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

WEATHERLY INN-KENT LLC
WEATHERLY INN AT LAKE MERIDIAN, THE
15101 SE 272ND ST
KENT, WA 98042

RE: WEATHERLY INN AT LAKE MERIDIAN, THE License # 1356

Dear Administrator:

This letter addresses Compliance Determination(s) 29064 (Completion Date 09/06/2023) and 26681 (Completion Date 07/14/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/06/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2485-1, WAC 388-78A-2485-2

The Department staff who did the on-site verification:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Angelica Rios, ALF Licensor

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

Sincerely,

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 07/14/2023 and 07/14/2023 of:

WEATHERLY INN AT LAKE MERIDIAN, THE
15101 SE 272ND ST
KENT, WA 98042

This document references the following SOD dated: 07/14/2023

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

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Angelica Rios, ALF Licensor

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

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

Residential Care Services

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

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 7 staff, Staff D, Caregiver, had a chest X-ray or was medically evaluated for signs and symptoms after a positive blood test result for tuberculosis (TB). This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included…

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received the first citation for this regulation on 03/03/2023 for Staff C. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 04/24/2023.

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a second citation for this regulation on 05/18/2023 for Staff C. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 06/09/2023.

Review of the facility's personnel staff records showed that the facility hired Staff D on 01/30/2023. Review of Staff D's personnel records showed documentation that Staff D received the first step of the two-step tuberculosis screening test on 02/08/2023. The first step test results were read on 02/11/2023 and showed a positive reaction. Further review showed Staff D completed a blood test on 05/09/2023 with a positive finding for TB. There was no documentation that showed the facility requested Staff D obtain a chest X-ray, as required. There was no documentation that showed Staff D was medically evaluated for signs and symptoms of TB.

Review of the facilities staff schedule showed that Staff D worked in the facility since their hire date. Staff D was allowed direct access to residents while they worked.

During an interview on 07/14/2023 at 11:45 AM, Staff B, Director of Nursing Services, stated that Staff D was instructed to obtain a chest x-ray. Staff B stated that Staff D reported in a phone interview on 07/14/2023 that they had not completed the chest X-ray as directed. Staff B also confirmed the facility had not received documentation that Staff D completed a medical evaluation for the signs and symptoms of tuberculosis.

This is a recurring deficiency cited on 05/18/2023 and 03/03/2023 and an uncorrected deficiency previously cited on 05/18/2023 and 03/03/2023.

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, WEATHERLY INN AT LAKE MERIDIAN, THE 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
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1356	Compliance Determination # 23691
Plan of Correction	WEATHERLY INN AT LAKE MERIDIAN, THE	Completion Date
Page 1 of 6	Licensee: WEATHERLY INN-KENT LLC	05/18/2023

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 05/08/2023 and 05/08/2023 of:
WEATHERLY INN AT LAKE MERIDIAN, THE
15101 SE 272ND ST
KENT, WA 98042

This document references the following SOD dated: 05/18/2023

The following sample was selected for review during the unannounced on-site visit: 0 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

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

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

Laurie Anderson — 06/01/2023
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) 6/1/23 Date

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

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1of 7 staff, Staff C, Caregiver, had a chest X-ray after a positive test result to a tuberculosis (TB) skin test. This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 03/28/2023 for Staff C. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 04/24/2023.

Review of Staff C's facility personnel records showed that the facility hired Staff C on 02/09/2023. The facility initiated the first step of the two-step TB screening on 02/03/2023. The test results were read on 02/05/2023 and showed a positive reaction. There was no documentation that showed the facility requested Staff C obtain a chest X-ray, as required. Additionally, there was no documentation that showed Staff C was evaluated for signs and symptoms of tuberculosis.

During an interview on 05/08/2023 at 11:45 AM, Staff B, Director of Nursing Services, stated that Staff C was not sent to have a chest X-ray completed after Staff C's initial TB skin test showed a positive result. Staff B also confirmed the facility had not received documentation that Staff C completed a medical evaluation for the signs and symptoms of tuberculosis. Staff B provided no explanation for the failure to correct the lack of follow through with TB testing for Staff C after the initial licensing inspection found facility failed practice.

This is an uncorrected deficiency previously cited on 03/03/2023.

Statement of Deficiencies	License #: 1356	Compliance Determination # 23691
Plan of Correction	WEATHERLY INN AT LAKE MERIDIAN, THE	Completion Date
Page 3 of 6	Licensee: WEATHERLY INN-KENT LLC	05/18/2023

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 6/9/23 .

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

Administrator (or Representative) 6/1/23 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 7 staff, (Staff A, General Manager, and Staff D, Caregiver) were screened for Tuberculosis (TB) as required. This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings Included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 03/28/2023 for Staff A and Staff D. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 04/24/2023.

Review of the facility's personnel staff records showed that the facility hired Staff A on 11/01/2022. Review of Staff A's personnel records showed no documentation that Staff A was screened for tuberculosis within three days of hire. Review of the facility's staff schedule showed that Staff A worked in the facility and was allowed direct access to residents.

Review of the facility's personnel staff records showed that the facility hired Staff D, caregiver, on 01/30/2023. Review of Staff D's personnel records showed documentation that Staff D received the first step of tuberculosis screening test on 02/08/2023, nine days after date of hire. There was no documentation of the first-step TB test results. There was no documentation that Staff D completed the second step of the two-step TB screening

process. Review of the facilities staff schedule showed that Staff D worked in the facility and was allowed direct access to residents.

During an interview on 05/08/2023 at 11:45 AM, Staff B, Director of Nursing Services, reported that in March 2020, Staff A previously worked as a beautician for the company at a different facility. Staff B stated that Staff A was screened for TB at that time. Staff B stated that Staff A had "helped out in the facility laundry, here, for a month during COVID so I didn't think she needed to be re-tested." Staff B confirmed that when Staff A was hired on 11/01/2022 at current facility, Staff A had not been screened for tuberculosis. Staff B provided no explanation for the failure to correct the lack of follow through with TB testing for Staff A and Staff D after the initial licensing inspection found facility failed practice.

This is an uncorrected deficiency previously cited on 03/03/2023 for subsections 1 and 2.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 6/9/23 .

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

Administrator (or Representative) — Date: 6/1/23

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610 ;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their required respiratory protection program (RPP) policy for 5 of 67 staff (Staff G, Care Staff, Staff I, Licensed Practical Nurse (LPN), Staff W, Dietary Cook, Staff FF, Care Staff, and Staff MM, Care Staff). This failure placed all the residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 03/28/2023 for Staff G, Staff I, Staff W, and Staff FF. The ALF signed an attestation

statement that stated the facility would have a system in place and the deficiency corrected by 04/24/2023.

The Centers for Disease Control and Prevention (CDC) developed guidelines for infection prevention and control practices in healthcare setting in response to the coronavirus disease (Covid-19) pandemic. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current infection control standards to prevent and control the spread of COVID-19 in healthcare settings.

Review of the CDC website, titled "Transmission-Based Precautions" (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html), showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission. The recommendations included the use of a fit-tested National Institute for Occupational Safety and Health (NIOSH) approved N95 (a filtering facepiece respirator) or higher-level respirator for healthcare personnel.

Review of the DOH publication, titled "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31, 2022, showed specific guidelines for RPP that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and annual fit tests for any employees identified as potentially being exposed to respirator hazard. The publication also stated that the facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

Review of the Dear Provider Letter titled "EMPLOYER RESPONSIBILITIES FOR RESPIRATORY PROTECTION PROGRAM AND PROVISION OF PERSONAL PROTECTIVE EQUIPMENT (PPE)", dated 04/30/2021, showed the guidelines for long-term care facilities (LTCF), healthcare workers (HCWs), and employers on when to use certain types of PPE. The letter further described requirements of LTCFs that included initial fit-testing for each HCW with the respirator that the HCW will be required to wear for protection against COVID-19 and other airborne hazards.

Review of the facility's undated document titled "Respiratory Protection Program for COVID-19 Prevention Weatherly Inn", showed the facility required employees who must wear N95 or other filtering facepiece respirator be medically evaluated and fit-tested. The document further showed that the facility had fit testing and instructions documentation that was part of the employee's recordkeeping through the human resources (HR) department.

Review of the facility's "Assisted Living Facility Characteristic Roster", dated 05/08/2023, showed that the facility provided services and care to 45 residents.

Review of the facility's undated "Employee File", showed that the facility hired 67

employees to provide services and care to their assisted living residents. The document showed that the facility hired Staff G on 01/19/2022, Staff I on 10/19/2021, Staff W on 05/17/2007, Staff FF on 05-27-2021, and Staff MM on 04/26/2023.

Review of the facility's respirator fit test documentation showed that Staff MM had not completed the initial respirator fit test. Further review of the documentation showed that Staff G, Staff I, Staff W, and Staff FF were overdue for their annual respirator fit test.

During an interview on 05/08/2023 at 9:15 AM, Staff B, Director of Nursing Services, stated that they were the designated staff for the RPP policy and procedures program. Staff B stated that all employees were fit-tested for respirators.

During an interview on 05/08/2023 at 12:07 PM, Staff B, Director of Nursing Services and Staff KK, Licensee Vice-President of Operations/Administrator of record, stated that some employees missed the required initial fit-testing and some staff were overdue for their annual respirator fit-test.

This is an uncorrected deficiency previously cited on 03/03/2021 for subsection 2k.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 6/9/23 .

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

Administrator (or Representative) — Date: 6/1/23

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1356	Compliance Determination # 20170
Plan of Correction	WEATHERLY INN AT LAKE MERIDIAN, THE	Completion Date
Page 1 of 8	Licensee: WEATHERLY INN-KENT LLC	03/03/2023

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 the unannounced on-site full inspection on 02/16/2023 and 02/21/2023 of:

WEATHERLY INN AT LAKE MERIDIAN, THE
15101 SE 272ND ST
KENT, WA 98042

The following sample was selected for review during the unannounced on-site visit: 9 of 49 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Jane Hermano, NCI

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

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

Residential Care Services

03-14-2023
Date

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

Administrator (or Representative) 3/24/23 Date

WAC 388-78A-2520 Administrator qualifications General.

(1) The licensee must appoint an administrator who is:

(c) Qualified to perform the administrator's duties specified in WAC 388-78A-2560 .

(2) The licensee must only appoint as an assisted living facility administrator an individual who meets the requirements of at least one of the following sections in WAC 388-78A-2522 through 388-78A-2527 .

This requirement was not met as evidenced by:

Based on record review and interview, the licensee failed to ensure 1of 7 sampled staff, Staff A, General Manager/Administrator, met the Washington State qualifications and requirements to be an assisted living facility administrator. Failure to ensure that facility staff have the required certification and training placed all 61 facility residents at risk for unmet care needs by untrained or unqualified staff.

Findings included ...

During a review of staff records on 02/16/2023, documents showed that the facility hired Staff A, on 11/01/2022. A review of available personnel documents showed that Staff A did not meet the requirements to be a long-term care facility administer (WAC 388-78A-2522 through WAC 388-78A-2527).

During an interview on 02/17/2023, Staff A stated that they had not provided direct care to vulnerable adults and had never provided supervision for individuals who provided care to vulnerable adults. [WAC 388-78A-2527 (1) and (2)]. Staff A stated that she was a licensed beautician. Staff A stated that they did not have an associate or bachelor's degree in any academic field. Staff A stated that they were scheduled to attend Administrator training in April 2023. Staff A stated that they were scheduled for Home Care Aide training in June 2023. Staff A stated that they were not currently participating in an on-site Administrator-In-Training program. Staff A stated that there was not a qualified Administrator on-site at the facility who provided training and supervision for Staff A. Staff A also stated that Staff KK, Vice-President of Corporate Operations, provided support by phone and e-mail.

During a telephone interview on 02/17/2023, Staff KK, stated that the company hired Staff A based on the documented "experience as a direct care provider while working as a beautician for Weatherly". Staff KK stated, "we believe the experience providing care as a hairdresser while at Weatherly meets the definition of providing direct care to vulnerable adults...". The Department Licensors informed Staff KK that Staff A did not meet the qualifications as an Assisted Living facility Administrator as required by Washington Administrative Code 388-78A-2540.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 4/24/23 .

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

Administrator (or Representative) — Date: 3/24/23

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

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1of 7 staff, Staff C had a chest X-ray after a positive test result to a tuberculosis (TB) skin test. This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Review of Staff C's facility personnel records showed that the facility hired Staff C, Caregiver, on 02/09/2023. The facility initiated the first step of the two-step TB screening on 02/03/2023. The test results were read on 02/05/2023 and showed a positive reaction. There was no documentation that showed the facility requested Staff C obtain a chest X-ray as required. Additionally, there was no documentation that showed Staff C was evaluated for signs and symptoms of tuberculosis.

During an interview on 02/16/2023 at 4:10 PM, Staff B, Director of Nursing Services, stated that Staff C was not sent to have a chest X-ray completed after Staff C's initial TB skin test showed a positive result. Staff B also confirmed the facility had not received documentation that Staff C completed a medical evaluation for the signs and symptoms of tuberculosis.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 4/24/23 .

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

Administrator (or Representative) 3/24/23 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 7 staff, (Staff A and Staff D) were screened for Tuberculosis (TB) as required. This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings Included...

Review of the facility's personnel staff records showed that the facility hired Staff A, General Manager, on 11/01/2022. Review of Staff A's personnel records showed no documentation that Staff A was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff A worked in the facility and was allowed direct access to residents.

Review of the facility's personnel staff records showed that the facility hired Staff D, caregiver, on 01/30/2023. Review of Staff D's personnel records showed documentation that Staff D received the first step of the two-step tuberculosis screening test on 02/08/2023, nine days after date of hire. There was no documentation of the first-step TB test results. There was no documentation that Staff D completed the second step of the two-step TB screening process. Review of the facilities staff schedule showed that Staff D worked in the facility and was allowed direct access to residents.

During an interview on 02/21/2023 at 4:00 PM, Staff B, Director of Nursing Services, reported that in March 2020, Staff A previously worked as a beautician for the company at a different facility and that Staff A was screened for TB at that time. Staff B confirmed that when Staff A was hired on 11/01/2022 at current facility, Staff A had not been screened for tuberculosis. Staff B provided no explanation for the lack of follow through with TB testing for Staff A and Staff D.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 4/24/23 .

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

Administrator (or Representative) — Date: 3/24/23

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610 ;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their required respiratory protection program (RPP) policy for 32 of 62 staff (Staff C, Staff D, Staff E, Staff F, Staff G, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, Staff U, Staff V, Staff W, Staff X, Staff Y, Staff Z, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, and Staff HH). This failure placed all the residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for infection prevention and control practices for healthcare setting in response to the coronavirus disease (COVID-19) pandemic. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current infection control standards to prevent and control the spread of COVID-19 in healthcare settings.

Review of the CDC website, titled "Transmission-Based Precautions" (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html), showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission. The recommendations included the use of a fit-tested National institute for Occupational Safety and Health (NIOSH) approved N95 (a filtering facepiece respirator) or higher-level respirator for healthcare personnel.

Review of the DOH publication titled "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31, 2022, showed specific guidelines for RPP that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and annual fit tests for any employees identified as potentially being exposed to respiratory hazard. The publication also stated that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

Review of the Dear Provider Letter titled "EMPLOYER RESPONSIBILITIES FOR RESPIRATORY PROTECTION PROGRAM AND PROVISION OF PERSONAL PROTECTIVE EQUIPMENT (PPE)," dated 04/30/2021, showed the guidelines for long-term care facilities (LTCF), healthcare workers (HCWs), and employers on when to use certain types of PPE. The letter further described requirements of LTCFs that included initial fit-tests for each HCW with the respirator that the HCW would be required to wear for protection against COVID-19 and other airborne hazards.

Review of the facility's undated document titled "Infection Control Policy", showed "the Safety Committee will oversee compliance with OSHA (Occupational Safety and Health Administration and WISHA (Washington Industrial Safety and Health Act) regulations and all infection control procedures".

Review of the facility's document titled "Infection Control Policy Specific to COVID-19", dated 08/10/2022, showed that the facility reviewed Local Health Jurisdiction (LHJ), DOH, DSHS, and CDC guidelines for infection control during the COVID-19 pandemic. The document further showed that the facility made infection control decisions with consideration of LHJ, DOH, and DSHS recommendations.

Review of the facility's "Assisted Living Facility Characteristic Roster", dated 02/16/2023, showed that the facility provided care and services to 49 residents.

Review of the facility's undated "Employee File" showed that the facility hired 62 employees to provide care and services to the 49 assisted living residents. The document showed that the facility hired Staff C as Care Staff on 02/09/2023, Staff D as Care Staff on 01/30/2023, Staff E as Care Staff on 11/22/2016, Staff F as Care Staff on 04/19/2015, Staff G as Care Staff on 01/19/2022, Staff H as Care Staff Coordinator on 06/24/2021, Staff I as Licensed Practical Nurse (LPN) on 10/19/2021, Staff J as Care Staff on 12/15/2022, Staff K as Care Staff on 11/16/2022, Staff L as Care Staff on 09/02/2022, Staff M as Care Staff on 09/06/2022, Staff N as Care Staff on 06/24/2022, Staff O as LPN on 08/23/2012, Staff P as LPN on 10/25/2019, Staff Q as LPN on 12/16/2022, Staff R as Maintenance Assistant on 12/05/2022, Staff S as Care Staff on 02/15/2007, Staff T as Care Staff on 06/14/2021, Staff U as OC Reception/Care Staff on 01/14/2021, Staff V as Care Staff on 02/22/2017, Staff W as Dietary Cook on 05/17/2007, Staff X as Care Staff on 09/01/2000, Staff Y as Care Staff on 09/17/2021, Staff Z as LPN on 05/03/2021, Staff AA as Community Relations Director on 04/01/2020, Staff BB as Care Staff on 04/14/2021, Staff CC as Care Staff on 12/27/2021, Staff DD as Care Staff on 07/29/2019, Staff EE as Director of Dietary Services on 12/02/1999, Staff FF as Care Staff on 05/27/2021, Staff GG as LPN on 04/29/2018, and Staff HH as Care Staff on 03/06/2020.

Review of the facility's respirator fit test documentation showed that Staff C, Staff D, Staff H, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, and Staff R had not completed the initial respirator fit test. Further review of the documentation showed that Staff E, Staff F, Staff G, Staff I, Staff S, Staff T, Staff U, Staff V, Staff W, Staff X, Staff Y, Staff Z, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, and Staff HH were overdue for their annual respirator fit test.

During an interview on 02/17/2023 at 12:30 PM, Staff B, Director of Nursing Services, stated that they were the designated staff for the RPP policy and procedures program. Staff B stated that all employees were fit-tested for respirators.

During an interview on 02/21/2023 at 10:00 AM, Staff II, Office Manager, stated that they kept all the files for the employee respirator fit-test documents. Staff II stated that not all employees completed the initial fit-test. Staff II also stated that some employees were overdue for their annual respirator fit test.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 4/24/23 .

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

Administrator (or Representative) — Date: 3/24/23

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on interview and record review, the facility licensee failed to notify the department of a change in their assisted living administrator within 10 calendar days of the effective date of change, as required. This failure placed residents at risk of receiving care from an unqualified staff member. This failure also limited residents and representatives of knowing the current administrator responsible for directing and supervising the overall operation of the assisted living facility.

Findings included...

Review of Department's Facilities Management System (FMS) database on 02/15/2023, showed that Staff JJ was the current Administrator of record. The FMS record further identified Staff JJ as the Administrator, since 07/01/2017.

Review of the facility's undated Disclosure of Services document showed that Staff JJ, Former General Manager, was listed as the person to contact for more information.

Review of the facility's document titled "Assisted Living Facility Information Changes", dated 02/16/2023, showed that Staff JJ was the former Administrator as of 08/01/2022. The document also showed that Staff A, General Manager, was named Administrator starting 11/01/2022. Further review showed that Staff KK, Vice President (VP) of Operations completed the Administrator change information. Review of the facility's electronic mail (email) document titled Change of Administrator, dated 02/16/2023, showed that Staff KK, VP of Operations, sent the change of Administrator information to the Department on this date.

During an interview on 02/16/2023 at 10:40 AM, Staff A stated that they were the current Assisted Living Administrator. Staff A stated that they were employed as the facility Administrator since 11/01/2022. Staff A further stated that notification of Administrator change was sent to the department on 02/16/2023.

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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 4/24/23 .

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

Administrator (or Representative) — Date: 3/24/23

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

03/14/2023

CERTIFIED MAIL

9489 0090 0027 6382 8694 60

WEATHERLY INN-KENT LLC
WEATHERLY INN AT LAKE MERIDIAN, THE
15101 SE 272ND ST
KENT, WA 98042

RE: WEATHERLY INN AT LAKE MERIDIAN, THE # 1356

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 03/03/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

The facility failed to provide safe medication services for one insulin depended resident when the resident's insulin dosage exceeded the physician's order on a single, isolated incident. Resident was not significantly affected by the error. The facility's Director of Nursing implemented improved guidelines for safe medication administration and assistance.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

(ii) During assisted living facility activities off of the assisted living facility premises.

(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:

(C) Cardiopulmonary resuscitation;

Review of employee personnel records showed that 2 of 7 facility staff failed to provide documentation they completed CPR (cardio-pulmonary resuscitation) training from an approved provider that included a hands-on demonstration of skills. The facility Director of Nursing (DNS) reported that the identified staff would be scheduled to attend the next CPR training available. The DNS stated that all shifts worked in the facility included staff

members with current certified CPR training.

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

Observation of the environment showed the facility used nine plug-in type Air Wick air fresheners throughout the common areas of their secured dementia care community. These electronic plug-in type air fresheners were composed of a liquid cartridge which was accessible to ambulatory residents. The liquid placed residents at risk of harm and injury had they ingested posed a risk for inadvertent ingestion of the hazardous liquid within the cartridges. The facility removed all plug-in air fresheners throughout the common areas of the community accessible to their residents.

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

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

During the entrance tour of the facility, licensors were unable to locate a publicly posted assisted living license. The facility staff reported the license was posted in the marketing office. The facility license posted in the marketing office expired in October 2022. Contact with the Department Business Operations and Analysis Unit representative confirmed the facility renewed the license and were current with the license. The facility General Manager and Business Office Manager reported that upon receipt of the renewed license, the document would be publicly posted in the front lobby.

WAC 388-110-220 Enhanced adult residential care service standards.

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(j) Ensure that the outdoor area for residents:

(i) Is accessible to residents without staff assistance;

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

The facility failed to ensure the secured outdoor areas were accessible to residents without staff assistance. Licensors provided the Washington Administrative Code (WAC) resources and contract requirements to facility staff related to resident access to outdoor areas. The General Manager and Director of Nursing Services unlocked the doors to the outdoor areas which allowed residents access to the outdoors without staff assistance.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (253)234-6020.

Sincerely,

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

Enclosure