STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

03/26/2025

BETHANY OF THE NORTHWEST
BETHANY AT SILVER CREST
2131 LAKE HEIGHTS DR
EVERETT, WA 98208

RE: BETHANY AT SILVER CREST License # 1346

Dear Administrator:

This letter addresses Compliance Determination(s) 56907 (Completion Date 03/25/2025) and 55023 (Completion Date 02/19/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/25/2025 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-2474-2-a, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2474-3

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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

The department completed data collection for an unannounced on-site follow-up on 02/19/2025 of:

BETHANY AT SILVER CREST
2131 LAKE HEIGHTS DR
EVERETT, WA 98208

This document references the following SOD dated: 02/19/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 53 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor
Allison Nunn, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

Statement of Deficiencies	License ID: 1024	Compliance Determination # 55023
Plan of Correction	BETHANY AT SILVER CREST	Completion Date
Page 1 of 3	Licensee: BETHANY OF THE NORTHWEST	02/19/2025

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.

Kim Ripley
Residential Care Services

02/27/2025
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.

Emily Scott
Administrator (or Representative)

2/25/25
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including, but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 4 staff (Staff B, D and E) completed or renewed Cardiopulmonary Resuscitation (CPR) and first aid training. This failure resulted in Staff B, D, and E not having the necessary training related to their job duties and expectations and placed all 53 residents at risk for compromised care and safety.

Findings included:

Review of WAC 388-112A-0720 What are the CPR and first-aid training requirements? showed:
(2) Assisted living facilities.

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 | Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) | Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 4 staff (Staff B, D, and E) completed or renewed Cardiopulmonary Resuscitation (CPR) and first aid training. This failure resulted in Staff B, D, and E not having the necessary training related to their job duties and expectations and placed all 53 residents at risk for compromised care and safety.

Findings included…

Review of WAC 388-112A-0720 What are the CPR and first-aid training requirements? showed:
(2) Assisted living facilities.

Statement of Deficiencies	License # 18[illegible]	Compliance Determination # 55023
Plan of Correction	BETHANY AT SILVER CREST	Completion Date
Page 4 of 8	Licensee: BETHANY OF THE NORTHWEST	02/19/2025

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 12/26/2024, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have a system in place and the deficiency corrected by 02/05/2025.

Review of the ALF's employee files showed the following:

Staff A, Caregiver, was hired on 06/26/2024. The ALF was unable to provide documentation that Staff A completed first aid training.

Staff D, Resident Care Coordinator, was hired on 01/09/2025. The ALF was unable to provide documentation that Staff D completed first aid training.

Staff E, Caregiver, was hired on 01/02/2025. The ALF was unable to provide documentation that Staff E completed CPR training. Staff E's first aid training card showed their certification expired on 03/01/2025.

On 02/19/2025 at 1:34 AM, Staff A stated that there was no first aid training on file for Staff B or D. Staff A stated that they had no current CPR/first aid card for Staff E on file.

On 02/19/2025 at 1:43 PM, Staff E stated their CPR/first aid card had expired.

This is an uncorrected deficiency for subsection (2) (d) previously cited on 12/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST is or will be in compliance with this law and/or regulation on Date 2/25/25.

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

Emily Scott — Administrator (or Representative)

2/25/25 — Date

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 12/26/2024, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have a system in place and the deficiency corrected by 02/05/2025.

Review of the ALF's employee files showed the following:

Staff B, Caregiver, was hired on 06/28/2024. The ALF was unable to provide documentation that Staff B completed first aid training.

Staff D, Resident Care Coordinator, was hired on 01/06/2025. The ALF was unable to provide documentation that Staff D completed first aid training.

Staff E, Caregiver, was hired on 01/02/2025. The ALF was unable to provide documentation that Staff D completed CPR training. Staff E's first aid training card showed their certification expired on 09/01/2024.

On 02/19/2025 at 1:34 AM, Staff A stated that there was no first aid training on file for Staff B or D. Staff A stated that they had no current CPR/first aid card for Staff E on file.

On 02/19/2025 at 1:43 PM, Staff E stated their CPR/first aid card had expired.

This is an uncorrected deficiency for subsection (2)(d), previously cited on 12/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST 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
3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 1346	Compliance Determination # 51879
Plan of Correction	BETHANY AT SILVER CREST	Completion Date
Page 1 of 17	Licensee: BETHANY OF THE NORTHWEST	12/26/2024

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

The department completed data collection for the unannounced on-site full inspection on 12/17/2024, 12/18/2024, 12/19/2024 and 12/20/2024 of:
BETHANY AT SILVER CREST
2131 LAKE HEIGHTS DR
EVERETT, WA 98208

The following sample was selected for review during the unannounced on-site visit: 7 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor
Jodi Condyles, ALF Licensor
Melissa Phillips, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

01/09/2025
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 12/17/2024, 12/18/2024, 12/19/2024 and 12/20/2024 of:

BETHANY AT SILVER CREST
2131 LAKE HEIGHTS DR
EVERETT, WA 98208

The following sample was selected for review during the unannounced on-site visit: 7 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor
Jodi Condyles, ALF Licensor
Melissa Phillips, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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 _____ 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.

Emily Scott
Administrator (or Representative)

1/13/24
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:

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a full assessment for 1 of 7 residents (Resident 2) within 14 days of admission. This failure resulted in Resident 2 not having an assessment to determine Resident 2's capabilities, needs, and preferences and placed Resident 2's needs at risk of being unmet.

Findings included...

Resident 2 was admitted to the ALF on [redacted] 2024 with multiple diagnoses including [redacted]

On 12/18/2024 at 1:14 PM, Staff G, Director of Nursing Services, stated they were unable to find any full assessments for Resident 2. Staff G stated that the full assessment should be completed within 14 days of move-in, so they weren't sure why one wasn't completed for Resident 2.

On 12/20/2024 at 10:05 AM, Staff G stated that they were able to find an assessment in a different staff member's computer, but they saw that the assessment wasn't completely filled out.

Review of an Annual/14 Day Full Resident Assessment, dated 01/23/2024, showed Resident 2 had an assessment completed by Staff I, Corporate Clinical Nurse. The assessment showed several sections were incomplete including the sections titled: Health Indicators/Current Observations, Special Conditions, Behavioral Concerns, Personal Care Needs, Decision Making, Activities, and Cultural/Ethnic Preferences.

Plan/Attestation Statement

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:

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a full assessment for 1 of 7 residents (Resident 2) within 14 days of admission. This failure resulted in Resident 2 not having an assessment to determine Resident 2's capabilities, needs, and preferences and placed Resident 2's needs at risk of being unmet.

Findings included…

Resident 2 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted].

On 12/18/2024 at 1:14 PM, Staff G, Director of Nursing Services, stated they were unable to find any full assessments for Resident 2. Staff G stated that the full assessment should be completed within 14 days of move-in, so they weren't sure why one wasn't completed for Resident 2.

On 12/20/2024 at 10:05 AM, Staff G stated that they were able to find an assessment in a different staff member's computer, but they saw that the assessment wasn't completely filled out.

Review of an Annual/14 Day Full Resident Assessment, dated 01/23/2024, showed Resident 2 had an assessment completed by Staff I, Corporate Clinical Nurse. The assessment showed several sections were incomplete including the sections titled: Health Indicators/Current Observations, Special Conditions, Behavioral Concerns, Personal Care Needs, Decision Making, Activities, and Cultural/Ethnic Preferences.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1346	Compliance Determination # 51879
Plan of Correction	BETHANY AT SILVER CREST	Completion Date
Page 3 of 17	Licensee: BETHANY OF THE NORTHWEST	12/26/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST is or will be in compliance with this law and / or regulation on (Date) 2/5/25.

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

Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 1 of 7 residents (Resident 1) had a preadmission assessment prior to being re-admitted to the ALF. This failure resulted in Resident 1 not having an updated assessment to instruct staff to address resident care and services, placing Resident 1 at risk of compromised care and safety.

Findings included...

Review of the ALF's undated policy titled "Resident Assessment", showed the facility shall ensure that each prospective resident receives a thorough assessment prior to admission by a qualified assessor to determine needed care and services.

Resident 1 was re-admitted to the ALF on [redacted]2024 with a diagnosis of [redacted]

Review of Resident 1's records showed that no preadmission assessment was available for review.

On 12/20/2024 at 10:09 AM, Staff G, Director of Nursing Services, stated that they were unable to locate a preadmission assessment for Resident 1

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST 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-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 1 of 7 residents (Resident 1) had a preadmission assessment prior to being re-admitted to the ALF. This failure resulted in Resident 1 not having an updated assessment to instruct staff to address resident care and services, placing Resident 1 at risk of compromised care and safety.

Findings included…

Review of the ALF's undated policy titled “Resident Assessment”, showed the facility shall ensure that each prospective resident receives a thorough assessment prior to admission by a qualified assessor to determine needed care and services.

Resident 1 was re-admitted to the ALF on [redacted]/2024 with a diagnosis of [redacted].

Review of Resident 1’s records showed that no preadmission assessment was available for review.

On 12/20/2024 at 10:09 AM, Staff G, Director of Nursing Services, stated that they were unable to locate a preadmission assessment for Resident 1.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1346	Compliance Determination # 51879
Plan of Correction	BETHANY AT SILVER CREST	Completion Date
Page 4 of 17	Licensee: BETHANY OF THE NORTHWEST	12/26/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST is or will be in compliance with this law and / or regulation on (Date) 2/5/25.

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

Emily Scott
Administrator (or Representative)

1/13/25
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;

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the resident's physician for 2 of 7 residents (Resident 4 and 7) when Residents 4 and 7 chose not to take their medications as prescribed. This failure resulted in the resident's physicians not being aware of the missed medications and placed Resident 2 and 7 at risk for not receiving informed decisions by their health care provider and complications related to untreated health care needs.

Findings included...

Resident 4

Resident 4 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

Resident 4's Negotiated Service Agreement (NSA) dated [redacted]/2024 showed staff were required to assist with daily medications as ordered by the prescriber.

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, BETHANY AT SILVER CREST 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-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;

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the resident's physician for 2 of 7 residents (Resident 4 and 7) when Residents 4 and 7 chose not to take their medications as prescribed. This failure resulted in the resident's physicians not being aware of the missed medications and placed Resident 2 and 7 at risk for not receiving informed decisions by their health care provider and complications related to untreated health care needs.

Findings included…

Resident 4

Resident 4 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

Resident 4's Negotiated Service Agreement (NSA) dated [redacted]/2024 showed staff were required to assist with daily medications as ordered by the prescriber.

Review of Resident 4's Electronic Medication Administration Record (EMAR) dated 09/11/2024 showed a physician's order for Aspercreme Lidocaine Patch 4% (a topical pain relief cream), apply 2 patches to the right shoulder daily for pain.

Review of Resident 4's EMAR dated October 2024, showed Resident 4 refused 1 of 31 prescribed doses, EMAR for November 2024, refused 15 of 30 prescribed doses and December 2024, refused 18 of 18 prescribed doses.

On 12/19/2024 at 10:40 AM, Resident 4 stated that she no longer uses the Lidocaine patch for pain relief because she found Voltaren (a nonsteroidal topical pain relief cream or gel available without a prescription) to be more effective. Resident 4 stated that she notified staff that the Lidocaine patch was not working for her.

Resident 7

Resident 7 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

Resident 7's NSA dated 09/19/2024 showed staff were required to assist with daily medication as ordered by the prescriber.

Review of Resident 7's EMAR dated 11/01/2024 showed a physician's order for Albuterol Sulfate Inhalation Aerosol Solution (a medication that relaxes the smooth muscles of the lung tissue making breathing easier), 2 puffs inhaled orally four times a day.

Review of Resident 7's EMAR dated November 2024, showed Resident 7 refused 109 of the 116 prescribed doses and EMAR dated December 2024 showed 61 of 70 doses refused.

Review of Resident 7's progress notes dated 11/02/2024 showed Resident 7 told staff they did not want to take the Albuterol inhaler and didn't believe they needed it anymore.

Review of Resident 7's progress notes dated 11/01/2024 through 12/19/2024 showed no entries stating contact was made with the resident physician regarding frequent medication refusals and wanting to discontinue the use of the medication.

On 12/19/2024 at 1:07PM, Resident 7 stated that they had not been taking the Albuterol

Sulfate Inhalation Aerosol Solution for about a year. Resident 7 stated that when the staff saw the inhaler, they automatically added it to the medication list. Resident 7 stated that they told the staff they did not want to take the medication routinely and to notify the physician if necessary to stop giving.

On 12/18/2024 at 1:35PM, Staff G, Director of Nursing Services, stated that medication refusals by ALF residents are documented on the EMAR and progress notes.

On 12/18/2024 at 1:50PM, Staff G stated that the ALF uses Consensus (a computerized healthcare tracking application) to send facsimile communication (fax) to the prescribing physician of the resident's medication refusals.

On 12/19/2024 at 9:49AM, Staff G stated that it didn't look like staff had been notifying the physician of resident refusals. Staff G was unable to provide documentation showing physicians were notified.

On 12/19/2024 at 1:57PM, Staff I, Corporate Clinical Nurse, stated that the facility communications with physicians regarding medication refusals was processed through Consensus but was unable to locate notification for resident medication refusals between the ALF and the physicians.

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, BETHANY AT SILVER CREST is or will be in compliance with this law and / or regulation on (Date) 2/5/25.

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

Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 388-78A-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow their Respiratory Protection Program, a program used to prevent the spread of infectious diseases, by not ensuring 5 of 6 care staff (Staff B, C, D, E, and F) were fit tested (a procedure that ensures a respirator fits a person's face and provides the expected level of protection) for N95 respirators (a respiratory protective device

Sulfate Inhalation Aerosol Solution for about a year. Resident 7 stated that when the staff saw the inhaler, they automatically added it to the medication list. Resident 7 stated that they told the staff they did not want to take the medication routinely and to notify the physician if necessary to stop giving.

On 12/18/2024 at 1:35PM, Staff G, Director of Nursing Services, stated that medication refusals by ALF residents are documented on the EMAR and progress notes.

On 12/18/2024 at 1:50PM, Staff G stated that the ALF uses Consensus (a computerized healthcare tracking application) to send facsimile communication (fax) to the prescribing physician of the resident's medication refusals.

On 12/19/2024 at 9:49AM, Staff G stated that it didn't look like staff had been notifying the physician of resident refusals. Staff G was unable to provide documentation showing physicians were notified.

On 12/19/2024 at 1:57PM, Staff I, Corporate Clinical Nurse, stated that the facility communications with physicians regarding medication refusals was processed through Consensus but was unable to locate notification for resident medication refusals between the ALF and the physicians.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow their Respiratory Protection Program, a program used to prevent the spread of infectious diseases, by not ensuring 5 of 6 care staff (Staff B, C, D, E, and F) were fit tested (a procedure that ensures a respirator fits a person's face and provides the expected level of protection) for N95 respirators (a respiratory protective device

designed to achieve a very close facial fit and very efficient filtration of airborne particles). This failure resulted in Staff B, C, D, E, and F not being fit tested for a respirator in the event of an infectious disease outbreak and placed all 52 residents, staff, and visitors at a higher risk of contracting and spreading communicable diseases.

Findings included…

Review of Washington Administrative Code 296-842-15005 showed the ALF would provide fit testing (a test used to determine which respirator model and size provides the proper fit for the user) before employees were assigned duties that may require the use of respirators and at least every twelve months after the initial testing.

Review of the ALF's undated Respiratory Protection Program showed that the ALF would ensure employees that were required to wear respiratory protection as a condition of their employment were protected from respiratory hazards through the proper use of respirators. The program showed that staff who could potentially be exposed to airborne respiratory illnesses during work were staff that performed patient care. The staff that were identified to be at risk were required to wear an N95 respirator and would need to be fit tested prior to use of an N95.

Review of the ALF's employee files showed the following:

Staff B, Caregiver, was hired on 06/28/2024. No N95 respirator fit testing documentation was available for review.

Staff C, Caregiver, was hired on 05/24/2022. Review of an undated Respirator Fit Test Record showed Staff C passed a fit test. The date of the fit test and the respirator make/model that Staff C was approved for was not documented.

Staff D, Caregiver, was hired on 06/17/2019. No N95 respirator fit testing documentation was available for review.

Staff E, Caregiver, was hired on 03/12/2018. Review of an undated Respirator Fit Test Record showed Staff E passed a fit test. The date of the fit test and the respirator make/model that Staff E was approved for was not documented.

Staff F, Caregiver, was hired on 05/17/2017. Review of an undated Respirator Fit Test Record showed Staff E was fit tested. The date of the fit test, the respirator make/model that Staff E was tested for, and whether Staff E passed or failed the fit test was not documented.

On 12/19/2024 at 1:50 PM, Staff I, Corporate Clinical Nurse, stated they were unsure

why the form wasn't complete. Staff I stated they will not be using this form in the future.

On 12/20/2024 at 11:18 AM, Staff B stated they had not been fit tested at this facility, but they had been fit tested at another job. Staff B stated the respirator they were approved for at the other job was not available at this facility.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST is or will be in compliance with this law and / or regulation on (Date) 2/5/25.

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

Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff completed a facility orientation prior to working with residents for 2 of 4 staff (Staff B and C), Orientation and Safety training for 1 of 4 staff (Staff A), specialized dementia and mental health training for 2 of 6 staff (Staff A and D), Cardiopulmonary Resuscitation (CPR) and first aid training for 2 of 6 staff (Staff B and C), and 12-hours of continuing education (CE) per year for 2 of 6 staff (Staff D and F). This failure resulted in Staff A, B, C, D, and F not having the necessary training related to their job duties and expectations and placed all 30 residents at risk for compromised care and safety.

why the form wasn't complete. Staff I stated they will not be using this form in the future.

On 12/20/2024 at 11:18 AM, Staff B stated they had not been fit tested at this facility, but they had been fit tested at another job. Staff B stated the respirator they were approved for at the other job was not available at this facility.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff completed a facility orientation prior to working with residents for 2 of 4 staff (Staff B and C), Orientation and Safety training for 1 of 4 staff (Staff A), specialized dementia and mental health training for 2 of 6 staff (Staff A and D), Cardiopulmonary Resuscitation (CPR) and first aid training for 2 of 6 staff (Staff B and C), and 12-hours of continuing education (CE) per year for 2 of 6 staff (Staff D and F). This failure resulted in Staff A, B, C, D, and F not having the necessary training related to their job duties and expectations and placed all 30 residents at risk for compromised care and safety.

Findings included…

Facility Orientation

Review of the ALF's employee files showed Staff B, Nursing Assistant Certified, was hired on 06/28/2024. Staff B's file showed no record of having a completed facility orientation.

On 12/20/2024 at 11:17 AM, Staff B stated that they did not complete a facility orientation upon hire.

Review of the ALF's employee files showed Staff C, Nursing Assistant Certified, was hired on 05/24/2022. Staff C's file showed no record of having a completed facility orientation.

On 12/19/2024 at 10:28 AM, Staff C stated that they did not complete a facility orientation upon hire.

On 12/20/2024 at 2:00 PM, Staff I, Corporate Clinical Nurse, stated that clinical training happens in the facility and is managed by the Director of Nursing Services.

Orientation and Safety Training

Review of the ALF's employee files showed Staff A, Administrator, was hired on 04/08/2024. Staff A had no documentation showing a completed Orientation and Safety training.

On 12/19/2024 at 9:35AM, Staff A stated that they did not do Orientation and Safety training as they were not aware they needed to have the training as the administrator.

Specialty Dementia and Mental Health Training

Review of the ALF's Resident Characteristic Roster, dated 02/07/2024, showed nine residents living in the ALF had a [redacted] diagnosis and 4 of 6 sampled residents (Resident 1, 2, 3, 4 and 5) had a [redacted] diagnosis.

Review of the ALF's Disclosure of Services dated 07/19/2024, Subsection 7, Care for Residents with Dementia, Developmental Disabilities, or Mental Illness showed that if the ALF choose to serve residents with dementia, developmental disabilities, or mental

health issues, must provide employees with specialty training.

Review of the ALF's employee files showed Staff A was hired on 04/08/2024. No documentation of the completion of specialty dementia or mental health training.

Review of the ALF's employee files showed Staff D, Caregiver, was hired on 06/17/2019. No documentation of the completion of specialty mental health training.

On 12/19/2024 at 9:41 AM, Staff A stated that they had not completed the dementia specialty training as they did not know they were required to complete it in their current position with the ALF.

CPR and First Aid Training

Review of the ALF's employee files showed Staff B was hired on 06/28/2024. The ALF was unable to provide documentation that Staff B completed CPR and first aid training.

On 12/19/2024 at 2:33 PM, Staff A stated that there was no CPR and first aid training on file for Staff B.

On 12/20/2024 at 11:18 AM, Staff B stated that they believed they had recently completed CPR and first aid training at another job. No copy of the CPR and first aid certificate was available for review.

Review of the ALF's employee files showed Staff C was hired on 05/24/2022. Staff C's CPR and First Aid training card showed their certification expired on 06/20/2024.

On 12/19/2024 at 3:40 PM, Staff C stated their card was expired and management was in the process of signing them up for a renewal course.

Continuing Education (CE)

Review of the ALF's employee files showed Staff D was hired on 06/17/2019. Staff D showed no CE hours for 12/20/2022 through 12/20/2023.

Review of the ALF's employee files Staff F, Caregiver, was hired on 05/17/2017. Staff F showed no CE hours for 06/07/2023 through 06/07/2024.

On 12/19/2024 at 9:52 AM, Staff A stated that staff CE documentation was maintained

in the employee's file. Staff A stated that if the CE documentation was not in the employees file, they cannot confirm it was completed.

On 12/19/2024 at 1:59 PM, Staff A stated that they were unable to locate CE documentation for Staff D and F.

Plan/Attestation Statement

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Emily Scott — Administrator (or Representative)

11/13/25 — Date

WAC 388-78A-2471 Background check Confidentiality Use restricted Retention. The assisted living facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have a process in place to maintain the Washington State Background Check completed upon hire for 3 of 6 sampled staff (Staff A, C and D). This failure resulted in Staff A, C and D not having the documentation of the background check completed upon hire for department review and placed all residents at risk of having staff provide care who may not be cleared to work with vulnerable adults.

Findings included...

Review of staff files showed:

Staff A, Administrator, was hired on 04/08/2024. A National Fingerprint was completed but there was no documentation of a Washington state name and date of birth background check completed upon hire.

Staff C, Caregiver, was hired on 05/24/2022. A National Fingerprint was completed but there was no documentation of a Washington state name and date of birth background

in the employee's file. Staff A stated that if the CE documentation was not in the employees file, they cannot confirm it was completed.

On 12/19/2024 at 1:59 PM, Staff A stated that they were unable to locate CE documentation for Staff D and F.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2471 Background check Confidentiality Use restricted Retention. The assisted living facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have a process in place to maintain the Washington State Background Check completed upon hire for 3 of 6 sampled staff (Staff A, C and D). This failure resulted in Staff A, C and D not having the documentation of the background check completed upon hire for department review and placed all residents at risk of having staff provide care who may not be cleared to work with vulnerable adults.

Findings included…

Review of staff files showed:

Staff A, Administrator, was hired on 04/08/2024. A National Fingerprint was completed but there was no documentation of a Washington state name and date of birth background check completed upon hire.

Staff C, Caregiver, was hired on 05/24/2022. A National Fingerprint was completed but there was no documentation of a Washington state name and date of birth background

check completed upon hire.

Staff D, Caregiver, was hired on 06/17/2019. A National Fingerprint was completed but there was no documentation of a Washington state name and date of birth background check completed upon hire.

On 12/19/2024 at 9:37AM, Staff A stated that they had a background check upon hire, but they don't know where the documentation of the background check was, if not in their employee file.

Plan/Attestation Statement

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

Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff B) completed a Washington State Name and Date of Birth background check and 2 of 6 staff (Staff B and D) completed a national fingerprint background check. This failure resulted in Staff B and D working with vulnerable adults while having an unknown criminal background with potentially disqualifying crimes and placed all 52 residents at risk for harm.

Findings included...

Review of the ALF's employee files showed the following:

check completed upon hire.

Staff D, Caregiver, was hired on 06/17/2019. A National Fingerprint was completed but there was no documentation of a Washington state name and date of birth background check completed upon hire.

On 12/19/2024 at 9:37AM, Staff A stated that they had a background check upon hire, but they don't know where the documentation of the background check was, if not in their employee file.

Plan/Attestation Statement

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

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Administrator (or Representative) Date

WAC 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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff B) completed a Washington State Name and Date of Birth background check and 2 of 6 staff (Staff B and D) completed a national fingerprint background check. This failure resulted in Staff B and D working with vulnerable adults while having an unknown criminal background with potentially disqualifying crimes and placed all 52 residents at risk for harm.

Findings included…

Review of the ALF's employee files showed the following:

Staff B, Caregiver, was hired on 06/28/2024. No Washington Name and Date of Birth background checks nor fingerprint background checks for Staff B were available for review.

Staff D, Caregiver, was hired on 06/17/2019. No fingerprint background check for Staff D was available for review.

On 12/18/2024 at 4:09 PM, Staff A, Executive Director, stated that they did not do any background checks for Staff B and D due to a miscommunication of responsibilities between themselves and the ALF's corporate Human Resources (HR) department. Staff A was unable to provide any records of a Washington Name and Date of Birth background check for Staff B nor national fingerprint background checks for Staff B or D.

On 12/20/2024 at 2:00PM, Staff I, Corporate Clinical Nurse, stated that HR initiates new hire paperwork, then sends the paperwork to the Administrator, who is responsible for managing the background and reference checks.

On 12/20/2024 at 11:17 AM, Staff B stated that they never got scheduled to go to a fingerprint appointment for their background check upon hire.

Plan/Attestation Statement

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Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff (Staff B and C) were screened for Tuberculosis (TB) (a contagious infection that is spread through bacteria in the air and primarily affects the lungs) within three days of employment. This failure placed all 52 residents at risk for possible exposure to

Staff B, Caregiver, was hired on 06/28/2024. No Washington Name and Date of Birth background checks nor fingerprint background checks for Staff B were available for review.

Staff D, Caregiver, was hired on 06/17/2019. No fingerprint background check for Staff D was available for review.

On 12/18/2024 at 4:09 PM, Staff A, Executive Director, stated that they did not do any background checks for Staff B and D due to a miscommunication of responsibilities between themselves and the ALF's corporate Human Resources (HR) department. Staff A was unable to provide any records of a Washington Name and Date of Birth background check for Staff B nor national fingerprint background checks for Staff B or D.

On 12/20/2024 at 2:00PM, Staff I, Corporate Clinical Nurse, stated that HR initiates new hire paperwork, then sends the paperwork to the Administrator, who is responsible for managing the background and reference checks.

On 12/20/2024 at 11:17 AM, Staff B stated that they never got scheduled to go to a fingerprint appointment for their background check upon hire.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff (Staff B and C) were screened for Tuberculosis (TB) (a contagious infection that is spread through bacteria in the air and primarily affects the lungs) within three days of employment. This failure placed all 52 residents at risk for possible exposure to

a communicable disease.

Findings included...

Review of employee files showed the following:

Staff B, Caregiver, was hired on 06/28/2024. The ALF was unable to provide documentation that Staff B completed TB testing upon hire.

Staff C, Caregiver, was hired on 05/24/2022. Staff C's TB test was initialized on 06/01/2022, eight days after their hire date.

On 12/19/2024 at 2:33 PM, Staff A stated that they understood TB was to be done within three days of hire, but that they were unable to find any TB documentation for Staff B.

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Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure documentation related to staff training and qualifications including continuing education (CE) and specialty training requirements were kept on-site for 3 of 6 staff (Staff B, C, and E). This failure resulted in management not knowing if staff were keeping their

a communicable disease.

Findings included...

Review of employee files showed the following:

Staff B, Caregiver, was hired on 06/28/2024. The ALF was unable to provide documentation that Staff B completed TB testing upon hire.

Staff C, Caregiver, was hired on 05/24/2022. Staff C's TB test was initialized on 06/01/2022, eight days after their hire date.

On 12/19/2024 at 2:33 PM, Staff A stated that they understood TB was to be done within three days of hire, but that they were unable to find any TB documentation for Staff B.

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Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure documentation related to staff training and qualifications including continuing education (CE) and specialty training requirements were kept on-site for 3 of 6 staff (Staff B, C, and E). This failure resulted in management not knowing if staff were keeping their

knowledge, expertise, and skills up-to-date through annual CE courses and if their staff had completed required specialty training related to dementia and mental health and placed all 52 residents at risk for compromised care and unmet needs.

Review of the ALF's employee files on 12/18/2024 showed Staff B, Caregiver, was hired on 06/28/2024. The ALF was unable to provide documentation that Staff B completed dementia and mental health specialty training.

On 12/18/2024 at 1:14 PM, Staff A, Executive Director, stated that they did not have documentation of Staff B's dementia and mental health specialty training and they were unsure if Staff B had completed these requirements. Staff A stated there has been miscommunication about responsibilities for new staff and their onboarding process between them and their Human Resources department.

On 12/20/2024 at 11:18 AM, Staff B stated that they had completed dementia and mental health specialty training and that they had copies at home that they will provide to Staff A.

Review of the ALF's employee files on 12/18/2024 showed Staff C, Caregiver, was hired on 05/24/2022. The ALF was unable to provide documentation that Staff C completed any CE courses for the year.

Review of the ALF's employee files on 12/18/2024 showed Staff E, Caregiver, was hired on 03/12/2018. The ALF was unable to provide documentation that Staff E completed any CE courses for the year.

On 12/19/2024 at 2:33 PM, Staff A stated that they weren't able to access Relias, an online resource for healthcare workers to complete their CE. Staff A stated that there was no system currently in place to assess whether staff were completing their CE requirements and that they would have to talk to Staff C and E to have them print out their CE certificates.

On 12/20/2024 at 10:19 AM, Staff A stated that Staff C and E were able to print their CE certificates showing they had completed the required 12-hours of annual CE training.

Plan/Attestation Statement

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

knowledge, expertise, and skills up-to-date through annual CE courses and if their staff had completed required specialty training related to dementia and mental health and placed all 52 residents at risk for compromised care and unmet needs.

Review of the ALF's employee files on 12/18/2024 showed Staff B, Caregiver, was hired on 06/28/2024. The ALF was unable to provide documentation that Staff B completed dementia and mental health specialty training.

On 12/18/2024 at 1:14 PM, Staff A, Executive Director, stated that they did not have documentation of Staff B's dementia and mental health specialty training and they were unsure if Staff B had completed these requirements. Staff A stated there has been miscommunication about responsibilities for new staff and their onboarding process between them and their Human Resources department.

On 12/20/2024 at 11:18 AM, Staff B stated that they had completed dementia and mental health specialty training and that they had copies at home that they will provide to Staff A.

Review of the ALF's employee files on 12/18/2024 showed Staff C, Caregiver, was hired on 05/24/2022. The ALF was unable to provide documentation that Staff C completed any CE courses for the year.

Review of the ALF's employee files on 12/18/2024 showed Staff E, Caregiver, was hired on 03/12/2018. The ALF was unable to provide documentation that Staff E completed any CE courses for the year.

On 12/19/2024 at 2:33 PM, Staff A stated that they weren't able to access Relias, an online resource for healthcare workers to complete their CE. Staff A stated that there was no system currently in place to assess whether staff were completing their CE requirements and that they would have to talk to Staff C and E to have them print out their CE certificates.

On 12/20/2024 at 10:19 AM, Staff A stated that Staff C and E were able to print their CE certificates showing they had completed the required 12-hours of annual CE training.

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Emily Scott
Administrator (or Representative)

1/13/25
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to provide a safe, sanitary, well-maintained environment for residents living at the ALF. This failure resulted in residents living in an unsafe and unsanitary environment and placed all 52 residents at risk for injury and a decreased quality of life.

Findings included...

The facility has one kitchen that serves all ALF residents.

On 12/17/2024 at 11:24 AM, two mops were observed laying in a heap on the floor sink in the kitchen housekeeping closet. The mops were wet to the touch.

On 12/17/2024 at 11:25 AM, Staff A, Administrator, was notified of the concern that the wet mops in the kitchen posed a hazard to resident safety due to risk of bacterial contamination.

On 12/17/2024 at 11:48 AM, a mop was observed in a plastic bag on the floor in the upstairs housekeeping closet. The mop was wet to the touch.

On 12/20/2024 at 1:01 PM, Staff A stated that they had not ordered the hooks for the mops yet.

On 12/20/2024 at 1:11 PM, a wet mop was observed to be sitting in a bucket in the kitchen housekeeping closet.

On 12/20/2024 at 1:13 PM, Staff H, Dietary Manager, stated that after each meal they mop the floor. The mop head was removed and placed in the soiled laundry and replaced with a clean mop head.

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to provide a safe, sanitary, well-maintained environment for residents living at the ALF. This failure resulted in residents living in an unsafe and unsanitary environment and placed all 52 residents at risk for injury and a decreased quality of life.

Findings included…

The facility has one kitchen that serves all ALF residents.

On 12/17/2024 at 11:24 AM, two mops were observed laying in a heap on the floor sink in the kitchen housekeeping closet. The mops were wet to the touch.

On 12/17/2024 at 11:25 AM, Staff A, Administrator, was notified of the concern that the wet mops in the kitchen posed a hazard to resident safety due to risk of bacterial contamination.

On 12/17/2024 at 11:48 AM, a mop was observed in a plastic bag on the floor in the upstairs housekeeping closet. The mop was wet to the touch.

On 12/20/2024 at 1:01 PM, Staff A stated that they had not ordered the hooks for the mops yet.

On 12/20/2024 at 1:11 PM, a wet mop was observed to be sitting in a bucket in the kitchen housekeeping closet.

On 12/20/2024 at 1:13 PM, Staff H, Dietary Manager, stated that after each meal they mop the floor. The mop head was removed and placed in the soiled laundry and replaced with a clean mop head.

Statement of Deficiencies	License #: 1346	Compliance Determination # 51879
Plan of Correction	BETHANY AT SILVER CREST	Completion Date
Page 17 of 17	Licensee: BETHANY OF THE NORTHWEST	12/26/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, BETHANY AT SILVER CREST is or will be in compliance with this law and / or regulation on (Date) 2/5/25 .

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

Emily Scott — Administrator (or Representative)

1/13/25 — Date

Plan/Attestation Statement

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Administrator (or Representative) Date