



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

THE SAMUEL & JESSIE KENNEY PRESBYT
THE KENNEY
7125 Fauntleroy Way SW
Seattle, WA 98136

RE: THE KENNEY License # 128

Dear Administrator:

This letter addresses Compliance Determination(s) 37753 (Completion Date 03/26/2024) and 33255 (Completion Date 01/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/26/2024 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-2730-1-a, WAC 388-78A-2730-1-b

The Department staff who did the on-site verification:
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 #: 128	Compliance Determination # 33255
Plan of Correction	THE KENNEY	Completion Date
Page 1 of 3	Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT	01/05/2024

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 off-site follow-up on 11/28/2023 and 01/05/2024 of:

THE KENNEY
7125 Fauntleroy Way SW
Seattle, WA 98136

This document references the following SOD dated: 01/05/2024

The following sample was selected for review during the unannounced off-site verification: 24 of 24 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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 off-site verification(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

01/16/2024
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 #: 128	Compliance Determination # 33255
Plan of Correction	THE KENNEY	Completion Date
Page 2 of 3	Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT	01/05/2024


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 interview and record review, the Assisted Living Facility (ALF) failed to implement the Federal and State regulated standards of a Respiratory Protection Program (RPP) by respirator mask fit-testing for staff. This placed 24 of 24 residents, staff, and visitors at risk for exposure to SARS-CoV-2, the virus responsible for COVID-19 (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).

Findings included...

NOTE: Washington Administrative Code (WAC) 296-842-12005 states that all long-term care facilities are required to develop and maintain an RPP.

NOTE: In a "Dear Administrator" letter, dated 04/30/2021, the Department informed ALFs of their responsibility to develop and maintain an RPP. An RPP is defined by the Department of Health as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALFs were required to provide initial and annual fit-tests for each Health Care Worker (HCW) with the same model, style, and size respirator mask that the HCW would be required to wear for protection against COVID-19 and airborne hazards. An RPP included ensuring all staff have respirator mask medical clearance and fit testing done on an annual basis.

Review of the undated Residents Characteristics Roster showed the ALF was providing care and services for 24 residents.

Review of the Secure Tracking and Reporting System database showed from April 2023 to October 2023 the ALF had been cited under this Washington Administrative Code 388-78A-2370 - Licensing responsibility for respiratory mask fit-testing for HCW on three

Statement of Deficiencies	License #: 128	Compliance Determination # 33255
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occasions. Review of the most recent Statement of Deficiencies, dated 10/04/2023, showed the ALF had signed an attestation statement stating they would be in compliance with this regulation by 11/18/2023.

Review of a telephone message from Staff A (Administrator), on 12/21/2023 at 11:51 AM, showed that on that day, over a month past the ALF's compliance date, four staff members would be receiving training on how to conduct respirator mask fit-testing. Staff A stated in the telephone message that the ALF had ordered a mask fit-test kit that should arrived the following week.

In a telephone interview, on 01/04/2024 at 11:44 AM, Staff B (Business Office Manager) stated that Staff A had ordered the mask fitting test kit and different types of respirator masks, but they had not yet arrived at the ALF. Staff B stated the ALF had still not done respiratory mask fit-testing for staff.

In a telephone interview, on 01/05/2024 at 1:32 PM, Staff A stated that the mask fitting test kit would arrive next Monday (01/08/2024). Staff A confirmed that the ALF had not yet initiated respiratory mask fit-testing for staff.

Record review showed the ALF had no documentation to show any of the HCW had completed respiratory mask fit-testing.

This is a recurring and uncorrected deficiency previously cited on 10/04/2023, 06/15/2023, and 04/07/2023.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) ~~2/29/2024~~ 2/19/2024

SB confirmed ammended POC date with provider on 1/23/2024.

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


Administrator (or Representative)

1/16/2024
Date



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 #: 128	Compliance Determination # 28548
Plan of Correction	THE KENNEY	Completion Date
Page 1 of 5	Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT	10/04/2023

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 follow-up on 08/14/2023 and 09/25/2023 of:

THE KENNEY
7125 Fauntleroy Way SW
Seattle, WA 98136

This document references the following SOD dated: 10/04/2023

The following sample was selected for review during the unannounced on-site visit: 5 of 27 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Keiko Kitano, Licensors
Alma Duran, 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

10/11/2023
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.

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

Administrator (or Representative)

Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Emergency and Disaster Preparedness Manual included names of on-duty staff person's responsibilities, alternate resident accommodations, provision of residents' food and medications in the event of an emergency evacuation and was readily available. This failure placed 27 of 27 residents at risk of compromised health due to lack of life sustaining provisions and displacement in the event of an emergency or disaster.

Findings included...

Review of the ALF's Resident Characteristic Roster, undated, showed the facility provided care and services to six residents in a Memory Care Unit and 21 residents in Assisted Living.

Record review of the ALF's Disaster Response Plan (DRP) showed it did not include names of on-duty staff person's responsibilities. The DRP had one alternate locations for resident evacuation listed, however it stated that location was still, "pending for approval." In addition, the DRP did not contain information regarding the provision of essential resident needs including food and medications.

In interview, on 09/25/2023 at 10:20 AM, Staff D (Administrator/Executive Director) stated they had an agreement with two [named] alternate locations for residents, in the event of an emergency. When the Department Representative asked Staff D for the DRP to review, Staff D could not locate it.

In interview, on 09/25/2023 at 12:45 PM, Staff E (Business Office Manager) stated it was

the responsibility of Staff G (Front Desk/Concierge) to maintain and update the DRP.

In interview, on 09/25/2023 at 1:30 PM, Staff H (Facilities Director) confirmed the ALF did not have an emergency food supply in place.

In interview, on 09/25/2023 at 2:35 PM, Staff D confirmed that the DRP was incomplete lacking names of on-duty staff person's responsibilities, alternate resident accommodations, provision of residents' food and medications or was readily available, "We will work on that right away."

This is a recurring and uncorrected deficiency previously cited on 06/15/2023, 04/07/2023, and 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date)_____.

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

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 interview and record review, the Assisted Living Facility (ALF) failed to implement the Federal and State regulated standards of a Respiratory Protection Program (RPP) including respirator mask fit testing for staff. This placed 27 of 27 residents, all staff, and visitors at risk for exposure to SARS-CoV-2, the virus responsible for COVID-19 (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).

Findings included...

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

NOTE: In a "Dear Administrator" letter, dated 04/30/2021, the Department informed ALFs of their responsibility to develop and maintain an RPP. An RPP is defined by the Department of Health as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALFs were required to provide initial 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. An RPP included ensuring all staff have respirator mask medical clearance and fit testing done on an annual basis.

Record review of the undated Residents Characteristics Roster showed the ALF was providing care and services for 27 residents.

In an interview, on 09/25/2023 at 10:20 AM, Staff D (Administrator) stated, "We are just now getting over a COVID-19 outbreak." Staff D stated that the ALF had recently had two COVID-19 outbreaks. Staff D stated that 10 residents and five staff members were affected.

In an interview, on 09/25/2023 at 1:15 PM, when asked whether caregivers, including Staff F (Resident Care Manager) had received a respiratory mask fit test, Staff F stated that they had never had the mask fit test.

In an interview, on 09/25/2023 at 1:18 PM, Staff A (Director of Nursing) stated that the ALF would have soon have respirator mask fit test training for selected people. When asked the date for the training, Staff A said, "I don't know." When asked whether they had ever had a respirator mask fitting test, Staff A stated, "No".

In a second interview, on 09/25/2023 at 2:28 PM, when asked whether the ALF had an RPP for staff, including medical clearance and respirator mask fit testing, Staff D stated that the ALF had not done mask fit testing for staff. Staff D confirmed, "The mask fit testing citation was still not corrected."

This is a recurring and uncorrected deficiency previously cited on 06/15/2023 and 04/07/2023.

Plan/Attestation Statement

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

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE KENNEY is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date



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 #: 128	Compliance Determination # 24882
Plan of Correction	THE KENNEY	Completion Date
Page 1 of 9	Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT	06/15/2023

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 follow-up on 06/01/2023 and 06/05/2023 of:

THE KENNEY
7125 Fauntleroy Way SW
Seattle, WA 98136

This document references the following SOD dated: 06/15/2023

The following sample was selected for review during the unannounced on-site visit: 6 of 31 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.

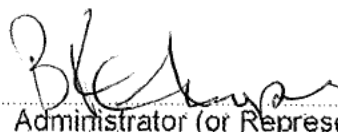

Residential Care Services

06/22/2023
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.

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

Statement of Deficiencies	License #: 128	Compliance Determination # 24882
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Page 2 of 9	Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT	06/15/2023



Administrator (or Representative)

6/22/23

Date

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:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(c) Other conditions that may require behavioral intervention strategies;

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to screen and document special needs related to dementia for 1 of 1 sampled resident (Residents 5). This placed Resident 5 at risk for not receiving proper care and services and a deteriorating health condition.

Findings included...

Review of an Admission Record, dated 02/22/2023, showed the ALF admitted Resident 5 on [REDACTED] 2023 with a diagnosis of [REDACTED].

Review of a Pre-Admission Assessment, dated 02/22/2023, showed Resident 5 was identified as having, "a memory issue that may be a concern, but did not interfere with everyday functions."

Review of Resident 5's Assessment showed no information as to whether the ALF used a dementia screening tool to assess Resident 5's dementia. The Assessment did not contain any information regarding the presence of memory loss and how that would affect care needs.

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

Statement of Deficiencies	License #: 128	Compliance Determination # 24882
Plan of Correction	THE KENNEY	Completion Date
Page 3 of 9	Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT	06/15/2023

In an interview, on 06/01/2023 at 11:00 AM, Staff D (Agency Registered Nurse) confirmed the ALF had not conducted a dementia screening as part of Resident 5's Assessment.

This is an uncorrected deficiency previously cited on 04/07/2023 and a recurring deficiency previously cited on 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) ~~7/3/2023~~ 7/30/2023

KK confirmed POC date with Provider on 7/6/2023.

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


 Administrator (or Representative)

6/22/2023
 Date

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

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (iii) On-going assessments of the resident;
 - (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.
- (5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to develop a Negotiated Service Agreement (NSA) that clearly defined the roles and responsibilities, including alternate plans of a Private Caregiver (PC) for 1 of 1 sampled resident (Resident 3), and failed to develop and document behavioral interventions for 1 of 1 sampled resident (Resident 5). This placed Residents 3 and 5 at risk for not receiving proper care and services.

Findings included...

RESIDENT 3

Review of an Admission Record (AR), dated 06/22/2022, showed the ALF admitted Resident 3 on [REDACTED] 2018 with multiple diagnoses including [REDACTED]. Review of the Resident Characteristic Roster, undated, showed Resident 3 was identified to have a PC.

Observation, on 06/01/2023 at 10:45 AM, showed Resident 3 in the ALF's lobby with her PC.

In an interview, on 06/01/2023 at 10:50 AM, the PC stated she visited Resident 3, six days a week, for one to two hours or longer, depending on Resident 3's needs for the day. The PC stated she assisted Resident 3 with medication reminders, medical care/appointments, picked up medications from two pharmacies, and assistance with shopping.

Review of Resident 3's record showed an ALF form titled, "Non-Medical services provided by [BLANK]." Although the form was included in Resident 3's record, it did not identify Resident 3, and had no resident name written on it.

Review of the NSA, dated 10/11/2022, showed no information about Resident 3's PC such as roles and responsibilities, frequency, hours, and days of the PC's visits to Resident 3. Resident 3's NSA did not have an alternate plan in the event the PC was unavailable to provide Resident 3's medications or drive to medical appointments.

RESIDENT 5

Review of an AR showed the ALF admitted Resident 5 on [REDACTED] 2023 with multiple diagnoses including [REDACTED]

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Record Review of the May 2023 electronic Medication Administration Record showed Resident 5 was ordered to take a routine dose of Alprazolam (a medication used to relieve anxiety) and three medications for depression: Wellbutrin XL, Trazodone HCl, and Venlafaxine HCL.

Review of an NSA, dated 02/23/2023, under the Mood and Cognitive Status section, showed a mark for that Resident 5 had, "depression." The NSA did not include baseline behaviors for staff to identify, behavioral interventions, or a crisis plan when Resident 5 exhibited decompensation state (worsening condition of mental health).

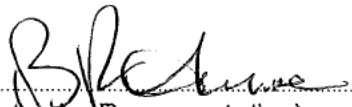
This is an uncorrected deficiency previously cited on 04/07/2023 and a recurring deficiency previously cited on 06/23/2021.

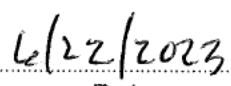
Plan/Attestation Statement

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) ~~7/21/2023~~ 7/30/2023

KK confirmed POC date with Provider on 7/6/2023.

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


Administrator (or Representative)


Date

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

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

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 128	Compliance Determination # 24882
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Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 4 sampled agency staff members (Staff A - Agency Caregiver and Staff D - Agency Registered Nurse) had valid Washington State Name and Date of Birth Background Checks (BGC). This placed 31 residents at risk for receiving care from staff whose criminal background history was unknown.

Findings included...

Review of the undated Residents Characteristics Roster showed the ALF was providing care and services for 31 residents.

In an interview, on 06/01/2023 at 9:20 AM, Staff F (Business Office Manager) stated that multiple staff members were working at the ALF from an outside agency contracted with the ALF.

Record review showed that Staff A began working at the ALF on 04/15/2023, and Staff D began working at the ALF on 04/11/2023. Record review showed no BGC for Staff A or D.

In an interview, on 06/05/2023 at 10:18 AM, Staff F stated that she was unable to find BGCs for Staff A or D in the ALF's system.

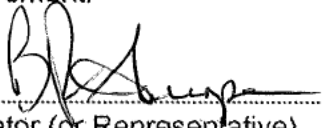
This is an uncorrected deficiency previously cited on 04/07/2023.

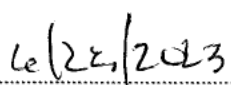
Plan/Attestation Statement

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) ~~6/15/2023~~ 7/30/2023

KK confirmed POC date with Provider on 7/6/2023.

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


Administrator (or Representative)


Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

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- (i) On-duty staff persons' responsibilities;
- (iv) Alternative resident accommodations;
- (v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Emergency and Disaster Preparedness Manual included names of on-duty staff person's responsibilities, alternate resident accommodations, and provision of residents' food and medications in the event of an emergency evacuation. This failure placed 31 residents at risk of compromised health due to lack of life sustaining provisions and displacement in the event of an emergency or disaster.

Findings included...

Review of the ALF's Resident Characteristic Roster, undated, showed the facility provided care and services to seven residents in a Memory Care Unit and 24 residents in Assisted Living.

Review of the ALF's Disaster Response Plan (DRP), on 06/01/2023, showed it did not include names of on-duty staff person's responsibilities. The DRP had one alternate locations for resident evacuation listed however it stated that location was still, "pending approval." The DRP did not contain information regarding the provision of essential resident needs including food and medications.

In an interview regarding emergency food supplies, on 06/05/2023 at 1:30 PM, Staff H (Dining Services Director) stated he had an emergency inventory but, "I'm not finished with my list. I just know we have enough food and I order more if I need to."

In interview, on 06/05/2023 at 2:05 PM, Staff E (Administrator/Executive Director) stated that the DRP was not done, "We will work on that right away."

This is an uncorrected deficiency previously cited on 04/07/2023.

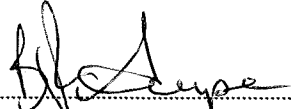
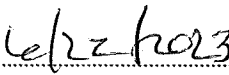
Plan/Attestation Statement

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) 7/30/2023 . 7/30/2023

KK confirmed POC date with Provider on 7/6/2023.

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

Statement of Deficiencies	License #: 128	Compliance Determination # 24882
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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 interview and record review, the Assisted Living Facility (ALF) failed to implement the Federal and State regulated standards of a Respiratory Protection Program (RPP) including implementing respirator mask fit-testing for staff. This placed 31 residents, ALF staff, and visitors at risk for exposure to SARS-CoV-2, the virus responsible for COVID-19 (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: 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 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. An RPP included ensuring all staff have respirator mask medical clearance and fit testing done on an annual basis.

Review of the undated Residents Characteristics Roster showed the ALF was providing care and services for 31 residents.

In an interview, on 06/05/2023 at 10:18 AM, when asked whether the ALF had an RPP for staff, including medical clearance and respirator mask fit testing, Staff E (Administrator) stated that the ALF had not yet implemented an RPP.

In an interview, on 06/05/2023 at 10:20 AM, Staff F (Business Office Manager) stated that

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she was supposed to take a class for training how to conduct respirator/mask fit testing for staff at the ALF, but she had not yet done so.

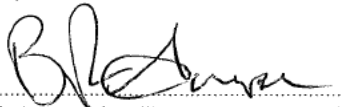
This is an uncorrected deficiency previously cited on 04/07/2023.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) 7/30/2023 . **7/30/2023**

KK confirmed POC date with Provider on 7/6/2023.

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



Administrator (or Representative)

6/22/2023

Date



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

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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 03/14/2023 and 03/16/2023 of:

THE KENNEY
7125 Fauntleroy Way SW
Seattle, WA 98136

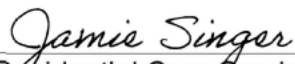
The following sample was selected for review during the unannounced on-site visit: 8 of 34 current residents and 0 former residents.

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

04/13/2023

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.

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

Statement of Deficiencies

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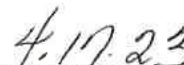
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Licensee: THE SAMUEL & JESSIE KENNEY PRESBYT

04/07/2023



Administrator (or Representative)



Date

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:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(c) Other conditions that may require behavioral intervention strategies;

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to assess the special needs related to dementia and behavior issues for 4 of 4 sampled residents (Residents 2, 3, 5, and 7). This placed Residents 2, 3, 5, and 7 at risk for not receiving proper care and services and a deteriorating health condition.

Findings included...

RESIDENT 2

Review of an Admission Record (AR), dated 04/22/2022, showed the ALF admitted Resident 2 on [REDACTED] 2022 with dementia (a group of symptoms that affects memory, thinking and interferes with daily life).

In an interview, on 03/14/2023 at 9:45 AM, Staff G (Nurse Manager), stated she was responsible in developing each resident's assessments and Negotiated Service Agreement (NSA).

Administrator (or Representative)

Date

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:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(c) Other conditions that may require behavioral intervention strategies;

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to assess the special needs related to dementia and behavior issues for 4 of 4 sampled residents (Residents 2, 3, 5, and 7). This placed Residents 2, 3, 5, and 7 at risk for not receiving proper care and services and a deteriorating health condition.

Findings included...

RESIDENT 2

Review of an Admission Record (AR), dated 04/22/2022, showed the ALF admitted Resident 2 on [REDACTED] 2022 with dementia (a group of symptoms that affects memory, thinking and interferes with daily life).

In an interview, on 03/14/2023 at 9:45 AM, Staff G (Nurse Manager), stated she was responsible in developing each resident's assessments and Negotiated Service Agreement (NSA).

In an interview, on 03/16/2023 at 8:30 AM, Resident 2 was unable to respond to simple questions and unable to express his needs due to severe cognitive impairment.

Review of the assessment, dated 12/22/2022, showed no information whether the facility evaluated Resident 2 cognition by using a screening tool to assess symptoms consistent with dementia such as short-term memory loss.

RESIDENT 3

Review of an AR showed that the ALF admitted Resident 3 on [REDACTED] 2022 with multiple diagnoses including [REDACTED]

Review of a pre-admission Assessment, dated 08/16/2022, showed that Resident 3 was identified as having a memory issue that may be a concern, but did not interfere with everyday functions. There was no information addressing whether Resident 3 had long-term or short-term memory loss. Review of Resident 3's active record showed no information as to whether the ALF used a proper tool when screening Resident 3 for dementia, and there was no complete Full Assessment done within 14 days of Resident 3's move-in date.

RESIDENT 5

Review of an AR showed that the ALF admitted Resident 5 on [REDACTED] 2021 with multiple diagnoses including [REDACTED]

Review of a Physician's Visit Note (PVN), dated 10/06/2022, showed Resident 5 purchased alcohol at a corner store, and consumed 4 – 5 mini bottles of alcohol daily. The PVN showed Resident 5 had an alarming amount of weight loss which was likely due to multiple factors, including her alcohol use.

In an interview, on 03/15/2023 at 1:15 PM, Staff G (Nurse Manager) stated that Resident 5 had been buying alcohol by herself at a corner store down the street at nighttime and drank them in her apartment. Staff G stated that Resident 5 had a history of falls on the ground related to alcohol intoxication and had a poor appetite due to alcohol consumption. Staff G stated that staff were aware of Resident 5's behavior related to alcohol use.

In an interview, on 03/16/2023 at 8:50 AM, Staff K (Medication Technician) stated that she had known Resident 5 had been drinking alcohol in her apartment. Staff K stated that she saw Resident 5 returning from the corner store at 5:30 AM with mini bottles of alcohol.

Review of an Assessment, dated 12/12/2022, showed Resident 5 was identified as having a history of drug or alcohol use, but there was no assessment regarding Resident 5's behavior related to alcohol use including purchasing alcohol at night and not eating food.

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RESIDENT 7

Review of an AR showed that the ALF admitted Resident 7 on [REDACTED] 2021 with multiple diagnoses including [REDACTED]

Review of Resident 7's Assessment, dated 03/03/2022, showed Resident 7 was identified as a memory issue that may interfere with everyday functions. The assessment showed no other information as to whether Resident 7 had long-term or short-term memory loss. Review of Resident 7's active record showed no information as to whether the ALF assessed, using a proper tool, Resident 7 for dementia.

This is a deficiency previously cited on 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) 4 May 19, 2023

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



Administrator (or Representative)



Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to annually assess the personal care needs for 1 of 1 sampled resident (Resident 7). This placed Resident 7 at risk for not receiving proper care and services due to unidentified care needs and a compromised health status.

Findings included...

Review of an Admission Record showed that the ALF admitted Resident 7 on [REDACTED] 2021

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

RESIDENT 7

Review of an AR showed that the ALF admitted Resident 7 on [REDACTED] 2021 with multiple diagnoses including [REDACTED].

Review of Resident 7's Assessment, dated 03/03/2022, showed Resident 7 was identified as a memory issue that may interfere with everyday functions. The assessment showed no other information as to whether Resident 7 had long-term or short-term memory loss. Review of Resident 7's active record showed no information as to whether the ALF assessed, using a proper tool, Resident 7 for dementia.

This is a deficiency previously cited on 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) _____.

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

Administrator (or Representative)

Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to annually assess the personal care needs for 1 of 1 sampled resident (Resident 7). This placed Resident 7 at risk for not receiving proper care and services due to unidentified care needs and a compromised health status.

Findings included...

Review of an Admission Record showed that the ALF admitted Resident 7 on [REDACTED] 2021

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THE KENNEY

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with multiple diagnoses including [REDACTED]

Observation and interview, on 03/16/2023 at 11:30 AM, showed Collateral Contact 1 (CC 1 - Resident 7's representative) residing in Resident 7's apartment. CC 1 stated that Resident 7 had been receiving shower assistance by staff twice a week and needed help from caregivers for personal care such as dressing and grooming.

Review of an Assessment, dated 03/03/2022, showed Resident 7 was identified as being independent with bathing and personal care, including dressing and undressing. Review of a Negotiated Service Agreement (NSA), dated 03/16/2022, showed Resident 7 was identified as being independent for bathing and personal care, but the NSA also marked as requiring staff assistance with shower. Review of Resident 7's active record showed, as of 03/16/2023, no updated assessment accurately showing Resident 7's current level of care needs, including the ability to perform bathing activities and personal care.

This is a deficiency previously cited on 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) 4 May 19, 2023

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

[Signature]
Administrator (or Representative)

4.19.23
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

with multiple diagnoses including [REDACTED]

Observation and interview, on 03/16/2023 at 11:30 AM, showed Collateral Contact 1 (CC 1 - Resident 7's representative) residing in Resident 7's apartment. CC 1 stated that Resident 7 had been receiving shower assistance by staff twice a week and needed help from caregivers for personal care such as dressing and grooming.

Review of an Assessment, dated 03/03/2022, showed Resident 7 was identified as being independent with bathing and personal care, including dressing and undressing. Review of a Negotiated Service Agreement (NSA), dated 03/16/2022, showed Resident 7 was identified as being independent for bathing and personal care, but the NSA also marked as requiring staff assistance with shower. Review of Resident 7's active record showed, as of 03/16/2023, no updated assessment accurately showing Resident 7's current level of care needs, including the ability to perform bathing activities and personal care.

This is a deficiency previously cited on 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
- (a) Departure from the resident's customary range of functioning; or
 - (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to identify, evaluate, and take appropriate action for the changing needs of 1 of 1 sampled resident (Resident 1) who experienced low pulse rates (PR). This placed Resident 1 at risk for a deteriorating health status.

Findings included...

RESIDENT 1

Review of an Admission Record showed that the ALF admitted Resident 1 on [REDACTED] 2014 with multiple medical diagnoses including [REDACTED]

In an interview, on 03/16/2023 at 8:50 AM, when asked who would monitor each resident's vital signs such as BP and PR, Staff K (Medication Technician ((MT)) stated, "MTs do." Staff K stated the MTs would document vital signs in the resident's electronic Medication Administration Records (eMARs).

Review of the Physician's Order list, dated 12/20/2022, showed that staff were required to monitor Resident 1's BP and PR twice a day, in the morning and in the evening. The Physician's Order instructed staff to notify the physician when Resident 1's PRs are lower than 50.

Review of Resident 1's January, February, and March 2023 eMAR showed that on multiple occasions Resident 1's PR was lower than 50: on 01/06/2023 in the morning the PR was 46, on 01/21/2023 in the morning the PR was 47, on 02/05/2023 in the evening the PR was 46, on 02/12/2023 in the morning the PR was 40, on 03/11/2023 in the morning the PR was 46.

Review of Resident 1's active records showed no documentation as to whether the ALF identified and evaluated Resident 1's low PR or reported the issue to the physician. Resident 1 had, on multiple occasions, low PRs which was not recognized and addressed by the ALF. There was no documentation as to whether the ALF took appropriate action for Resident 1's low PR.

In an interview, on 03/16/2023 at 2:40 PM, Staff G (Nurse Manager) stated that she was not aware of the issue, and she had not received any information about Resident 1's low PR from MTs. Staff G stated that she had not notified the physician about Resident 1's low PR.

Plan/Attestation Statement

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) May 19, 2023

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


 Administrator (or Representative)

4.17.23
 Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to review and update a Negotiated Service Agreement (NSA) for 1 of 8 sampled residents (Resident 7) to reflect current care and service needs. This placed Resident 7 at risk for not receiving proper care and services.

Findings included...

Review of an Admission Record showed that the ALF admitted Resident 7 on [REDACTED] 2021 with multiple diagnoses including [REDACTED].

Observation and Interview, on 03/16/2023 at 10:35 AM with Staff G (Nurse Manager) in Resident 7's apartment, showed Collateral Contact 1 (CC 1 - Resident 7's Representative) in the bathroom with Resident 7. CC 1 told Staff G that he was helping Resident 7 with toileting. Staff G engaged Resident 7's call light and told CC 1 that a caregiver (CG) would come soon to help Resident 7 with toileting, and to wait for the CG. Staff G reminded CC 1 to push the call light to get help from a CG when Resident 7 needed to go to the bathroom.

In an interview, on 03/16/2023 at 10:40 AM, Staff G stated that CC 1 resided with Resident 7 in the same apartment. Resident 7 required staff assistance with toileting, but sometimes, CC 1 helped her without CG's assistance, and that was an issue.

Review of an Incident Report and Investigation (IRI), dated 12/22/2022, showed that Resident 7 had fallen on the bathroom floor in her apartment. The IRI showed that Resident 7 told a caregiver she hit her head and back. The IRI showed that Resident 7 would need to

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE KENNEY is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to review and update a Negotiated Service Agreement (NSA) for 1 of 8 sampled residents (Resident 7) to reflect current care and service needs. This placed Resident 7 at risk for not receiving proper care and services.

Findings included...

Review of an Admission Record showed that the ALF admitted Resident 7 on [REDACTED] 2021 with multiple diagnoses including [REDACTED]

Observation and interview, on 03/16/2023 at 10:35 AM with Staff G (Nurse Manager) in Resident 7's apartment, showed Collateral Contact 1 (CC 1 - Resident 7's Representative) in the bathroom with Resident 7. CC 1 told Staff G that he was helping Resident 7 with toileting. Staff G engaged Resident 7's call light and told CC 1 that a caregiver (CG) would come soon to help Resident 7 with toileting, and to wait for the CG. Staff G reminded CC 1 to push the call light to get help from a CG when Resident 7 needed to go to the bathroom.

In an interview, on 03/16/2023 at 10:40 AM, Staff G stated that CC 1 resided with Resident 7 in the same apartment. Resident 7 required staff assistance with toileting, but sometimes, CC 1 helped her without CG's assistance, and that was an issue.

Review of an Incident Report and Investigation (IRI), dated 12/22/2022, showed that Resident 7 had fallen on the bathroom floor in her apartment. The IRI showed that Resident 7 told a caregiver she hit her head and back. The IRI showed that Resident 7 would need to

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void every 3-4 hours and before meals. The IRI showed that staff were to encourage CC 1 to use the call light for a caregiver to assist Resident 7 with all transfers and activities of daily living.

Review of a Progress Note (PN), dated 01/20/2023, showed Resident 7 had fallen when CC 1 was assisting her while leaving the bathroom. The PN showed caregiver assistance had not been requested which could have resulted in the fall. The PN showed that CC 1 was sometimes unable to assist Resident 7 fully, thus increasing the likelihood for falls.

Review of an NSA, dated 03/16/2022, showed Resident 7 required staff assistance with toileting and incontinence care at night. There was no information or interventions for toileting and incontinence care for Resident 7 during the daytime. The NSA did not identify the current issue of CC 1 helping Resident 7 with toileting without staff assistance, and there was no plan to help prevent Resident 7 from a similar fall.

This is a recurring deficiency previously cited on 12/14/2021, 09/15/2021, and 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) May 19, 2023

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



Administrator (or Representative)



Date

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

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

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

(iii) On-going assessments of the resident;

(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.

void every 3-4 hours and before meals. The IRI showed that staff were to encourage CC 1 to use the call light for a caregiver to assist Resident 7 with all transfers and activities of daily living.

Review of a Progress Note (PN), dated 01/20/2023, showed Resident 7 had fallen when CC 1 was assisting her while leaving the bathroom. The PN showed caregiver assistance had not been requested which could have resulted in the fall. The PN showed that CC 1 was sometimes unable to assist Resident 7 fully, thus increasing the likelihood for falls.

Review of an NSA, dated 03/16/2022, showed Resident 7 required staff assistance with toileting and incontinence care at night. There was no information or interventions for toileting and incontinence care for Resident 7 during the daytime. The NSA did not identify the current issue of CC 1 helping Resident 7 with toileting without staff assistance, and there was no plan to help prevent Resident 7 from a similar fall.

This is a recurring deficiency previously cited on 12/14/2021, 09/15/2021, and 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

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

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

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

(iii) On-going assessments of the resident;

(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.
- (5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to develop and document a behavioral intervention in the Negotiated Service Agreement (NSA) for 5 of 5 sampled residents (Residents 2, 3, 4, 5, and 7) and failed to develop a plan for the use of a medical device for transfer for 1 of 1 sampled resident (Resident 1). The ALF failed to develop NSA that clearly defined the roles and responsibilities, including alternate plans of a Private Companion (PC) for 1 of 1 sampled resident (Residents 6). This placed Residents 1, 2, 3, 4, 6, and 7 at risk for not receiving proper care and services and compromised their health conditions, and placed 34 of 34 residents at risk of harm from Resident 5's unidentified [REDACTED] behavior.

Findings included...

RESIDENT 1

Review of the undated Resident Characteristics Roster showed Resident 1 used a medical device.

In an interview, on 03/15/2023 at 1:30 PM, when asked what kind of a medical device Resident 1 had been using, Staff G (Nurse Manager) stated that staff assisted him with a sit-to-stand lift (a medical device, used to assist mobility people when they are unable to transition from a sitting position to a standing position on their own) for transferring.

Review of an Admission Record (AR) showed the ALF admitted Resident 1 on [REDACTED] 2014 with multiple diagnoses, including [REDACTED]. Review of an Annual Assessment, dated 09/28/2022, showed that Resident 1 required a sit-to-stand lift for transfers.

In an interview, on 03/16/2023 at 12:10 PM, Staff O (Memory Care Caregiver) stated that caregivers had been using the sit-to-stand lift for Resident 1 when transferring.

Review of the NSA, dated 01/03/2023, showed Resident 1 required staff assistance with getting into and out of the wheelchair. The NSA showed no information or interventions that a sit-to-stand lift was required for transferring Resident 1 to/from the wheelchair.

RESIDENT 2

Review of an AR, dated 04/12/2022, showed the ALF admitted Resident 2 in the Memory Care Unit (MCU) on [REDACTED] 2021 with a diagnosis of [REDACTED]. Review of Resident 2's NSA, dated 10/28/2022, showed Resident 2 was dependent on facility staff for most of his care needs. The NSA, under the section of Mood and Cognitive Status, stated Resident 2's had combative behaviors during transfers and showers.

Review of a ALF's Progress Notes, dated 02/20/2023, showed Resident 2 refused to have his vital signs taken, became "Very aggressive, hitting, spitting, and cussing" at staff.

In an interview on 03/15/2023 at 2:10 PM, Staff G, Nurse Manager, stated she was concerned about Resident 2's behavior issues.

Review of Resident 2's NSA, dated 10/28/2022, showed no interventions or staff approaches related to behavior issues.

RESIDENT 3

Review of an AR showed the ALF admitted Resident 3 on [REDACTED] 2022 with multiple diagnoses including [REDACTED] and [REDACTED].

Review of a pre-admission assessment, dated 08/16/2022, showed Resident 3 was identified as having anxiety, depression, and hallucinations that were a "current concern" but did not interfere with everyday functioning.

Review of Progress Notes (PN), dated 01/19/2023 and 03/12/2023, showed that Medication Technicians (MTs) observed Resident 3 exhibiting behavior (no documentation identifying what kind of behavior Resident 3 exhibited). Review of a PN, dated 01/05/2023, showed that 0.5 milligrams of Lorazepam (a medication used to relieve anxiety) was given to Resident 3 at the family's request due to Resident 3 being anxious.

Review of an NSA, dated [REDACTED] 2022, showed a mark on "yes" Resident 3 had, "Anxiety, Depression, and Hallucinations" but the section for listing the signs manifested by depression was left blank. The NSA had no plan or interventions for Resident 3's behaviors, including decompensating behavior (worsening condition of mental illness).

RESIDENT 4

Review of an AR, dated 12/13/2022, showed the ALF admitted Resident 4 on [REDACTED] 2019 with multiple diagnoses including [REDACTED].

Review of the electronic Medication Administration Records (eMARs) for January, February, and March 2023, showed Resident 4 was ordered to take risperidone, two tablets at bedtime for anxiety/agitation.

Review of the NSA, dated 02/01/2023, showed Resident 4 received a monthly treatment of electro convulsive therapy (ECT - a medical treatment most used in patients with severe major depression or bipolar disorder that has not responded to other treatments for bipolar disorder). The NSA instructed staff to monitor Resident 4 for headaches, fast heartbeat, changes in mood or mental state following ECT treatment. The NSA did not include baseline behaviors for staff to identify, behavioral interventions, or a crisis plan when Resident 4 exhibited decompensation state (worsening condition of mental illness).

RESIDENT 5

Review of the ALF's policy for a "Smoke-Free Campus", dated 07/16/2013, showed that the ALF did not permit smoking anywhere on campus. The law required that people smoke at least 25 feet from entrances, exits, windows that open, and ventilation intakes that may infiltrate are to non-smoking areas.

Review of the ALF's undated Residents' Characteristics Roster showed the ALF had 34 residents and identified one resident as a [REDACTED] (Resident 5).

Review of the ALF's undated Disclosure of Services showed that the ALF will permit smoking in designated outside areas consistent with Initiative 901 as specified in the resident's NSA.

Review of an AR showed the ALF admitted Resident 5 on [REDACTED] 2021 with multiple diagnoses. Review of an Assessment, dated 12/12/2022, showed Resident 5 was identified as a [REDACTED] (there was no additional assessment for her [REDACTED] behavior).

In an interview, on 03/14/2023 at 9:20 AM, Staff G stated that Resident 5 had been [REDACTED] outside of the ALF.

Observation and interview, on 03/16/2023 at 9:40 AM, showed a [REDACTED] on the kitchen table in Resident 5's apartment. Resident 5 stated that she had been [REDACTED] outside of the ALF, such as on sidewalks.

In interview, on 03/16/2023 at 2:40 PM, Staff A (Administrator) stated the ALF did not permit any smoking on the premises, and there was no designated smoking area. If a smoker wanted to smoke, they were required to smoke outside of the ALF, 25 feet away from doors or windows. Staff G stated that Resident 5 usually [REDACTED] outside of the ALF building, but at night, she sat on a bench in front of the main entrance to [REDACTED]. The bench might not be 25 feet away from the main entrance.

Review of Resident 5's NSA, dated 12/15/2022, showed that Resident 5's [REDACTED] behavior was not addressed, and there was no plan for staff guidance about Resident 5's [REDACTED] behavior.

RESIDENT 6

Review of an AR, dated 06/22/2022, showed the ALF admitted Resident 6 on [REDACTED] 2018 with multiple medically disabling diagnoses including [REDACTED]

Review of the Resident Characteristic Roster, undated, showed Resident 6 was identified to have a private caregiver.

In an interview, on 03/14/2023 at 1:45 PM, Staff G (Nurse Manager) stated Resident 6 had a PC, not private caregiver. Staff G stated the family members (FM) told facility staff that all communications regarding Resident 6 goes through the PC, then the PC would contact the FM.

Observation, on 03/16/2023 at 9:15 AM, showed Resident 6 seated in the ALF's lobby with her PC.

In an interview, on 03/16/2023 at 9:30 AM, the PC stated she visited Resident 6, six days a week, 1-2 hours or longer, depending on Resident 6's needs for the day, such as driving for shopping, medical appointments, and picking up medications from two pharmacies. The PC stated after picking up Resident 6's medications from the pharmacies, she dropped them off at the front desk to be delivered to the nurse's station.

Review of the NSA, dated 10/11/2022, showed no information about Resident 6's PC such as roles and responsibilities, frequency, hours, and days of the PC's visits to Resident 6. Resident 6's NSA did not have an alternate plan in the event the PC was unavailable to provide Resident 6's medications or drive to medical appointments.

RESIDENT 7

Review of an AR showed the ALF admitted Resident 7 on [REDACTED] 2021 with multiple diagnoses including [REDACTED] and [REDACTED].

Observation and interview, on 03/16/2023 at 11:30 AM, showed Collateral Contact 1 (CC 1 - Resident 7's representative) present in Resident 7's apartment. CC 1 stated that Resident 7 had a memory issue and needed to be reminded of things multiple times, and sometimes exhibited agitation.

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Review of January, February, and March 2023 electronic Medication Administration Records (eMARs) showed Resident 7 was prescribed 12.5 milligrams (mg) of Quetiapine (an antipsychotic medication) at 8:00 PM daily, and another 12.5 mg of Quetiapine as needed for agitation/anxiety.

Review of January, February, and March 2023 eMARs showed on 01/30/2023, 01/31/2023, and 03/09/2023, Resident 7 took an as needed dose of quetiapine for agitation/anxiety.

Review of a PN, dated 01/11/2023, showed that when Staff G visited Resident 7 the previous day, CC 1 looked very upset and frustrated due to Resident 7's behavior. Review of a PN, dated 03/09/2023, showed Resident 7 was in a "very angry mood" that morning. Resident 7 was combative towards the staff, punching and attacking caregivers while they provided assistance with dressing. At breakfast, Resident 7 threw her food and spilled juice all over the table, "making CC 1 embarrassed."

Review of Resident 7's NSA showed a mark under "No" for "Inappropriate Behavior", but stated Resident 7 was on an antipsychotic medication to treat anxiety and depression. The NSA instructed staff to document Resident 7's unusual behavior and report them to a nurse for follow-up. The NSA had no intervention measures for Resident 7's aggressive behaviors such as punching and attacking caregivers during care.

This is a deficiency previously cited on 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) April 19, 2023

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


Administrator (or Representative)

4/19/23
Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided; unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person:

(i) Conducts an evaluation; and

Review of January, February, and March 2023 electronic Medication Administration Records (eMARs) showed Resident 7 was prescribed 12.5 milligrams (mg) of Quetiapine (an antipsychotic medication) at 8:00 PM daily, and another 12.5 mg of Quetiapine as needed for agitation/anxiety.

Review of January, February, and March 2023 eMARs showed on 01/30/2023, 01/31/2023, and 03/09/2023, Resident 7 took an as needed dose of quetiapine for agitation/anxiety.

Review of a PN, dated 01/11/2023, showed that when Staff G visited Resident 7 the previous day, CC 1 looked very upset and frustrated due to Resident 7's behavior. Review of a PN, dated 03/09/2023, showed Resident 7 was in a "very angry mood" that morning. Resident 7 was combative towards the staff, punching and attacking caregivers while they provided assistance with dressing. At breakfast, Resident 7 threw her food and spilled juice all over the table, "making CC 1 embarrassed."

Review of Resident 7's NSA showed a mark under "No" for "Inappropriate Behavior", but stated Resident 7 was on an antipsychotic medication to treat anxiety and depression. The NSA instructed staff to document Resident 7's unusual behavior and report them to a nurse for follow-up. The NSA had no intervention measures for Resident 7's aggressive behaviors such as punching and attacking caregivers during care.

This is a deficiency previously cited on 06/23/2021.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

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(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate after medication refusal for 1 of 1 sampled resident (Resident 5). This placed Resident 5 at risk for a compromised medical condition.

Findings included...

Review of the undated ALF policy for, "Medication Refusal and Missed Doses" showed, "Missed or refused medications are documented in the resident's medication record and the prescribing physician notified immediately or according to physician's parameters. The physician parameters must be retained in writing and kept on the file."

Review of an Admission Record showed that the ALF admitted Resident 5 on [REDACTED] 2021 with multiple diagnoses including [REDACTED]

[REDACTED] 10 [REDACTED] and [REDACTED] 10 [REDACTED] Review of a Negotiated Service Agreement, dated 12/15/2022, showed Resident 5 required staff assistance with medication services.

Review of the January, February, and March 2023 electronic Medication Administration Records (eMARs) showed Resident 5 had been taking multiple medications including Gabapentin (used to relieve the pain of post-herpetic neuralgia ((the burning, stabbing pain or aches that may last for months or years after an attack of shingles)) twice a day (at lunch and bedtime), and Sertraline (used to treat depression) daily.

Review of the January, February, and March 2023 eMARs showed that Resident 5, on multiple occasions, refused to take Gabapentin and Sertraline. Resident 3 refused the lunch time dose of Gabapentin three times in January 2023, and the bedtime dose on 01/13/2023, 01/26/2023, and 03/03/2023. Resident 5 refused to take Sertraline on 01/08/2023, 01/18/2023, and 01/24/2023. Resident 5 refused to take a daily dose of Prenatal Vitamins (supplement) on 01/26/2023.

In an interview, on 03/16/2023 at 08:50 AM, Staff K (Medication Technician) stated that Resident 5 sometimes refused Gabapentin and Sertraline, and Resident 5 told Staff K that these medications gave her stomach upset.

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In an interview, on 03/16/2023 02:40 PM, Staff G (Nurse Manager) stated that she was aware of the pattern of Resident 5's medication refusal, and she previously reported the issue to the physician.

Review of a visit note from the physician's office, dated 10/06/2022, showed the ALF nurse reported to the physician that Resident 5 had not been taking medications. The physician's visit note showed, "Continue to address (medication) non-adherence." There was no physician's instruction for what the ALF staff should do when Resident 5 refused her medications.

Review of Resident 5's active records showed no documentation as to whether the ALF evaluated Resident 5's condition and notified the physician about Resident 5's continued pattern of refusing her medications. There were no physician's directions for how to address Resident 5's medication refusal. The ALF did not follow its own policy for Medication Refusal.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) May 19, 2023

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


Administrator (or Representative)

4.17.23
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 Assisted Living Facility (ALF) failed to obtain prescribed medications in a timely manner for 2 of 7 sampled residents (Residents 1 and 6), who required staff to administer or assist with medications. This failure resulted in Residents 1 and 6 not receiving medications as prescribed.

Findings included...

Review of the undated policy for, "Medication Refills" showed that medication refills would be obtained in a timely manner to ensure residents had all physician ordered medication

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In an interview, on 03/16/2023 02:40 PM, Staff G (Nurse Manager) stated that she was aware of the pattern of Resident 5's medication refusal, and she previously reported the issue to the physician.

Review of a visit note from the physician's office, dated 10/06/2022, showed the ALF nurse reported to the physician that Resident 5 had not been taking medications. The physician's visit note showed, "Continue to address (medication) non-adherence." There was no physician's instruction for what the ALF staff should do when Resident 5 refused her medications.

Review of Resident 5's active records showed no documentation as to whether the ALF evaluated Resident 5's condition and notified the physician about Resident 5's continued pattern of refusing her medications. There were no physician's directions for how to address Resident 5's medication refusal. The ALF did not follow its own policy for Medication Refusal.

Plan/Attestation Statement

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Administrator (or Representative)

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 Assisted Living Facility (ALF) failed to obtain prescribed medications in a timely manner for 2 of 7 sampled residents (Residents 1 and 6), who required staff to administer or assist with medications. This failure resulted in Residents 1 and 6 not receiving medications as prescribed.

Findings included...

Review of the undated policy for, "Medication Refills" showed that medication refills would be obtained in a timely manner to ensure residents had all physician ordered medication

available. The policy showed that medications were never allowed to run out unless directed to in writing by the physician.

RESIDENT 1

Review of an Admission Record (AR) showed the ALF admitted Resident 1 on [REDACTED] 2014 with multiple diagnoses including [REDACTED] and [REDACTED]. Review of an Assessment, dated 09/28/2022, showed the ALF would order and store medications for Resident 1.

Review of the January, February, and March 2023 electronic Medication Administration Records (eMARs) showed Resident 1 was prescribed multiple medications, and staff had been administering those medications for him.

Observation and interview, on 03/16/2023 at 8:50 AM, showed Resident 1's medication was stored in a medication cart on the second floor. Staff K (Medication Technician ((MT)) stated that MTs had been administering medications to Resident 1. When asked what she needed to do when Resident 1's medications run out, Staff K stated she would call the pharmacy or tell a nurse.

Review of the January 2023 eMARs showed Resident 1 was required to take two tablets of Tums (Calcium carbonate, a dietary supplement. used when the amount of calcium taken in the diet is not enough) twice a day. The January 2023 eMARs showed that from 01/14/2023 through 01/23/2023, MTs documented charting code "9" in a column for Tums. The code "9" was referenced as Other/See Progress Notes. Review of the Progress Notes from 01/14/2023 to 01/23/2023 showed MTs documented "medication not available", "Awaiting the pharmacy delivery", and "Waiting for delivery".

Review of the February 2023 eMARs showed that Resident 1 was required to take Amlodipine (used to treat high blood pressure) and Lasix (diuretics, used to treat high blood pressure) once a day. The MT documented charting code "9" in columns for amlodipine and Lasix on 02/12/2023. Review of a Progress Note, dated 02/12/2023, showed that the MT documented, "the medication is on order", indicating Amlodipine and Lasix were not given as prescribed.

RESIDENT 6

Review of an Admission Record (AR), dated 4/22/2022, showed the ALF admitted Resident 6 on [REDACTED] 2018. with multiple diagnoses including [REDACTED]. Resident 6's Negotiated Service Agreement (NSA), dated 10/11/2022, showed staff assistance was required for oral and topical medications.

Review of the electronic Medication Administration Records (eMARs) showed on 12/21/2022 Resident 6 was prescribed a routine Lidocaine external patch for pain relief.

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In interview, on 03/16/2023 at 10:05 AM, when asked how she was doing Resident 6 stated, "This is the first day I can tell that I felt better, mild pain, aside from the 'wiggles. It gets tiring." When questioned whether she had been using the prescribed lidocaine patch to treat her pain, Resident 6 stated they used to, but had not been for a while. Resident 6 stated she applied [Aspercreme with Lidocaine] ointment to her shoulder with some relief.

Review of the January, February, and March 2023 eMARs showed Medication Technicians (MTs) had initialed the columns for Lidocaine External Patch, and documented code "9" to indicate, "Other/See Progress Notes. The code "9" had been documented for 31 days in January 2023, and 15 days in February and March 2023.

Review of the Resident 6's Progress Notes, showed a pattern of staff documented "N/A (not available)" for the lidocaine pain patch in January, February, and March 2023.

In interview during a medication pass, on 03/15/2023 at 8:15 AM, when questioned where the lidocaine patch was stored, Staff K (MT) stated Resident 6 had not had the lidocaine patch for a while and does not know how long the medication was unavailable. When asked what the procedure when a resident ran out of medication, Staff K stated she would report to the Licensed Nurse and would document non-availability of the medication. Staff K stated she was unaware if a Licensed Nurse knew the non-availability of Resident 6's lidocaine pain patch.

In an interview, on 03/16/2023 at 9:15 AM, Staff G (Nurse Manager) stated she was unaware Resident 6 did not have lidocaine patch for 3 months or longer. Staff G stated the lidocaine patch should have been discontinued or change the order to "as needed (PRN)."

This is a recurring deficiency previously cited on 12/14/2021 and 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) May 19, 2023

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


Administrator (or Representative)

4.17.23
Date

In interview, on 03/16/2023 at 10:05 AM, when asked how she was doing Resident 6 stated, "This is the first day I can tell that I felt better, mild pain, aside from the 'wiggles. It gets tiring." When questioned whether she had been using the prescribed lidocaine patch to treat her pain, Resident 6 stated they used to, but had not been for a while. Resident 6 stated she applied [Aspercreme with Lidocaine] ointment to her shoulder with some relief.

Review of the January, February, and March 2023 eMARs showed Medication Technicians (MTs) had initialed the columns for Lidocaine External Patch, and documented code "9" to indicate, "Other/See Progress Notes. The code "9" had been documented for 31 days in January 2023, and 15 days in February and March 2023.

Review of the Resident 6's Progress Notes, showed a pattern of staff documented "N/A (not available)" for the lidocaine pain patch in January, February, and March 2023.

In interview during a medication pass, on 03/15/2023 at 8:15 AM, when questioned where the lidocaine patch was stored, Staff K (MT) stated Resident 6 had not had the lidocaine patch for a while and does not know how long the medication was unavailable. When asked what the procedure when a resident ran out of medication, Staff K stated she would report to the Licensed Nurse and would document non-availability of the medication. Staff K stated she was unaware if a Licensed Nurse knew the non-availability of Resident 6's lidocaine pain patch.

In an interview, on 03/16/2023 at 9:15 AM, Staff G (Nurse Manager) stated she was unaware Resident 6 did not have lidocaine patch for 3 months or longer. Staff G stated the lidocaine patch should have been discontinued or change the order to "as needed (PRN)."

This is a recurring deficiency previously cited on 12/14/2021 and 06/23/2021.

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

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

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

(b) Nurse delegation, if provided;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to follow the criteria for nurse delegation (ND) for 1 of 1 sample residents (Resident 1) who required staff to administer medications. This resulted in non-licensed staff members conducting nursing tasks, such as administering medications, without receiving proper nurse delegation trainings, and placed Resident 1 at risk for a compromised health condition.

Findings included...

NOTE: The Nurse Delegation Program, under Washington State law, allowed nursing assistants (NAs) and Home Care Aides (HCAs) working in certain settings to perform certain tasks--such as administering medications--normally performed only by licensed nurses. A Registered Nurse (RN) must teach and supervise the nursing assistant, as well as provide nursing assessments of the patient's condition.

NOTE: Washington Administrative Code (WAC) 246-840-930 Criteria for delegation, included the following subsections: (8) Verify that the nursing assistant or home care aide: (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training; (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record (m) Supervision shall occur at least every ninety days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent. (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). (17) The registered nurse delegator supervises and evaluates the

performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

Review of the ALF's undated Disclosure of Services showed that the ALF used Nursing Assistants under the Delegation of a Registered Nurse to provide some authorized nursing services.

During the entrance interview, on 03/14/2023 at 9:20 AM, Staff G (Nurse Manager) stated that the ALF had been providing ND services to residents. Staff G stated that Staff M (Registered Nurse) had been the Registered Nurse Delegator. When asked what sorts of nursing tasks were delegated to Medication Technicians (MTs), Staff G stated that there were multiple tasks, including medication administration.

Review of an Admission Record showed the ALF admitted Resident 1 on [REDACTED] 2014 with multiple diagnoses including [REDACTED] and [REDACTED]. Review of a Negotiated Service Agreement, dated 01/03/2023, showed Resident 1 required staff to administer medications.

Review of the January, February, and March 2023 electronic Medication Administration Records (eMARs) showed Resident 1 was prescribed multiple medications, and staff had been administering those medications for Resident 1.

Review of the ND binder showed a Nurse Visit document, dated 11/30/2022, that indicated Staff M delegated to MTs the nursing tasks of blood sugar checks and administration of oral medications, ear drops, topical creams, and eye drops for Resident 1. Review of the 11/30/2022 Nurse Visit document showed Staff M would return visit on or before 03/02/2023.

In an interview, on 03/16/2023 at 8:25 AM, when asked when Staff M returned to the ALF to review MTs' skills for ND tasks, Staff G stated that it had been over 90 days since Staff M had visited the ALF.

Observation and interview, on 03/16/2023 at 8:50 AM, showed Resident 1's medication in a medication cart on the second floor. Staff K (MT) stated that Resident 1 required MTs to administer medications for him. When asked how MTs would administer medications to Resident 1, Staff K stated that crushed pills were mixed with apple sauce, and then put in his mouth with a spoon because Resident 1 was unaware that he was taking medications. When asked when she last received a ND training from Staff M, Staff K stated she did not remember when but not in the past two months.

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04/07/2023

Review of the ND binder showed no information as to whether Staff M returned to visit the ALF for delegating the nursing tasks to MTs on or before 03/02/2023.

Review of the January, February, and March 2023 eMARs showed that on multiple occasions, Staff H (Agency MT) and Staff J (Agency MT) put their initials in a column for medications, indicating they had administered the medications for Resident 1.

Review of the March 2023 eMARs showed that on 03/07/2023 and 03/10/2023, Staff L (MT) put her initials in columns for multiple medications indicating she administered those medications for Resident 1.

Review of Resident 1's 11/30/2022 ND Nurse Visit document showed Staff H, J, and L were not included on the list of MTs who received the ND training on that day. Review of the ND binder showed no information as to whether Staff M delegated nursing tasks of medication administration for Resident 1 to Staff H, Staff J, or Staff L.

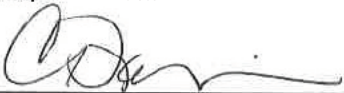
In an interview, on 03/16/2023 at 10:30 AM, Staff A (Administrator) stated that Staff L was a newly hired employee, and she was still in training. Staff A stated that Staff L had not yet had the ND training.

This is a recurring deficiency previously cited on 09/15/2021 and 06/23/2021.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) April 19, 2023

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



Administrator (or Representative)



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

Review of the ND binder showed no information as to whether Staff M returned to visit the ALF for delegating the nursing tasks to MTs on or before 03/02/2023.

Review of the January, February, and March 2023 eMARs showed that on multiple occasions, Staff H (Agency MT) and Staff J (Agency MT) put their initials in a column for medications, indicating they had administered the medications for Resident 1.

Review of the March 2023 eMARs showed that on 03/07/2023 and 03/10/2023, Staff L (MT) put her initials in columns for multiple medications indicating she administered those medications for Resident 1.

Review of Resident 1's 11/30/2022 ND Nurse Visit document showed Staff H, J, and L were not included on the list of MTs who received the ND training on that day. Review of the ND binder showed no information as to whether Staff M delegated nursing tasks of medication administration for Resident 1 to Staff H, Staff J, or Staff L.

In an interview, on 03/16/2023 at 10:30 AM, Staff A (Administrator) stated that Staff L was a newly hired employee, and she was still in training. Staff A stated that Staff L had not yet had the ND training.

This is a recurring deficiency previously cited on 09/15/2021 and 06/23/2021.

Plan/Attestation Statement

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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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff consistently and accurately documented medication services in residents' electronic Medication Administration Records (eMARs) for 7 of 7 sampled residents (Residents 1, 2, 3, 4, 5, 6, and 7), who required staff to administer or assist with medications. This failure resulted in no identification being provided as to who had provided medication services for Residents 1, 2, 3, 4, 5, 6, and 7, and placed all seven residents at risk for compromised health conditions.

Findings included...

In an interview, on 03/14/2023 at 9:20 AM, Staff G (Nurse Manager) stated that occasionally the ALF used Medication Technicians (MTs) from an outside agency.

Review of the undated Resident Characteristics Roster showed the ALF identified Residents 1, 2, 3, 4, 5, 6, and 7 as requiring staff to assist or administer their medications. Review of Negotiated Service Agreements for those seven residents showed staff would provide medication services, including medication assistance or administration for them.

Review of the January, February, and March 2023 electronic Medication Administration Records (eMARs) for the seven residents (Residents 1, 2, 3, 4, 5, 6, and 7) showed that MTs, on multiple occasions, put their initials as "agk" or "mt6" in columns for medications, indicating they assisted or administered the medications. The eMARs did not provide the identities of "agk" or "mt6".

In an interview, on 03/16/2023 at 8:25 AM, when asked to identify who "agk" or "mt6" was, Staff G (Nurse Manager) was unable to identify who they were.

In an interview, on 03/16/2023 at 10:10 AM, Staff A (Administrator) stated that Staff N (Assistant Administrator/Human Resources/Business Office Manager) set up the initials of the agency's MTs in the computer system using labels instead of names, like "mt1", "mt2", so on. Staff A stated there was a list identifying staff's names and their initials.

Review of the undated list of staff's names and initials showed no staff name identified for the initials of "agk" or "mt6". The list identified the initials "agk" as "Agency", and "mt6" as "med tech 6". There was no list giving the identity of Agency or med tech 6. Review of the seven residents' active records showed no information as to the names of those who provided the residents with their medication services.

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) May 19, 2023

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



Administrator (or Representative)

4.17.23

Date

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

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

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

NOTE: Washington Administrative Code 388-78A-2462 Background checks—Who is required to have. (2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks: (a) A Washington state name and date of birth background check; and (b) A national fingerprint background check.

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 4 sampled agency staff members (Staff G, I, and J) had valid Washington State Name and Date of Birth Background Checks (BGC) and/or National Fingerprint BGC (NFBGC). This placed 34 of 34 residents in the ALF at risk for receiving care from staff whose criminal background history was unknown.

Findings included...

In an interview, on 03/14/2023 at 9:20 AM, Staff G (Nurse Manager) stated that multiple

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE KENNEY is or will be in compliance with this law and / or regulation on (Date)_____.

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Administrator (or Representative)

Date

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

NOTE: Washington Administrative Code 388-78A-2462 Background checks—Who is required to have. (2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks: (a) A Washington state name and date of birth background check; and (b) A national fingerprint background check.

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 4 sampled agency staff members (Staff G, I, and J) had valid Washington State Name and Date of Birth Background Checks (BGC) and/or National Fingerprint BGC (NFBGC). This placed 34 of 34 residents in the ALF at risk for receiving care from staff whose criminal background history was unknown.

Findings included...

In an interview, on 03/14/2023 at 9:20 AM, Staff G (Nurse Manager) stated that multiple

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caregivers, from an outside agency contracted with the ALF, had been working at the ALF. Staff G stated that she was also from the same agency and had been working at the ALF as the Nurse Manager for about one year.

On 03/16/2023, review of staff records showed that Staff I (Agency Caregiver ((ACG)) and Staff J (ACG) had not had a BGC.

On 03/28/2023, the Department received additional information from the ALF, including the BGC for Staff I and Staff J. Review of the BGCs for both Staff I and Staff J showed the date of the BGCs was 03/28/2023.

On 03/16/2023, review of Staff G's staff record showed that Staff G's BGC expired on 03/20/2022. There was no valid BGC or the NFBGC for Staff G.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) May 14, 2023

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


Administrator (or Representative)

4.17.23
Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Emergency and Disaster Preparedness Manual included names of on-duty staff person's responsibilities, alternate resident accommodations, and provision of residents' food and medications in the event of an emergency evacuation. This failure placed 34 residents at risk of compromised health due to lack of life sustaining provisions and displacement in

caregivers, from an outside agency contracted with the ALF, had been working at the ALF. Staff G stated that she was also from the same agency and had been working at the ALF as the Nurse Manager for about one year.

On 03/16/2023, review of staff records showed that Staff I (Agency Caregiver ((ACG)) and Staff J (ACG) had not had a BGC.

On 03/29/2023, the Department received additional information from the ALF, including the BGC for Staff I and Staff J. Review of the BGCs for both Staff I and Staff J showed the date of the BGCs was 03/28/2023.

On 03/16/2023, review of Staff G's staff record showed that Staff G's BGC expired on 03/20/2022. There was no valid BGC or the NFBGC for Staff G.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Emergency and Disaster Preparedness Manual included names of on-duty staff person's responsibilities, alternate resident accommodations, and provision of residents' food and medications in the event of an emergency evacuation. This failure placed 34 residents at risk of compromised health due to lack of life sustaining provisions and displacement in

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the event of an emergency or disaster.

Findings included...

Review of the ALF's "Disaster Manual" on 03/14/2023, showed no names of on-duty staff person's responsibilities, alternate locations, and no provision of essential resident needs including food and medications.

Review of the ALF's Resident Characteristic Roster, undated, showed the facility provided care and services to 7 residents in the Memory Care Unit and 25 current residents in Assisted Living.

In an interview, on 03/14/2023 at 1:30 PM, Staff N (Administrative Assistant/Human Resources/Business Office Manager) stated the management including Maintenance Supervisor were in the process of updating their Disaster Manual. Staff N stated she would ask Staff A (Administrator/Executive Director) for further information.

As of 03/23/2023, no further information about the ALF's Disaster Manual was provided to the Department.

In a follow-up interview, on 03/29/2023 at 11:00 AM, Staff A stated she had expected the Disaster Manual to be updated by the ALF's Maintenance Supervisor and Front Desk person in 2022. However, Staff A stated she did not review the Disaster Manual to ensure it met the requirements.

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, THE KENNEY is or will be in compliance with this law and / or regulation on (Date) April 19, 2023

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


Administrator (or Representative)

4.17.23
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;

the event of an emergency or disaster.

Findings included...

Review of the ALF's "Disaster Manual" on 03/14/2023, showed no names of on-duty staff person's responsibilities, alternate locations, and no provision of essential resident needs including food and medications.

Review of the ALF's Resident Characteristic Roster, undated, showed the facility provided care and services to 7 residents in the Memory Care Unit and 25 current residents in Assisted Living.

In an interview, on 03/14/2023 at 1:30 PM, Staff N (Administrative Assistant/Human Resources/Business Office Manager) stated the management including Maintenance Supervisor were in the process of updating their Disaster Manual. Staff N stated she would ask Staff A (Administrator/Executive Director) for further information.

As of 03/23/2023, no further information about the ALF's Disaster Manual was provided to the Department.

In a follow-up interview, on 03/29/2023 at 11:00 AM, Staff A stated she had expected the Disaster Manual to be updated by the ALF's Maintenance Supervisor and Front Desk person in 2022. However, Staff A stated she did not review the Disaster Manual to ensure it met the requirements.

Plan/Attestation Statement

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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 interview and record review, the Assisted Living Facility (ALF) failed to implement a Respiratory Protection Program (RPP) including respirator mask fit-testing for staff. This placed 34 of 34 residents, ALF staff, and visitors at risk for exposure to SARS-CoV-2, the virus responsible for COVID-19 (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).

RESPIRATORY PROTECTION PROGRAM (RPP)

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: 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 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. An RPP included ensuring all staff have respirator mask medical clearance and fit testing done on an annual basis.

In an interview, on 03/16/2023 at 8:25 AM, when asked whether the ALF had an RPP, including medical clearance and respirator fit testing for HCW, Staff G (Nurse Manager) stated that the ALF did not have an RPP. Staff G stated that she had been working at the ALF over one year, but she had not seen the ALF conducted any mask fitting test or medical clearance for staff. Staff G stated she had not had any mask fitting test or medical clearance.

In an interview, on 03/16/2023 at 2:40 PM, when asked whether the ALF implemented an RPP for staff, including mask fit testing, Staff A (Administrator) stated that the ALF had not conducted the RPP since she began working at the ALF in June 2021.

The ALF was not able to produce any documentation of RPP, medical clearance or mask fitting for staff.

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Administrator (or Representative)

4.17.23

Date

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