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) 24751 (Completion Date 06/01/2023) and 21277 (Completion Date 04/04/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/01/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610-2-d, WAC 388-78A-2610-2-f

The Department staff who did the on-site verification:
Deborah Corlis, Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: RED OAK RESIDENCE OF NORTH BEND
Provider Type: Assisted Living Facility
License/Cert.#: 1158
Intake ID: 74520
Compliance Determination #: 21277
Region/Unit #: RCS Region 2 / Unit D
Investigator: Mary Hayes
Investigation Date(s): 03/20/2023 through 04/04/2023
Complainant Contact Date(s): 03/17/2023, 03/20/2023, 03/21/2023, 03/29/2023

Allegation(s):

1. The facility did not report a Norovirus outbreak
2. Concerns that the facility was not using an effective cleaning product (for Norovirus)
3. Concerns that staff did not use proper enteric precautions
4. Concerns related to sick employee return to work policy
5. Concerns related to facility response to Norovirus outbreak (oversight staff)

Investigation Methods:

Sample:	Total residents: 14 Resident sample size: 4 Closed records sample size: 0
Observations:	Kitchen environment (food storage, food prep, hand washing and, dishwashing station), housekeeping/laundry activities, in-room meal delivery/dining services, system for readily available Personal Protective Equipment (PPE) supplies, masking, gloving, staff-resident interactions, sanitizing/disinfecting products
Interviews:	Administrator, Cook, Nurse, front desk, housekeeping and care staff, resident, representatives, persons not affiliated with facility
Record Reviews:	Characteristic Roster, 24-log, Internal Endemic Plan, resident records, temporary plan, Environmental Protection Agency (EPA) registered cleaning product/label, email with timeline reporting to King County Public Health (KCPH)

Investigation Summary:

1. The Assisted Living Facility experienced a Norovirus outbreak amongst residents and staff. The Assisted Living Facility failed to immediately report the outbreak to the local health department (LJD) when at least seven residents exhibited nausea, vomiting and diarrhea. Failed practice identified.
2. Review of EPA list and agent labels, the facility used cleaning products that were available and effective against a gastrointestinal communicable illness. No failed practice identified.

3. Observations and interviews showed that PPE supplies were available and stored in the first floor medication room. There was no system or procedure to ensure PPE supplies were stored and readily available when anyone entered resident rooms under isolation during infectious period. Written Consult for lack of procedures for infection control and prevention.
4. Facility staff reported signs of gastrointestinal and muscle achiness to facility and did not report back to work until after 72 hours after symptoms subsided. Review of policy and interviews with employee showed the facility had a policy for preventing ill staff from working until symptoms resolved.
5. Nursing and Administrative Staff did not report a gastrointestinal outbreak to public health or Department Complaint Resolution Unit. Lack of reporting delayed Department's response for investigating the outbreak and may have contributed to the on-going outbreak.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 1158	Compliance Determination # 21277
Plan of Correction	RED OAK RESIDENCE OF NORTH BEND	Completion Date
Page 1 of 4	Licensee: RED OAK MANAGEMENT AND DEVELOPMENT	04/04/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 03/20/2023, 03/20/2023 and 03/20/2023 of:

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

This document references the following complaint number(s): 74520

The following sample was selected for review during the unannounced on-site visit: 3 of 14 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Mary Hayes, 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.

Residential Care Services

04-14-2023
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.

DSHS/ALTSA
Residential Care Services
APR 27 2023
Received

Administrator (or Representative)

4/24/2023
Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

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

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to report a gastrointestinal illness outbreak after 7 of 14 residents (Resident 1, 2, 3, 4, 5, 6 and 7), two staff (Staff G, Staff H) and 3 visitors exhibited symptoms of Norovirus (nausea, vomiting, diarrhea). This failure prevented the local health department from supporting and guiding the facility for managing further outbreak of the illness.

Findings included...

According to the Center for Disease Control (CDC), "General Information about Norovirus" (last reviewed December 2010), showed that Norovirus is found in feces and vomit of infected people, is very contagious and easily spread via direct contact with a person or contaminated item or object. Noroviruses are a group of viruses that cause gastroenteritis (an inflammation of the lining of the stomach and intestines, causing an acute onset of severe vomiting and diarrhea) in people. Young children, the elderly, and people with other medical illnesses are most at risk for more severe or prolonged infection. Symptoms of Norovirus usually include nausea, vomiting, diarrhea, and some experience stomach cramping. These symptoms may occur suddenly and last 1-2 days.

Norovirus: Standards of infection prevention:
Per the CDC, if an outbreak of Norovirus gastroenteritis is suspected, notify appropriate local and state health departments.

Review of the Department of Health (DOH) memo 420-170 "Norovirus Background", updated 05/03/2017, showed that health care providers should report outbreaks of acute gastroenteritis to the local health jurisdiction.

Review of the Department of Health memo 420-174 "Norovirus Outbreak Control Checklist for Local Health Jurisdictions: Health and Long-Term Care Facilities" updated 05/05/2017, showed a food outbreak was defined as "an incident in which two or more persons experience a similar illness after exposure to the same food source and if onset dates are clustered around one point in time that falls within the incubation period of 12-48 hours

after a shared food exposure. The facility did not report a possible gastrointestinal outbreak after Residents 1, 2 and 3 exhibited Norovirus symptoms.

Review of the facility's document titled "Internal Pandemic Plan", updated 01/28/2021, showed that the facility referenced a consultation, dated from 2008, with an authority from the "Communicable and Epidemiology Program" and "should report when greater than 10 clients are affected". The document further stated that the facility "should work with the Public Health authorities".

Review of the Department's secure tracking and reporting system (STARS) showed that on 03/16/2023, the Department's Complaint Resolution Unit (CRU) received a report that the facility failed to report an outbreak of Norovirus to the local health jurisdiction (LHJ). Further review of STARS showed that at 3:34 PM on 03/17/2023, the facility filed a report with CRU, which stated that there were seven residents and one staff sick with norovirus. The report further showed that the "incident" first appeared on 03/13/2023. The report filed by the facility did not show the facility called the LHJ, as recommended.

Review of an undated facility document titled "List of Residents with Norovirus Symptoms" showed the dates of when residents reportedly experienced on-going signs and symptoms (nausea, vomiting, diarrhea) of a gastrointestinal illness: Resident 1 on 03/13/2023; Residents 2, 3, and 4 on 03/14/2023; Resident 5 on 03/15/2023; and Resident 6 and 7 on 03/17/2023.

Review of the facility's document titled "24-hour" log (shift-to-shift documentation that is reviewed by staff), dated between 03/07/2023 through 03/20/2023, showed the dates and symptoms when residents first complained of, or exhibited signs of, nausea, vomiting or diarrhea: O 3/13/2023, Residents 6 and Resident 7 complained of diarrhea and weakness, Resident 1 "had diarrhea a couple of times" and that Resident 2 was "still feeling sick" on 03/13/2023. On 03/14/2023, Resident 1 and Resident 3 had "many" and "excessive" episodes of diarrhea" and were sent to the hospital and on 03/15 and 03/16/2023; two additional residents reportedly had diarrhea, weakness and vomiting on 03/16/2023. The 24-hour log showed no documentation that the facility reported the incidents to the Department or the local health department.

Review of an email sent from King County Public Health (KCPH) to Staff B, nurse, at 12:02 PM on 03/16/2023, showed that a KCPH representative instructed the facility to report the outbreak to the Department.

During an interview at 12:55 PM on 03/20/2023, Staff A, Administrator, stated that on 03/13/2023, they were unaware of what the facility "was dealing with" when multiple residents and non-residents (Independent) exhibited nausea, vomiting and diarrhea. Staff A stated that they became aware of a Norovirus outbreak after it was reported to them "late in the afternoon" on 03/15/2023. Staff A stated that they reported the outbreak to the Department's CRU "as soon as they could" on 03/17/2023. The facility did not report the gastrointestinal illness to KCPH after a cluster of residents exhibited signs of nausea, vomiting and diarrhea and after confirmation of a Norovirus on 03/15/2023, did not report the illness to the complaint unit until 03/17/2023.

During an interview on 03/22/2023 at 2:26 PM, Staff B stated that prior to 03/16/2023, they reviewed the CDC guidelines and determined that Norovirus was not a reportable event. A follow-up email from Staff B to the Department investigator, dated 03/22/2023, showed that on 03/15/2023, a KCPH representative called the facility to discuss the circumstances of the Norovirus outbreak. Staff B could not reach the KCPH until 03/16/2023. Staff B stated they did not call KCPH or the Department's CRU to report a Norovirus outbreak until 03/17/2023.

During interview on 03/29/2023, at 9:56 AM, Collateral Contact 1 (CC1, resident representative) stated that the facility reported that on 03/13/2023, Resident 1 became dehydrated and was sent to the hospital for further evaluation. During an interview on 03/29/2023, at 10:19 AM, Collateral Contact 2 (CC2, resident representative) stated that on 03/12/2023, they provided care to Resident 2 after Resident 2 vomited and experienced diarrhea. CC2 stated that on 03/15/2023, they became aware of the outbreak in the facility after speaking with a caregiver and became ill soon after they provided care to Resident 2 on 03/12/2023.

On 04/04/2023 at 2:30 PM, Staff A confirmed that they did not report a gastrointestinal illness to the local health department or the Department's CRU until 03/17/2023, four days after the first signs were reported or that a sign of an outbreak first appeared on 03/13/2023.

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) 4/30/2023 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. RED OAK MISTAKELY MISCALCULATED THE REPORTING DATE IN THIS INCIDENT. WE WILL DOUBLE CHECK DUE DATES IN THE FUTURE.

Administrator (or Representative)

4/24/2023
Date

DSHS/ALTSA
Residential Care Services
APR 27 2023
Received