STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

RED OAK MANAGEMENT AND DEVELOPMENT
RED OAK RESIDENCE OF NORTH BEND
650 E NORTH BEND WAY
NORTH BEND, WA 98045

RE: RED OAK RESIDENCE OF NORTH BEND License # 1158

Dear Administrator:

This letter addresses Compliance Determination(s) 45713 (Completion Date 08/15/2024) and 41954 (Completion Date 06/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/15/2024 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-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-3040-5, WAC 388-78A-2950-6, WAC 388-78A-2630-2, WAC 388-78A-2660-1, WAC 388-78A-2090-2-b, WAC 388-78A-2480-1, WAC 388-78A-2474-2-a, WAC 388-78A-2474-3, WAC 388-78A-2240, WAC 388-78A-2410-8-a-iii, WAC 388-78A-2410-8-b

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Steven Garrett, LTC Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License # 1158	Compliance Determination # 41954
Plan of Correction	RED OAK RESIDENCE OF NORTH BEND	Completion Date
Page 1 of 13	Licensee: RED OAK MANAGEMENT AND	06/18/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 06/04/2024 and 06/06/2024 of:
RED OAK RESIDENCE OF NORTH BEND
650 E NORTH BEND WAY
NORTH BEND, WA 98045

The following sample was selected for review during the unannounced on-site visit: 4 of 9 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Steven Garrett, LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Laurie Anderson — Residential Care Services

06/25/2024 — 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)

7/3/2024
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:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Individual Service Plan (ISP) for 1 of 4 sampled residents (Resident 2). This failure placed the residents at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2022.

Review of Resident 2's undated current medication list showed an order for Glucophage XR (medication for lowering blood sugar levels), 500 milligrams daily.

Review on 06/05/2024 of Resident 2's Assessment and Service Plan, dated 03/02/2021, showed there were 10 pages total. Review showed that pages 4, 5, 6, 7, and 8 were missing. There was no documentation in the service plan that showed Resident 2 was a diabetic, that identified the signs and symptoms of low or high blood sugar, or provided caregivers with instructions on what to do should Resident 2 exhibit any diabetic symptoms.

Review of Resident 2's Assessment and Service Plan, dated 03/02/2024, received on 06/17/2024 at 11:58 AM via email, showed that there was no documentation in the service plan that showed Resident 2 was a diabetic, that identified the signs and symptoms of low or high blood sugar, or provided caregivers with instructions on what to do should Resident 2 exhibit any diabetic symptoms.

During an interview on 06/05/2024 at 2:30 PM, Staff D, Activity Director and Administrator Designee, stated that there were pages missing from the service plan and therefore Staff D was unable show whether the service plan identified Resident 2 as a diabetic and what staff were to do should Resident 2 exhibit any diabetic symptoms.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 7/29/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. UPDATED ASSESSMENT COMPLETED W/SERVICE PLAN

Administrator (or Representative) 7/3/2024 Date

WAC 388-78A-3040 Laundry.

(5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off site commercial laundry services.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 2 of 2 laundry rooms (first and third floor laundry rooms) were operational and provided proper air flow and ventilation to the outside of the facility. This failure placed all nine residents at risk of diminished quality of life and potential respiratory illnesses from poor air circulation in the building.

Findings included...

During the environmental tour on 06/04/2024 between 12:26 PM and 2:15 PM, observation of the first and third floor laundry rooms showed non-functioning ventilation systems.

Observation on 06/05/2024 at 3:00 PM, showed Staff G, Administrative Assistant, placed a paper towel directly over the vent cover to test the first, second, and third floor laundry room ventilation. The ventilations systems in the first and second floor laundry rooms failed to draw in air to pull the paper towel towards the ventilation fans.

During an interview on 06/05/2024 at 3:00 PM, Staff G stated that they were unaware the two ventilation fans on the first and third floor were not operational.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 7/29/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. * FIXED DAY OF (06/05/2024) BY SERVICE PROVIDER WHO TURNED OFF BY SWITCH

Administrator (or Representative) — Date: 7/3/2024

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 ensure hot temperatures were maintained no higher than 120 degrees Fahrenheit in 5 of 5 sampled sinks (second floor laundry room sink, third floor laundry room sink, first floor men's bathroom sink, first floor women's bathroom sink, and third floor library). This failure placed all nine residents at risk for burns from scalding water.

Findings included...

Observations on 06/04/2024 showed: at 12:30 PM, the second-floor laundry room sink hot water temperature measured 135.7 degrees Fahrenheit (F). At 12:39 PM, the third-floor laundry room sink hot water temperature measured 130.6 degrees F. At 1:06 PM, the men's first floor common bathroom sink hot water temperature measured 125.6 degrees F. At 1:08 PM, the women's first floor common bathroom sink hot water temperature measured 126.6 degrees F. At 1:22 PM, the third-floor library sink hot water temperature measured 124.3 degrees F.

Review of the hot water temperature log showed the last water temperatures were checked on 01/09/2024 and 02/08/2024.

During an interview on 06/05/2024 at 3:00 PM, Staff G, Administrative Assistant, accompanied by an unidentified contractor, stated that they adjusted the water tank thermostat to a lower temperature. Staff G stated that a few months ago, the facility replaced a faulty hot water thermostat.

Observations on 06/06/2024 at 8:35 AM and 9:59 AM showed three of the previously tested sinks water temperatures were rechecked and the water temperatures measured

within the required range: both the men's and women's first floor common bathroom sinks hot water temperatures each measured 112.6 degrees F and the third-floor library sink hot water temperature measured 105.2 degrees F.

Observations on 06/06/2024 at 9:35 AM and 9:57 AM showed two previously tested sinks still measured outside of the required temperature range. The second-floor laundry room sink hot water temperature measured 131 degrees F and the third-floor laundry room sink hot water temperature measured 128.2 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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 07/29/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. * FIXED BY SERVICE PROVIDER DAY OF (6/5+6/6/2024)

Administrator (or Representative) 7/3/2024 Date

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 post the state and local long-term ombuds information in a conspicuous place for 9 of 9 residents (Resident 1 through Resident 9) to access easily. This failure violated the nine residents' rights to contact state agencies acting as client advocates.

Finding included...

Observation on 06/06/2024 at 8:40 AM, showed an Ombuds hotline Complaint resolution sign was posted inside the health center office. At 10:15 AM, observation showed an Ombuds hotline complaint resolution sign was posted inside the front office. Observation throughout the rest of the facility showed there was no Ombuds hotline poster, in a conspicuous place, in any public common area within the facility.

During an interview on 06/05/2024 at 2:00 PM, Staff G, Administrative Assistant, stated that the Ombuds hotline CRU sign was posted next to the Assisted Living License located in the front lobby area, next to the resident's mailboxes. Upon observation of the front

lobby, Staff G stated that the ombuds hotline poster used to be posted there. Staff G stated that they were unaware the poster was no longer posted in the front lobby.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 07/29/2024

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. * NOTE: NOTICE REMOVED BY PAINTERS & DIDN'T REPLACE/ ADVISE STAFF THEY TOOK IT DOWN. PUT BACK UP 6/7/2024

~~Administrator~~ (or Representative) 7/3/2024 Date

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 9 of 9 residents (Resident 1 through Resident 9) were able to review the last Department of Social and Health Services (DSHS) inspection report by posting a copy of the document in an easily accessible place within the facility. This failure violated the residents' rights to access and review the last inspection report.

Findings included...

Observation on 06/04/2024 at 10:30 AM, showed a sign posted on top of a cabinet, inside the front office, that showed the last DSHS report was available upon request.

Observations on 06/04/2024, 06/06/2024, and 06/07/2024 between 10:00 AM and 3:00 PM showed the door to the front office was periodically closed, at random times throughout the day, which obscured the notification of how to access the last DSHS inspection report.

During an interview on 06/04/2024 at 2:00 PM, and on 06/07/2024 at 1:00 PM Staff D, Activity Director and Administrator Designee, stated that the last DSHS report was not available for review. Staff D stated that they were unable to locate the last DSHS inspection report.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 7/29/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. * DSHS SURVEY REPORT WAS INSIDE METAL CABINET TOP SHELF FOR REVIEW. STAFF CONTACTED WAS UNABLE TO LOCATE LABELED METAL BASKET SO STAFF CAN READILY SEE IN FUTURE

Administrator (or Representative) — Date: 7/3/2024

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess the ability of 1 of 1 resident (Resident 2) to self-administer their own medications. This failure place Resident 2 at risk for medication errors and incorrectly administering their medications.

Findings included...

Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2022.

Observation of Resident 2's apartment on 06/05/2024 at 2:43 PM, showed there were no medications visible in the apartment.

During an interview on 06/05/2024 at 2:43 PM, Resident 2 stated that their family member was concerned that Resident 2 forgot to take their medications or took them incorrectly. Resident 2 stated that the facility took over management of their medications.

Review of Resident 2's Resident Assessment and Service Plan, dated 03/02/2024, showed Resident 2 self-managed their own medications.

Review of Resident 2's record found no electronic Medication Administration Record (eMAR). The records showed a list of prescribed medications. There was no documentation of a resident self-administration assessment.

During an interview on 06/05/2024 at 2:30 PM, Staff D, Activity Director and Administrator Designee, stated that Resident 2's family member expressed concerns that Resident 2 had forgotten to take their medications and there may have been incidences where Resident 2 mixed up their medications. Staff D stated that Resident 2's family member requested the facility take over Resident 2's medication management. Staff D stated the facility was in the process of entering Resident 2's medication orders into the eMAR system so the facility could take over Resident 2's medication management that evening. Staff D stated that the facility did not complete a self-medication assessment for Resident 2 when they admitted to the facility.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 7/29/2024 .

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

Administrator (or Representative) — Date 7/03/2024

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 5 sampled staff (Staff B) was screened for Tuberculosis (TB) as required. This failure placed all residents at risk of exposure to TB, an infectious disease.

Findings included...

Review of the facility's personnel records showed that the facility hired Staff B, Caregiver, on 02/01/2023. Review of Staff B's records showed no documentation that Staff B completed any testing to be screened for TB.

During an interview on 06/06/2024 at 1:10 PM, Staff D, Activity Director, stated that they were the designee while the Administrator was out of the facility. Staff D stated that they

were aware of the TB screening requirements. Staff D stated that they were unaware that Staff B did not complete the required TB testing.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 7/29/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. * Employee had xray showing @ TB. STAFF WILL HAVE HER 2 STEP TB TESTING COMPLETED.

Administrator (or Representative) 7/3/2024 Date

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;

(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 2 of 5 staff (Staff A and Staff C) completed facility orientation to perform their job duties and responsibilities. This failure placed all residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's personnel records showed the facility hired Staff A, Caregiver, on 01/09/2023; and Staff C, Caregiver, on 12/28/2023.

Review of facility's Red Oak Residence of North Bend Caregiver (Long Term Care Worker) Orientation Training 2023 document, showed the facility provided orientation to their care staff in areas covering client rights, basic job responsibilities, communication, documentation, and their role as mandated reporters. Review showed the facility provided this orientation to give caregivers an overview of what is needed to know and do their job.

Review of the facility's personnel records showed no documentation that Staff A completed any Facility Orientation, as required.

Review of the facility's personnel records showed no documentation that Staff C completed any Facility Orientation, as required.

During an interview on 06/06/2024 at 1:10 PM, Staff D, Activity Director, stated that they were the designee while the Administrator was out of the facility. Staff D stated that they were aware of the Facility orientation requirements. Staff D stated that they were unaware that Staff A and Staff C did not complete the required Facility orientation or that the documentation was missing from the personnel records.

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, RED OAK RESIDENCE OF NORTH BEND is ~~of~~ will be in compliance with this law and / or regulation on (Date) 08/07/2024 AWS 08/07/24 RW DSHS 7/11/24

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. *BOTH EMPLOYEES WILL HAVE TRAINING DONE. EMP # C COMPLETED 7/2/24.

Administrator (or Representative) 07/03/2024 Date

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 ensure 1 of 4 sampled residents (Resident 3) prescribed medications were available in the facility and administered as ordered. This failure placed Resident 3 at risk for a potential decline in their health for not receiving their medications, as ordered.

Findings included...

Review of Resident 3's Resident Assessment and Service Plan, dated 09/30/2023, showed the facility provided Resident 3 with medication management assistance.

Review of Resident 3's March 2024, April 2024, and May 2024 electronic Medication Administration Records (eMARs), showed an original physician order, dated 02/11/2024,

for Asper creme patch lidocaine 4%, (pain relieving patch), one patch applied to Resident 3's back every morning. The eMARs showed Staff C, contracted caregiver, and Staff F, nighttime caregiver, initialed that Resident 3 received the application of the patch 19 times in March 2024, 11 times in April 2024, and 16 times in May 2024.

During an interview on 06/05/2024 at 11:22 AM, Resident 3 stated that the asper crème lidocaine patch was not applied that morning. Resident 3 stated that the staff had not applied the pain patch for months.

During an interview on 06/05/2024 at 3:00 PM, Staff C, Contracted Caregiver, stated that they had never administered or applied the asper crème lidocaine patch to Resident 3 even though Staff C's initials on the eMAR showed they had.

During an interview on 06/06/2024 at 8:40 AM, Staff F, nighttime Caregiver, stated that when the medication was originally ordered, Staff F applied the patch one time. Staff F stated that Resident 3 frequently refused the pain patch. Staff F stated that since Resident 3 refused so often, they stopped applying the patch. Staff F stated that there were no boxes of asper crème lidocaine patches available in the facility for Resident 3, until last night. Staff F stated that last night, on 06/05/2024, the facility reordered the patches. Staff F stated that they were unsure how long Resident 3 was out of pain patches.

Observation on 06/06/2024 at 8:40 AM, showed three boxes of asper crème lidocaine patches in the bottom of the medication cart. The pharmacy labels on all three boxes showed the order was filled on 06/05/2024.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 08-05-2024 08/02/24 POS DSHS Rules 7/1/2024

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. * RESIDENT REFUSED PATCHES MAJORITY OF TIME OFFERED.

Administrator (or Representative) 7/3/2024 Date

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 interview and record review, the facility staff failed to correctly document when a medication was administered or was unavailable in the facility for 1 of 1 sampled resident (Resident 3). This failure placed Resident 3 at risk for medication errors and a potential decline of medical condition by not receiving medications as prescribed.

Findings included...

Review of Resident 3's March 2024, April 2024, and May 2024 electronic Medication Administration Records (eMARs), showed an original physician order, dated 02/11/2024, for Asper creme patch lidocaine 4%, (pain relieving patch), one patch applied to Resident 3's back every morning. The eMARs showed that in March 2024, Facility care staff which included Staff C, Contracted Caregiver, and Staff F, Nightshift Caregiver, initialed that the patch was applied 19 times, 11 times in April 2024, and 16 times in May 2024.

During an interview on 06/05/2024 at 11:22 AM, Resident 3 stated that the asper crème lidocaine patch was not applied that morning. Resident 3 stated that the staff had not applied the pain patch for months.

During an interview on 06/05/2024 at 3:00 PM, Staff C, Contracted Caregiver, stated that they had never administered or applied the asper crème lidocaine patch to Resident 3 even though Staff C's initials on the eMAR showed they had. Staff C stated that the patch was applied by nighttime caregivers. Staff C stated they were unsure why their initials were present on the eMAR.

During an interview on 06/06/2024 at 8:40 AM, Staff F stated that when Resident 3's asper crème medication was originally ordered, Staff F applied the patch once. Staff F stated that Resident 3 often refused the pain patch. Staff F stated that since Resident 3 refused so often, Staff F stopped asking Resident 3 if they wanted the patch and stopped applying the patch. Staff F stated that there were no boxes of asper crème lidocaine patches for Resident 3 available in the facility. Staff F stated that they were unsure how long Resident 3 was out of pain patches. Staff F stated that they realized they documented incorrectly that Resident 3 received the asper crème lidocaine patches multiple times over the past three months. Staff F stated that they had just stopped applying the patch altogether.

During an interview on 06/06/2024 at 10:47 AM, Collateral Contact 1 (CC1, Resident Representative) stated that they understood Resident 3's primary physician discontinued

the asper crème lidocaine patch several months ago. CC1 stated that Resident 3 no longer received the patch.

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, RED OAK RESIDENCE OF NORTH BEND is or will be in compliance with this law and / or regulation on (Date) 8/5/2024 8/2/24 per DSHS 7/17/24

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

Administrator (or Representative)

07/03/2024
Date