



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

KEIRO NORTHWEST
NIKKEI MANOR
700 6TH AVE S
SEATTLE, WA 98104

RE: NIKKEI MANOR License # 1186

Dear Administrator:

This letter addresses Compliance Determination(s) 40880 (Completion Date 05/09/2024) and 37227 (Completion Date 03/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/09/2024 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-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-a, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2730-1-a, WAC 388-78A-2730-1-b

The Department staff who did the on-site verification:

Alma Duran, Licensors
Keiko Kitano, Licensors

If you have any questions, please contact me at (253)312-1446.

Sincerely,


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

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



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

Statement of Deficiencies	License #: 1186	Compliance Determination # 37227
Plan of Correction	NIKKEI MANOR	Completion Date
Page 1 of 6	Licensee: KEIRO NORTHWEST	03/08/2024

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 02/22/2024 and 02/22/2024 of:

NIKKEI MANOR
700 6TH AVE S
SEATTLE, WA 98104

This document references the following SOD dated: 03/08/2024

The following sample was selected for review during the unannounced on-site visit: 8 of 39 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensors
Keiko Kitano, Licensors

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

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.


Residential Care Services

03/20/2024
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.

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

Statement of Deficiencies

License #: 1186

Compliance Determination # 37227

Plan of Correction

NIKKEI MANOR

Completion Date

Page 2 of 6

Licensee: KEIRO NORTHWEST

03/08/2024


 Administrator (or Representative)

 3/20/24
 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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on observation, interview and record review, Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) included all required contents for 4 of 4 sampled residents (Residents 1, 2, 3, and 5). This placed Residents 1, 2, 3, and 5 at risk for not having their care and services needs met.

Findings included...

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2020 with multiple medically disabling conditions including non-insulin diabetes (a

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Administrator (or Representative)

Date

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disorder in which the body has high blood sugar levels for prolonged periods of time). Record review of an electronic Medication Administration Records (eMARs) for February 2024, showed Resident 1 was taking medication to treat their diabetes.

Review of the Assessment/Service Plan (A/SP-equivalent to a Full Assessment and NSA (A/SP), dated 09/18/2023, showed Resident 1's family member would manage medications and diabetic needs for Resident 1.

The A/SP did not show an alternate plan on managing medications and diabetic needs should Resident 1's family member be unavailable.

RESIDENT 2

Review of a RI form, dated 08/21/2023, showed the ALF admitted Resident 2 on [REDACTED]/2018 with multiple disabling diagnoses including [REDACTED]. Review of Resident 2's A/SP, dated 02/13/2023, a section titled, "Daily Routine/Habits Support," showed Resident 2 had a "Private Caregiver 24/7 [24 hours a day, seven days a week] due to high care level." Review of an A/SP, dated 02/13/2023, showed Resident 2 required maximum assistance with all Activities of Daily Living (ADLs - a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc).

Interview, on 02/27/2024 at 4:24 PM, Staff L (Registered Nurse) stated Resident 2 had a private caregiver (PCG) who provided all care and services 24/7.

Review of an A/SP, dated 02/13/2023, did not show an alternate plan on how the ALF would provide care and services should Resident 2's PCG be unavailable.

Interview, on 02/22/2024 at 3:00 PM, Staff E, (Wellness Director) confirmed there was no alternate plan in place to provide care and services to Resident 2 if the PCG was unavailable.

RESIDENT 3

Records review showed that the ALF admitted Resident 3 on [REDACTED]/2015 with multiple medical diagnoses. Review of the Residents' Characteristics Roster, dated 02/20/2024, showed that Resident 3 required maximum assistance with all ADLs.

Observation and interview, on 02/22/2024 at 12:15 PM, showed Collateral Contact 1 (CC1 - a Private Caregiver (PCG)) taking a lunch plate to Resident 3's table in the dining room on the second floor. CC -1 stated that they were a PCG from an outside agency and had been providing all care and services for Resident 3, 24 hours a day, seven days a week.

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Review of the Assessment/Service Plan (A/SP-equivalent to a Full Assessment and NSA (A/SP), dated 09/18/2023, showed Resident 1's family member would manage medications and diabetic needs for Resident 1.

The A/SP did not show an alternate plan on managing medications and diabetic needs should Resident 1's family member be unavailable.

RESIDENT 2

Review of a RI form, dated 08/21/2023, showed the ALF admitted Resident 2 on [REDACTED] 2018 with multiple disabling diagnoses including [REDACTED]. Review of Resident 2's A/SP, dated 02/13/2023, a section titled, "Daily Routine/Habits Support," showed Resident 2 had a "Private Caregiver 24/7 [24 hours a day, seven days a week] due to high care level." Review of an A/SP, dated 02/13/2023, showed Resident 2 required maximum assistance with all Activities of Daily Living (ADLs - a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc).

Interview, on 02/27/2024 at 4:24 PM, Staff L (Registered Nurse) stated Resident 2 had a private caregiver (PCG) who provided all care and services 24/7.

Review of an A/SP, dated 02/13/2023, did not show an alternate plan on how the ALF would provide care and services should Resident 2's PCG be unavailable.

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Records review showed that the ALF admitted Resident 3 on [REDACTED] 2015 with multiple medical diagnoses. Review of the Residents' Characteristics Roster, dated 02/20/2024, showed that Resident 3 required maximum assistance with all ADLs.

Observation and interview, on 02/22/2024 at 12:15 PM, showed Collateral Contact 1 (CC1 – a Private Caregiver (PCG)) taking a lunch plate to Resident 3's table in the dining room on the second floor. CC -1 stated that they were a PCG from an outside agency and had been providing all care and services for Resident 3, 24 hours a day, seven days a week.

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Review of Resident 3's Assessment/Service Plan (A/SP-equivalent to a Full Assessment and NSA), dated 08/18/2023, did not include an alternate plan on how the ALF would provide care and services for Resident 3 should the PCG not be available.

In an interview, on 02/22/2024 at 2:55 PM, Staff E (Wellness Director) confirmed that there was no back-up plan on how the ALF would provide care and services for Resident 3 developed in Resident 3's A/SP.

RESIDENT 5

Records review showed that the ALF admitted Resident 7 on [REDACTED]/2016 with multiple medical diagnoses. Records review showed that Resident 5 had been receiving hospice (end of life care) care and services. Review of Resident 5's A/SP, dated 01/17/2024, showed that Resident 5 required one-person assistance with bathing twice a week.

In interviews, on 02/22/2024 at 1:15 PM, Staff H (Resident Assistant (RA)) and Staff I (RA) stated that Resident 5 had been receiving shower assistance twice a week from a hospice agency.

Review of Resident 5's A/SP, dated 01/17/2024, showed no plan as to whether Resident 5 required hospice care and services, including that a hospice bath aide would provide showers. The A/SP showed no alternate plan should the hospice bath aide not be able to provide services.

In an interview, on 02/22/2024 at 2:55 PM, Staff E confirmed there was no other A/SP to show the roles and responsibilities of the hospice bath aide, including a back-up plan.

This is a recurring deficiency previously cited on 04/05/2022 and uncorrected deficiency previously cited on 12/26/2023.

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, NIKKEI MANOR is or will be in compliance with this law and / or regulation on (Date) ~~4/30/24~~ 4/22/2024

SB confirmed ammended POC date with provider on 4/4/2024.

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

Review of Resident 3's Assessment/Service Plan (A/SP-equivalent to a Full Assessment and NSA), dated 08/18/2023, did not include an alternate plan on how the ALF would provide care and services for Resident 3 should the PCG not be available.

In an interview, on 02/22/2024 at 2:55 PM, Staff E (Wellness Director) confirmed that there was no back-up plan on how the ALF would provide care and services for Resident 3 developed in Resident 3's A/SP.

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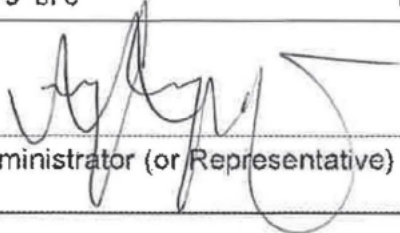
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	3/20/24
Administrator (or Representative)	Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement federal, and state regulated standards of a Respiratory Protection Program (RPP) to ensure respirator mask fit-testing was completed for health care workers (HCWs). This resulted in staff not having fit tests for respirator masks for four days during outbreak in the ALF and placed 39 of 39 residents, ALF staff, and visitors at potential risk for exposure to COVID-19 (is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death).

NOTE: Washington Administrative Code (WAC) 296-842-12005 stated all long term-care facilities were required to develop and maintain a Respiratory Protection Program.

NOTE: Review of a "Dear Administrator" letter, dated 04/30/2021, showed the Department informed ALFs of their responsibility to develop and maintain an RPP. An RPP is defined by Department of Health as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALF were required to provide initial and annual fit-tests for each Health Care Worker (HCW) with the same model, style, and size respirator that the HCW would be required to wear for protection against COVID-19 and airborne hazards. The ALF were required to provide fit-tested respirators, such as N95, to all HCWs with the potential to have contact with residents with known or suspected COVID-19. The ALF were required to provide gowns, gloves, and eye protection to staff who are providing care to residents.

Record review of the ALF's policy, "Respiratory Protection Protocol" dated 04/2020, showed fit testing of employees who were required to wear respirators would be fit tested prior to being allowed to wear any respirator with a tight fitting facepiece; annually; and when there were changes in the employee's physical condition that could affect respiratory fit (obvious changes in body weight, facial scarring, etc). The employees would be fit tested with the make model, style, and size of respirator that they would actually wear in the facility.

Administrator (or Representative)

Date

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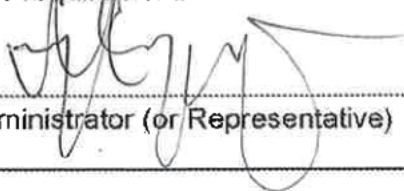
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Observation and interview, on 02/22/2024 at 10:10 AM, showed Staff D (Executive Director) was wearing a surgical mask. Staff D stated that there was currently a COVID-19 outbreak in the ALF.

This Washington Administrative Code (WAC) was previously cited for not having staff fit-testing for respirator masks on 12/26/2023. The ALF signed an attestation statement, on 01/02/2024, stating they would take active measures to correct the deficiency, be in compliance, and implement a system to monitor and ensure continued compliance by 02/09/2024.

Record review showed the ALF had a COVID-19 outbreak that occurred on 02/09/2024. Review of mask fit-test records, on 02/22/2024, showed the ALF did not initiate fit-testing for staff until 02/13/2024, four days after the outbreak and plan of correction date.

This is an uncorrected deficiency previously cited on 12/26/2023.

Plan/Attestation Statement	
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AGING AND LONG-TERM SUPPORT ADMINISTRATION
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The department staff that inspected the Assisted Living Facility:

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Residential Care Services

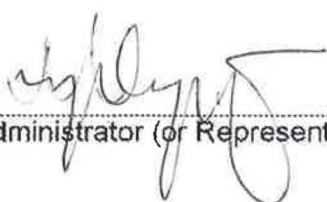
12/28/2023

Date

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 Administrator (or Representative)

12/28/2023

Date

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Findings included...

DIABETIC CARE

Review of the American Diabetes Association website showed diabetes is a disorder in which the body has high sugar levels for prolonged periods of time. The disease may be

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controlled with oral medications, injectable medications such as insulin, and by diet modification. According to the American Diabetes Association hyperglycemia, or high blood sugar, occurs when the body has too little insulin or cannot use insulin properly. Hypoglycemia, or low blood sugar, is defined as blood sugar below 70 mg/dL (milligrams per deciliter).

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2020 with multiple medically disabling conditions including non-insulin diabetes (a disorder in which the body has high BS levels for prolonged periods of time). Record review of an electronic Medication Administration Records (eMARs) for September, October, and November 2023, showed Resident 1 was taking medication to treat their diabetes.

Review of the Resident 1's NSA, dated 09/18/2023, showed to report to nurse any signs and symptoms of low and high BS levels or changes in level of consciousness however did not outline what the signs and symptoms of low and high BS levels were. The NSA stated to, "See medication administration record [MAR] for description of signs and symptoms" However, the MAR also did not list signs and symptoms of high and low blood sugar levels for staff to follow and report.

RESIDENT 5

Review of a RI form, dated 10/23/2023, showed the ALF admitted Resident 5 on [REDACTED]/2020 with multiple medically disabling diagnoses to include [REDACTED]. Record review of an electronic Medication Administration Records (eMARs) for September, October, and November 2023, showed Resident 5 required was taking medication to treat their diabetes.

Review of an NSA, dated 05/01/2023, did not outline what the signs and symptoms of low and high BS levels were, what the caregivers were to watch out for and who to report to.

Interview, on 11/17/2023 at 3:30 PM, Staff H, (Wellness Director) confirmed there were no signs and symptoms of high or low BS for the caregivers to monitor Resident 1 or 5 in their NSAs.

MEDICATION MANAGEMENT

RESIDENT 1

Review of the A/SP, dated 09/18/2023, showed a family member, a non-sampled resident (Resident 9) would manage medications and diabetic needs for Resident 1.

Observation and interview, on 11/17/2023 at 1:15 PM, showed Resident 1 and Resident 9 (spouse), in their shared apartment. Referring to their medication care Resident 1 stated, "I do not do anything. He [referring to Resident 9] does everything for me including my

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medicine." Resident 9 confirmed he ordered and managed all of Resident 1's medications.

Review of the NSA, dated 09/18/2023, showed it did not clearly define the role Resident 9 took in managing Resident 1's medications. The NSA had no alternate plan on how Resident 1 would receive medication services and diabetic needs should Resident 9 be unavailable.

PRIVATE CAREGIVER

RESIDENT 2

Review of a RI form, dated 08/21/2023, showed the ALF admitted Resident 2 on [REDACTED]/2018 with multiple disabling diagnoses including [REDACTED]. Review of Resident 2's A/SP, dated 02/13/2023, a section titled, "Daily Routine/Habits Support", showed Resident 2 had a "Private Caregiver 24/7 due to high care level."

Observation and interview, on 11/17/2023 at 1:30 PM, showed Resident 2 in her apartment asleep in her wheelchair, a Collateral Contact 1 (CC1 - a Private Caregiver) was also present. When questioned on who provided care and services, CC1 stated Resident 2 had been receiving care and services from Private Caregivers (PCG) 24 hours a day and seven days a week since November 2021. CC1 stated that PCGs assisted Resident 2 with all activities of daily living (ADLs - a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc) and the use of a breathing machine (continuous positive airway pressure).

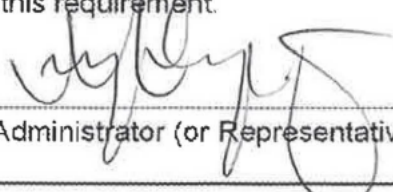
Review of an NSA, dated 02/13/2023, did not clearly define roles and responsibilities of the PCGs and the ALF staff. The NSA showed no alternate plan and how Resident 2 would receive care and services should the PCG be unavailable.

This is a deficiency previously cited on 04/05/2022.

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, NIKKEI MANOR is or will be in compliance with this law and / or regulation on (Date) 2/9/24.

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


Administrator (or Representative)

1/2/2024
Date

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WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the primary care provider as ordered for 1 of 1 sampled resident's (Resident 2) who had low blood pressure. This placed Resident 2 at risk of compromised health conditions.

Findings included...

Review of a Resident Information form, dated 08/21/2023, showed the ALF admitted Resident 2 on [REDACTED]/2018 with multiple disabling diagnoses including [REDACTED]. Review of a physician order, dated 04/01/2023, showed an order to check Resident 2's blood pressure (BP) in the morning every Saturday, and notify their Primary Care Physician (PCP) if BP is less than 110/60.

Review of the electronic Medication Administration Records (eMARs) for September and October 2023, showed Resident 2 had the following BP readings: 100/50 on 10/04/2023; 108/62 on 10/05/2023; 109/82 on 09/02/2023; and 97/62 on 09/09/2023.

Record review showed no documentation Resident 2's PCP was notified regarding low BP readings as ordered. There was no documentation for what signs or symptoms Resident 2 showed when her BP were out of range.

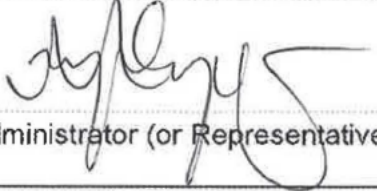
Interview, on 12/20/2023 at 4:50 PM, Staff H (Wellness Director) stated, "Yes, that was an order, but if there was no documentation, then the doctor was not notified of the [Resident 2's] pattern of low BP."

Plan/Attestation Statement

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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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff providing medication assistance or administration, documented their signature or initials as medications were given for 2 of 2 sampled residents (Residents 5 and 8). This caused Resident 5 and 8 to have incomplete and incorrect medical records.

Findings included...

RESIDENT 5

Review of a Resident Information (RI) Form, dated 10/23/2023, showed the ALF admitted Resident 5 on [REDACTED] 2020 with multiple medically disabling diagnoses including [REDACTED] and [REDACTED]. Review of a Negotiated Service Agreement (NSA), dated 05/05/2023, showed Resident 5 required staff administration (by Registered Nurse or Licensed Practical Nurse) for her eye drops.

Record review the September 2023 electronic Medication Administration Record (eMAR) showed Resident 5 had a physician ordered Refresh eye drops (used to relieve eye dryness) 0.5-0.9% instill 1 drop in each eye four times a day. The September 2023 eMAR showed no signature or initials of the nurse who administered the Refresh eye drops on 09/02/2023, 09/03/2023, 09/04/2023, 09/06/2023, 09/09/2023, 09/11/2023, 09/12/2023, 09/19/2023, 09/21/2023, and 09/28/2023 for 8:00 PM dose.

Review of the October and November 2023 eMAR, showed Resident 5 had a physician order for Latanoprost solution (used to treat glaucoma) 0.005% instill 1 drop in each eye every evening. The October and November 2023 eMAR showed no signature or initials of the nurse who administered the Latanoprost on 10/06/2023 and 11/03/2023.

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Review of the October eMAR, showed Resident 5 had a physician order Brimonidine solution (used to lower pressure in the eye in patients with glaucoma) 0.2% instill 1 drop in each eye daily at 6:00 PM. The October 2023 eMAR showed no signature or initials of the nurse who administered the Brimonidine solution on 10/06/2023.

Resident 8

Review of an RI form, showed the ALF admitted Resident 8 on [REDACTED]/2022 with multiple medically disabling diagnoses including [REDACTED]

and [REDACTED].

Review of Resident 8's Assessment and Negotiated Service Agreement, dated 10/21/2023, under Medication Status, showed Resident 8 required staff assistance with medication.

Record review of the October 2023 eMAR showed Resident 8's physician ordered entacapone (used to treat involuntary muscle movements) tablet 200 milligram (mg) give 1 tablet in the morning and afternoon at 7:00 AM and 2:00 PM. The October 2023 eMAR showed no signature or initials of the nurse who administered the entacapone on 10/21/2023, 10/25/2023, and 10/26/2023 at the 2:00 PM.

Review of the November 2023 eMAR showed no signature or initials of the nurse who administered the entacapone on 11/01/2023 and 11/02/2023 at 2:00 PM.

Interview, on 11/17/2023 at 3:30 PM, Staff H, (Wellness Director) confirmed the nurses were not signing or initialing medications as required.

In interview, on 12/19/2023 at 12:20 PM, Staff N (on-call Registered Nurse) stated medications were given to Resident 5 and 8, but signatures and initials were missed due to record systems were being changed from written to electronic.

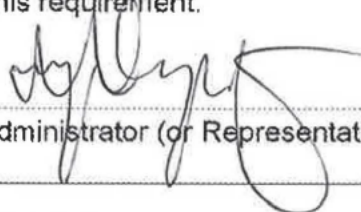
In interview, on 12/20/2023 at 4:50 PM, Staff H (Director of Wellness) stated, they would find solutions on how their software system (PCC) would capture missed staff signature or initials in the eMARs.

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Administrator (or Representative)

1/2/24
Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to implement federal, and state regulated standards of a Respiratory Protection Program (RPP) to include implementing respirator mask fit-testing for 2 of 2 sampled staff (Staff A and E). This placed 40 of 40 residents, ALF staff, and visitors at potential risk for exposure to SARS-CoV-2, the virus responsible for COVID-19 (is an infectious disease by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death).

NOTE: Washington Administrative Code (WAC) 296-842-12005 stated all long term-care facilities were required to develop and maintain a Respiratory Protection Program.

NOTE: Review of a "Dear Administrator" letter, dated 04/30/2021, showed the Department informed ALFs of their responsibility to develop and maintain an RPP. An RPP is defined by Department of Health as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALF were required to provide initial and annual fit-tests for each Health Care Worker (HCW) with the same model, style, and size respirator that the HCW would be required to wear for protection against COVID-19 and airborne hazards. The ALF were required to provide fit-tested respirators, such as N95, to all HCWs with the potential to have contact with residents with known or suspected COVID-19. The ALF were required to provide gowns, gloves, and eye protection to staff who are providing care to residents.

Record review of the ALF's policy, "Respiratory Protection Protocol" dated 04/2020, showed fit testing of employees who were required to wear respirators would be fit tested prior to

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being allowed to wear any respirator with a tight fitting facepiece; annually; and when there were changes in the employee's physical condition that could affect respiratory fit (obvious changes in body weight, facial scarring, etc). The employees would be fit tested with the make model, style, and size of respirator that they would actually wear in the facility.

Record review, showed Staff A (Resident Assistant/Caregiver), hired on 03/18/2023, had no documentation of a completed respiratory mask fit-test.

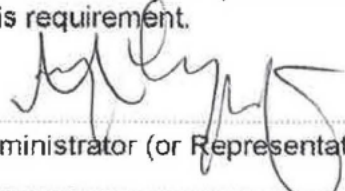
Record review, showed Staff E, (Resident Assistant/Caregiver), hired on 07/10/2017, was fit-tested for a respiratory mask on 01/13/2022. There was no documentation Staff E was fit-tested at least annually by January 2023.

Interview, on 11/17/2023 at 4:45 PM, Staff H (Wellness Director) stated that the respiratory mask fit testing was done in January 2022 by an outside Agency. Staff H stated she was aware of the annual fit testing requirements, and that no fit testing for employees who are required to wear respirators were done in 2023.

Plan/Attestation Statement

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Administrator (or Representative)

1/2/24
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

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(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 sampled staff (Staff A, B, and C) received orientation to the facility. This failure placed 40 of 40 residents at risk of harm from care staff unfamiliar with the ALF and their expected duties.

Findings included...

Review of an undated Resident Characteristic Roster showed the ALF provided care and services to 40 residents.

Record review showed Staff A (Resident Assistant) was hired on 03/18/2023. Staff A's record showed no documentation of orientation to the facility upon hire.

Record review showed Staff B (Maintenance) was hired on 10/05/2023. Staff B's record showed no documentation of orientation to the facility upon hire.

Record review showed Staff C (Food Service Assistance) was hired on 04/30/2023. Staff C's record showed no documentation of orientation to the facility upon hire.

Interview, dated 11/15/2023 at 2:45 PM, Staff F (Executive Director) acknowledged the lack of facility orientation for Staff A, B, and C.

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, NIKKEI MANOR is or will be in compliance with this law and / or regulation on (Date) 1/5/2024.

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

Administrator (or Representative)

1/2/2024
Date

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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:

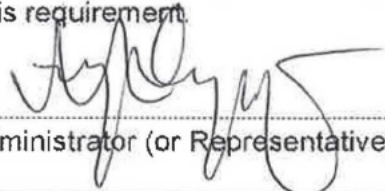
Based on interview and record review, the Assisted Living Facility (ALF) failed to screen 2 of 4 sampled staff (Staff A and B) for tuberculosis (TB) within three days of employment. This placed 40 residents at risk of exposure to a communicable disease.

Findings included...

Review of records showed the ALF hired Staff A (Resident Assistant) on 03/18/2023. Staff A's record showed TB screening was done on 03/31/2023, 13 days after date of hire.

Review of record showed the ALF hired Staff B (Maintenance) on 10/05/2023. Staff B's record showed TB screening was done on 10/18/2023, five days from hire date.

Interview, on 11/17/2023 at 3:15 PM, Staff F (Executive Director) confirmed Staff A and Staff B's TB screening was not completed within the required time frame.

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)	<u>1/2/2024</u> _____ Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

- (1) Ensure that the staff person has a chest X-ray within seven days;
- (2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and
- (3) Follow the recommendation of the resident or staff person's health care provider.

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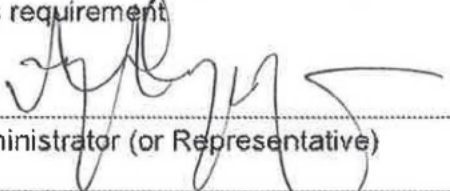
This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have a chest x-ray completed within seven days for 1 of 4 sampled staff (Staff C), after a positive TB screen test result. This placed 40 residents at risk of exposure to a communicable disease.

Findings included...

Review of records showed the ALF hired Staff C (Food Services Assistant) on 04/30/2023. Staff C's record showed a TB screening was done on 05/03/2023, with a positive result dated 05/09/2023. Staff C did not have a chest x-ray done within 7 days.

Interview, on 12/06/2023 at 11:15 PM, Staff F (Executive Director) confirmed Staff C's chest x-ray was not completed within the required time frame.

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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:
- (a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;
 - (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:
 - (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

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This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to complete a full assessment for 2 of 2 sampled residents (Residents 3 and 6) of Resident 3's ability to safely use a bed mobility device (a bed-side rail ((BSR)) and to accurately direct caregivers to administer a pain patch, and Resident 6's ability to safely use a BSR. This placed Resident 3 at risk for not receiving proper medication administration and compromised their pain control and placed both Residents 3 and 6 at risk for serious bodily harm, including death by entrapment from a bed mobility device.

Findings included...

Note: On 05/15/2013, a "Dear Assisted Living Facility Administrator" letter was issued to Assisted Living Facility Providers related to the safety risks associated with the use of all medical devices to include, i.e. "some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted."

Review of the United States Food and Drug Administration (FDA) website, on 01/05/2022, showed the FDA developed a document regarding side bed rail use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessment to monitor for resident's physical and mental status, monitoring high risk residents, and ensuring side bed rail safe installation. The document outlined risks of using side rails including strangling, suffocating, bodily injury or death when a person can get caught, increased fall risk if not used properly, feelings of isolation and unnecessary restriction and prevention of completing activities of daily living.

RESIDENT 3

Review of a Resident Information (RI) form showed the ALF admitted Resident 3 on [REDACTED]/2023 with multiple disabling diagnoses. Review of an Assessment and Care Plan (ACP, equivalent to a full assessment and a Negotiated Service Agreement), dated 08/15/2023, showed Resident 3 had a quarter size BSR and a Transfer Pole (TP).

Observation and interview, on 11/16/2023 at 1:30 PM, showed a BSR 10 inches wide and 12 inches tall attached on the left side of Resident 3's bed and covered with a pillowcase type cloth. Resident 3 stated that she had been using the BSR to get in and out of the bed for a while. Observation showed no TP in Resident 3's room.

Record review showed no assessment for the BSR, identifying the safety considerations including the risks and benefits, the need and ability of Resident 3 to safely use it, or ensuring the proper and safe installation of the BSR.

In an interview, on 11/17/2023 at 10:30 AM, Staff G (Health Services Director) stated that Resident 3 did not have a TP, but had a BSR on the bed. Staff G confirmed there was no BSR

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assessment for Resident 3.

Review of the Medication Level and Support section in the Full Assessment, dated 08/15/2023, showed that Resident 3 required staff assistance with medications, and required Licensed Nurses to administer pain patches.

Review of the September, October, and November electronic Medication Administration Records (eMARs) showed that Resident 3 was prescribed to apply a Lidocaine patch (used to relieve pain) on their back at 8:00 AM, and to remove it at 8:00/8:30 PM. Review of the eMARs showed that Medication Resident Assistants (MRAs, non-licensed caregivers) signed in the column for the Lidocaine patch, showing they were administering the patch to Resident 3.

In an interview, on 11/17/2023 at 1:15 PM, Resident 3 stated that MRAs had been putting a pain patch on their back every morning and removing it at bedtime.

Record review showed no assessment of Resident 3's ability to safely and accurately direct MRAs to apply the Lidocaine patch.

RESIDENT 6

Review of a RI form showed the ALF admitted Resident 6 on [REDACTED]/2022, with multiple disabling diagnoses including [REDACTED]. Review of an ACP, dated 11/14/2023, showed Resident 6 had a TP in their apartment.

Observation and interview, on 11/17/2023 at 1:45 PM, showed a BSR 12 inches wide and 8 inches tall attached at the foot of Resident 6's bed and covered with a pillowcase type cloth. Resident 6 stated that they had been using the BSR for getting in and out of bed. Observation showed no TP in the apartment.

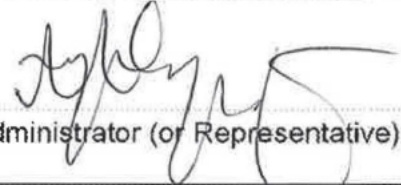
In an interview, on 11/17/2023 at 10:30 AM, Staff G stated that Resident 6 had not had a TP but had a BSR on the bed. Staff G confirmed there was no BSR assessment for Resident 6.

Plan/Attestation Statement

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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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(c) Initial and on-going assessments of the nursing needs of each resident;

(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:

(b) Chapter 18.88A RCW, Nursing assistants;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that pain assessments were conducted by licensed staff for 1 of 1 sampled resident (Resident 4) prior to administering and determining the effectiveness of pain medication. This failure resulted in Resident 4 experiencing uncontrolled pain and placed Resident 4 at risk for a deteriorated health condition.

Findings included...

Note: Revised Code of Washington (RCW) 18.88A.030 - Scope of practice— (1)(a) A nursing assistant may assist in the care of individuals as delegated by and under the direction and supervision of a licensed (registered) nurse or licensed practical nurse (c) Nothing in this chapter shall be construed to confer on a nursing assistant the authority to administer medication unless delegated as a specific nursing task pursuant to this chapter or to practice as a licensed (registered) nurse or licensed practical nurse as defined in chapter 18.79 RCW.

Review of a Disclosure of Services (DOS), dated 10/31/2023, showed the ALF would provide Intermittent Nursing Services but would not use Nursing Assistants (non-licensed staff) under the delegation of a Registered Nurse (RN). The DOS showed that the ALF typically had a RN in the building 10 hours per day.

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In an interview, on 11/15/2023 at 9:15 AM, Staff F (Administrator) stated that the ALF did not provide Nurse Delegation services for residents.

Review of a Resident Information form showed the ALF admitted Resident 4 on [REDACTED]/2022 with multiple medical diagnoses. Review of an Assessment and Care Plan (ACP - equivalent to a combined Assessment and Negotiated Service Agreement), dated 03/20/2023, showed Resident 4 required staff assistance with medications.

Review of the November 2023 electronic Medication Administration Records (eMARs) showed that Resident 4 was prescribed two medications for pain: one was 650 milligrams (mg) of acetaminophen (used to relieve mild to moderate pain and to reduce fever) to be taken three times a day as needed; and the other was 50 mg of Tramadol (a medication in a class of narcotic pain relievers used to relieve moderate to moderately severe pain) every eight hours as needed.

Review of the November 2023 eMAR showed the orders for acetaminophen and Tramadol did not include a pain scale (a tool to determine pain level using numbers from 0 to 10. A score of 0 means no pain, and 10 means the worst pain a person has ever felt) which would show what medication should be given according to Resident 4's pain level. Without pain scale instructions, Resident 4 would require a nursing assessment to determine what pain medication was appropriate and if the pain medication was effective.

Review of the November 2023 eMARs and Progress Notes (PN) showed that on multiple occasions, Medication Resident Assistants (MRAs- Nursing Assistants) determined, assessed and medicated outside of their scope of practice Resident 4's pain without LNs' evaluation gave Tramadol (narcotic) or acetaminophen for Resident 4's pain without LNs' instruction. There was no documentation as to whether LNs assessed Resident 4's pain condition or provided clear instruction to MRAs for Resident 4's pain management.

Review of a PN written by Staff J (MRA), dated 11/03/2023 at 7:57 PM, showed, "Tramadol was given to [Resident 4] for possible pain. [Resident 4] denied it, but you can tell by [Resident 4's] facial expression". Staff J documented they determined Resident 4's pain level to be "4" on the pain scale. The PN, showed at 10:10 PM, Staff J documented they assessed Resident 4's, "follow up pain scale" was a "4/Ineffective", indicating that the Tramadol was ineffective at controlling Resident 4's pain.

Record review showed that on 11/04/2023 at 8:22 PM, Resident 4 complained of pain in the left thigh and hip, with a pain scale of 5. Staff K (MRA) gave Tramadol to Resident 4. Review of a PN written by Staff K, dated 11/04/2023 10:26 PM, showed Resident 4 still had a lot of pain, and the Tramadol had been ineffective.

Review of a PN written by Staff A (MRA), dated 11/05/2023 at 4:36 AM, showed that Resident 4 was in maximum pain on the left thigh up to the hip. The pain level was "10" on the pain scale. Staff A gave Tramadol to Resident 4.

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Record review showed that on 11/05/2023 at 7:55 PM, Resident 4 complained of pain on the left leg. Staff L (MRA) determined the pain level was "5", and they gave acetaminophen (instead of Tramadol) to Resident 4. Records review showed that two hours after Resident 4 took Acetaminophen, Staff K (MRA) documented that Acetaminophen was ineffective, and that Resident 4 still had a lot of pain with a pain scale of "5".

Record review showed that on 11/06/2023 at 12:50 PM, Staff J documented that Resident 4 was having a hard time walking, and Staff J gave them acetaminophen for pain on the hip, where the pain scale was 3. At 1:55 PM, Staff J documented that acetaminophen was ineffective, and the pain scale remained at 3.

Record review showed that on 11/07/2023 at 6:19 AM, Staff O (MRA) documented that Resident 4 had lower back pain at "10" on the pain scale, and the MRA gave Tramadol. Review of a PN, dated 11/07/2023 at 9:01 AM, about three hours after Resident 4 took Tramadol, showed another MRA documented Resident 4's pain was "4", and Tramadol was effective.

Record review showed in all of the above outlined PN's there was no documentation to show a licensed nurse assessed Resident 4's pain and the effectiveness of pain medication. There was no documentation to show the MRA's notified a licensed nurse that Resident 4's pain was not well controlled.

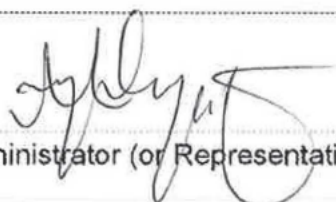
In a telephone interview, on 12/15/2023 at 11:32 AM, Staff H (Director of Wellness) stated that they had been responsible for nursing services for 24 hours a day, seven days a week. Staff H stated that MRAs had not contacted to Staff H about Resident 4 experiencing significant pain during the evening or at night. Staff H stated that there was no specific pain parameter for selection of pain medications to be given for Resident 4. Staff H confirmed that MRAs were Certified-Nursing Assistants, not licensed staff. Staff H acknowledged that MRAs made their own decisions to give acetaminophen or Tramadol to Resident 4. Staff H acknowledged that LNs should have assessed Resident 4's pain condition to determine which pain medication should be given.

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, NIKKEI MANOR is or will be in compliance with this law and / or regulation on (Date) 2/9/24.

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

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Administrator (or Representative)1/2/24
Date