go purchase a thermometer to test the hot water temperatures.

In an interview on 12/12/2023 at 8:20 AM, Staff A, Executive Director, stated the facility just had the water heater replaced the day prior.

In an interview and observation on 12/13/2023 at 3:00 PM, Staff L, checked the hot water temperature in room S2 with the facility's thermometer, and the bathroom sink hot water temperature measured at 122.9 degrees F. Staff L stated the hot water temperatures should be checked weekly. Staff L was asked what the required hot water temperature

requirements were. Staff L stated they were unaware of the hot water temperature range requirement. At 3:05 PM, Staff L took the temperature of the bathroom sink hot water temperature in room N10 and the temperature was 122.1 degrees F. At 3:09 PM, Staff L took the temperature of the bathroom sink hot water temperature in room N23 and the temperature was 122 degrees F.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/2/24 .

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

Lawrya Law — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-2381 General design requirements for memory care.

(1) When planning for new construction, renovations or change of service to include memory care services, the facility must document design considerations appropriate to residents with dementia, mental health issues, or cognitive and developmental disabilities within its functional program consistent with WAC 388-78A-2380 .

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed allow residents access to their rooms without staff assistance for 2 of 2 units (North unit and South unit) reviewed. This failure placed all 81 of 81 residents at risk of decreased quality of life and independence of not having free will to go in their room at any given time.

Findings included...

Washington Administrative Code (WAC), "388-110-220 Enhanced adult residential care service standards. (3) In an assisted living facility with an enhanced adult residential care-

specialized dementia care services contract, for residents served under that contract, the contractor must (n) Ensure residents have access to their own rooms at all times without staff assistance".

In an observation on 12/12/2023 at 5:40 AM, Staff F, Medication Technician, walked to Resident 2 bedroom door. Staff F unlocked the door with a key as the door was locked, and walked inside.

In an observation on 12/12/2023 at 5:45 AM, Staff F walked to Resident 3's bedroom door. Staff F unlocked R3's door with a key as the door was locked, and walked inside.

In an observation on 12/13/2023 at 10:36 AM, Staff E, Medication technician, used a key to unlock Resident 4's (R4) door, located on the south unit, as the door was locked. R4 was observed sitting in his reclined in the far corner of the room in the dark.

In an interview on 12/14/2023 at 11:56 AM, Collateral Contact 5 (CC5), daughter to Resident 6 (R6), stated that R6's door, located on the north unit, automatically locked when closed, and that R6 had been asking for a key to their door.

In an interview on 12/13/2023 at 3:00 PM, Staff L, Maintenance Manager, stated all resident's doors locked automatically from the outside .

Plan/Attestation Statement

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Administrator (or Representative) — Date: 2/1/24

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:

(a) Orientation and safety;

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 7 of 7 sampled Staff (Staff A, Staff F, Staff G, Staff H, Staff D, Staff I, and Staff J) had completed their facility orientation training. The facility failed to have 4 of 6 sampled staff (Staff A, Staff F, Staff H, and Staff D) complete the Department of Health and Social Services 5-hour Orientation and Safety. The facility failed to have 3 of 4 sampled staff (Staff A, Staff F, and Staff D) complete their required continued education. These failures placed 81 of 81 residents at risk for staff being unaware of the facility's expectations and not having the required education and training.

Findings included...

WAC 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-

term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."
Record review of the State of Washington document titled, Proclamation by the Governor 20-10, dated 02/09/2020, showed the requirement for the facility's to have staff completed their training requirements in relation to orientation and safety, continued education, and all the training requirements in chapter 388-112A Washington Administrative Code.

Record review of the Department of Social and Health Services letter 2023-017, dated 04/28/2023, showed the required long-term care workers basic training deadline dates they needed to complete by

Record review of the Department of Social and Health Services letter 2023-025, dated 10/13/2023, showed the deadline remained as 08/31/2023, for continued education (CE) that was due while training waivers were in place, as well as for CE cycles between and included 10/28/2022 and 8/31/2023.

Facility Orientation

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff A, Executive Director, was hired at the facility on 11/07/2020 and first day of employment was on 11/16/2020.

Record review on 12/12/2023 of Staff A's personnel file showed there was no facility orientation training, no certificate of the DSHS orientation and safety, and CE records for review.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff F, Medication Technician, was hired at the facility on 05/29/2023 and first day of employment was on 06/02/2023.

Record review on 12/12/2023 of Staff F's personnel file showed there was no facility

orientation training no certificate of the DSHS orientation and safety, and CE records for review.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff G, Caregiver, was hired at the facility on 09/01/2023 and first day of employment was on 09/02/2023.

Record review on 12/12/2023 of Staff G's personnel file showed there was no facility orientation training, no certificate of the DSHS orientation and safety, and CE records for review.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff H, Dietary Aide, was hired at the facility on 06/29/2023 and first day of employment was on 07/07/2023.

Record review on 12/12/2023 of Staff H's personnel file showed there was no facility orientation training record for review.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff D, Medication Technician, was hired at the facility on 04/12/2022 and first day of employment was on 04/17/2022.

Record review on 12/12/2023 of Staff D's personnel file showed there was a "orientation and skills checklist for new employees", dated 04/12/2022, that showed Staff D signed that they were reviewed all of the required orientation task. There was no documentation of whom the trainer was that showed the orientation tasks to STaff D or signature that it was completed by the trainer for review. There was no certificate of the DSHS orientation and safety, and CE records for review.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff I, Caregiver, was hired at the facility on 07/14/2020 and first day of employment was on 07/14/2020.

Record review on 12/12/2023 of Staff I's personnel file showed there was no facility orientation training and CE records for review.

Record review of the facility provided untitled and undated document that had a list of employees, showed Staff J, Cook, was hired at the facility on 04/30/2021 and first day of employment was on 05/04/2021.

Record review on 12/12/2023 of Staff J's personnel file showed there was a document titled, "Orientation & skills checklist for new employees", dated 05/01/2021, that Staff J had initial some of the orientation tasks as reviewed. There were some trainer initials documented for some of the orientation tasks. The document was unsigned and
undated by the trainer.

In an interview on 12/12/2023 at 2:35 PM, Staff A stated all employee's facility orientation and safety was documented on the facility's document titled "Orientation & skills checklist for new employees". Staff A stated the form would be in the employee's file if had been completed. Staff A stated all certificates, if the employee had them would have been filed in the employee's file. Staff A stated all CE records were electronic and would provide those for Staff A, Staff F, and Staff D.

On 12/14/2023 at 11:50 AM, the Department requested for review Staff A, Staff F, Staff I's DSHS orientation and safety, Staff A, Staff F, Staff D, and Staff I's facility orientation, and Staff A, Staff F, Staff G, Staff H, and Staff I's orientation & skills checklist for new employees for review.

In an email sent to the Department on 12/15/2023 at 12:55 PM, Staff A only provided official continued education transcripts for 2 of 4 request staff members (Staff F and Staff D).

Record review of Staff F's "Official Transcript" undated showed Staff F had completed 2.75 hours of 12 required hours of continued education credits.

Record review of Staff D's "Official Transcript", undated, showed Staff D completed 5.75 hours of 12 hour required of continued education credits prior to the entrance of the full inspection.

As of 12/15/2023 at 5 PM, did not provide Staff A, Staff F, Staff I's DSHS orientation and safety, Staff A, Staff F, Staff D, and Staff I's facility orientation, and Staff A, Staff F, Staff G, Staff H, and Staff I's orientation & skills checklist for new employees, and Staff A, Staff F, Staff D, and Staff I's completed CE completed for review.

The Department was unable to review the facility's electronic record for the requested employee documents.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/25/24 .

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

Lawriyal Lau — Administrator (or Representative)

2/1/24 — Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(4) How residents with special needs are individually protected without unnecessary

restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 2 locations within the facility (North side cabinets and North side resident public restroom). This failure placed 81 of 81 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's policy "Chemical/Hazardous Chemicals", undated, showed extra chemicals not on the housekeeping cart would be secured away from resident areas and kept locked. They may be stored in locked housekeeping closets with carts when not in use.

In an observation on 12/12/2023 at 6:11 AM on the North side of the facility by the medication room was an unlocked cabinet. Inside the unlocked cabinet were two tubs of micro-kill bleach germicide bleach wipes. The tubs showed on the label, "keep out of reach of children CAUTION". The was a seven-ounce tube of soothe and cool barrier moisture barrier ointment, two cans of shaving cream all in the cabinet unlocked. Resident 1 (R1) was wander and walking by the near the unlocked cabinet.

In an interview on 12/12/2023 at 6:15 AM, Staff M, Caregiver, stated they did not lock up the shaving cream, barrier creams, and bleed wipes. When Staff M was asked how they were trained to store chemicals in the unlocked cabinets, Staff M stated, "just what we do."

In an observation on 12/12/2023 at 6:18 AM, at the end of the North hallway near NB2 and N11 was an unlocked cabinet. Inside the unlocked cabinet was a tube of intensive skin therapy lotion and a tube of soothe and cool total body cleanser.

In an observation on 12/12/2023 at 6:20 AM, inside the NB2 resident public bathroom on the counter by the sink, unsecured was one bottle of "Pantene miracle moisture boost sulfate free conditioner", one bottle of "soap & glory clean on me body wash", and one bottle of "miracle moisture boost sulfate free shampoo". All three bottles were sitting on the top of the counter and accessible to residents.

In an observation on 12/13/2023 at 10:17 AM, by the North side NS2 bathroom room the cabinet up against the wall was unlocked. Inside the unlocked cabinet the bleach wipes, shaving creams, and barrier creams that were observed on 12/12/2023 remained unsecured. There were multiple un-named residents wander and walking around the unlocked cabinet.

In an interview on 12/13/2023 at 8:13 AM, Staff A, Executive Director, stated that all chemicals, shaving creams, cleaning wipes, or any solution with chemicals were always to be locked up.

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) — Date: 2/1/24

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(h) In the event of an internal or external disaster, consistent with WAC 388-78A-2700 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure implementation of their disaster policy when there was a gas leak for one of one facility reviewed. This failure placed all 81 of 81 residents, staff, and visitors at risk of harm during an emergency.

Findings included...

Record review of the facility's policy, titled, "Utility Emergency Procedure", undated, showed in the event of a gas line break the facility was to notify the fire department via 911; notify the Maintenance Director and Administrator immediately; notify the gas company; if a gas leak was evident, shut off main gas valve to the building; evacuate residents from the immediate area of the gas leak (out of fire zone); open doors and windows to ventilate; do not use matches, candles, or any open flame devices; and do not activate any light switches or electrical appliances in the area of the gas leak.

In an observation on 12/12/2023 at 8:03 AM, there was a strong gas odor (sulfur/rotten eggs smell) present upon entering the basement door to the laundry room, storage area, and the water heater room. The smell was observed to be strong smelling of gas coming from the water heater room.

In an observation and interview on 12/12/2023 at 8:08 AM, Staff N, Housekeeping, stated that the gas smell was really strong. Staff N stated, "I'm afraid those fumes can get to me". Staff N was then observed to proceed to the laundry room and begin loading the washer to start a new cycle, despite the strong gas odor present.

In an interview on 12/12/2023 at 8:20 AM, Staff A, Executive Director, stated she was aware of the gas smell. Staff A stated that they had their water heater replaced the day before, and they left a gap in the vent, and that a back flow draft of air was carrying the gas smell into the water heater room.

In an interview on 12/12/2023 at 8:09 AM, Staff K, Maintenance Assistance, stated they smelled gas that morning when they entered the basement area. Staff K stated a company was to come out today to fix the gas leak smell. Staff K was unsure what time that was scheduled for.

In an interview on 12/13/2023 at 8:40 AM, Staff A, stated they were still waiting on a company to come out and check on the gas leak smell.

In an interview on 12/13/2023 at 3:00 PM, Staff L, Maintenance Manager, stated there was gas leaking from the propane gas vent to the water heater room yesterday but that it was now fixed. When asked what staff were supposed to do if they smelled gas, Staff L stated they should evacuate the area, call the utility company, let the Executive Director know, and to call a company out to fix it. Staff L stated they did not evacuate the area, notify the utility company, or implement their policy related to gas leaks.

Plan/Attestation Statement

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

Lauryn Hall — Administrator (or Representative)

2/1/24 — Date