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) 50817 (Completion Date 11/25/2024) and 46849 (Completion Date 09/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/25/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-2-b, WAC 388-78A-2300-1-c-ii, WAC 388-78A-2300-1-c-i, WAC 388-78A-2300-1-c-iii, WAC 388-78A-2300-2-a-i, WAC 388-78A-2300-2-a-ii, WAC 388-78A-2300-2-a-iii, WAC 388-78A-2300-2-a, WAC 388-78A-2381-2-a-i, WAC 388-78A-2381-2-a-iv, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-2-c-iv, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-2610-1

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Kathy Young, Licensor

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

Sincerely,

Laurie Anderson

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

Statement of Deficiencies	License #: 1356	Compliance Determination # 46849
Plan of Correction	WEATHERLY INN AT LAKE MERIDIAN, THE	Completion Date
Page 1 of 11	Licensee: WEATHERLY INN-KENT LLC	09/27/2024

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 09/09/2024 and 09/27/2024 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: 7 of 53 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, 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.

Laurie Anderson
Residential Care Services

10/30/2024
Date

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

Administrator (or Representative) 11/6/24 Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 9 residents (Resident 3, Resident 4, Resident 5, and Resident 9) received all medications as prescribed and were not expired. This failure placed Resident 3, Resident 4, Resident 5, and Resident 9 at risk for a potential decline in their health.

Findings included...

Review of the facility's policy, titled, "Medication Services Policy", dated 06/01/2023, showed the facility assisted and administered medications and maintained records of medication assistance/administration. Medication administration assistance included residents who could not indicate understanding they are taking medication. Nurses recorded prescribed orders for residents receiving medication assistance or administration, using the electronic Medication Administration Record (eMAR).

MEDICATIONS NOT GIVEN AS PRESCRIBED
Resident 5

Review of Resident 5's Physician order, dated 06/21/2024, showed Resident 5 was prescribed Gabapentin (anticonvulsant drug for seizures and nerve pain) for spinal issues.

Review of the facility's document titled, "Medication Orders as of July 5, 2024", showed Resident 5 started Gabapentin on 07/02/2024. Review of Resident 5's July 2024 eMar showed there were 13 missing Gabapentin entries between 07/08/2024 and 07/13/2024. Review of Resident 5's September 2024 eMAR showed there were two missed entries for Gabapentin on 09/08/2024.

During an interview on 09/12/2024 at 1:44 PM and 09/13/2024 at 2:26 PM, Staff I,

Director of Nursing Services, stated that they were unaware that Resident 5 missed several doses of Gabapentin. Staff I stated that they were unsure why Resident 5 did not receive their medications as prescribed.

EXPIRED MEDICATIONS
Resident 3

Review of Resident 3's July 2024, August 2024, and September 2024 eMARs showed an order for Senna (medication used to treat constipation), 8.6 milligrams (mg) to be given daily at 7:00 AM.

Observation of medication cart four on 09/12/2024 at 9:30 AM, showed a bottle labeled Geri-Kot (Senna) was opened on 04/16/2023. The label showed the medication expired on 04/2024. Resident 3's name was written on the bottle.

During an interview on 09/12/2024 at 9:30 AM, Staff M, Licensed Practical Nurse, stated that the label on the bottle of Geri-Kot showed it was expired. Staff M stated that Resident 3 did not receive the Geri-Kot that morning. Staff M stated that the Assistant Director of nurses and the pharmacy consultant checked the medication cart for expired medications every three months.

Resident 4
Review of Resident 4's July 2024, August 2024, and September 2024 eMARs showed an order for Hyoscyamine (medication used to control symptoms associated with disorder of the digestive track), 0.125 mg, given sublingually (under the tongue) as needed for "excessive secretions".

Observation of medication cart four on 09/12/2024 at 9:30 AM, showed a bubble packed card with medications inside each bubble. The label showed the bubble card contained Hyoscyamine for Resident 4. The label showed the medication expired on 08/08/2024.

Resident 9
Observations of medication cart one on 09/12/2024 at 9:55 AM, showed a bubble pack card with medications in each bubble. The card was labeled with Resident 9's name and the name of the medication, Quetiapine (for schizophrenia and treatment for major depressive disorder), 25 mg tablets. The label showed the medication expired on 08/31/2024.

During an interview on 09/12/2024 at 9:55 AM Staff N, Licensed Practical Nurse, stated that the Geri-Kot for Resident 3 was not actually expired. Staff N stated that the nurses filled the smaller bottle of Geri-Kot from a larger bottle when needed. Staff N stated that the nurses who refilled the smaller bottle of Geri-Kot did not change the expiration date.

During an interview on 09/12/2024 at 1:30 PM Staff I, confirmed that the small bottle of

Geri-Kot was filled from a larger bottle. Staff I stated that it was the nurses responsibility to check the medications before giving them, to ensure they were not expired. Staff I stated that the Director and Assistant Director of Nurses audited the carts monthly and Licensed Nurses audited the cart weekly.

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) 11/11/24 .

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

Administrator (or Representative) 11/5/24 Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure at least one week of menus of all meals and snacks were posted for 53 of 53 residents (Resident 1 through Resident 53) to review. The facility failed to ensure 1 of 1 dietary manual (manual one) was available to the kitchen staff responsible for food preparation. These failures placed all 53 residents at risk of a diminished quality of life and potential for unmet dietary needs.

Findings included...

Review of the facility's Disclosure of Services showed the facility provided residents with three meals and nutritious snacks daily. The document showed the facility provided for special dietary needs including general diabetic, general low sodium, pureed, and mechanical soft diets (a diet with soft textured foods including chopped, ground, and foods that break apart without a knife).

MENUS
Observation during the full inspection between 09/09/2024 and 09/13/2024 of the facility's four secured memory care units showed that between Unit 1 and Unit 2, the lunch and dinner meals for that day were written on a blackboard. There were no meals posted anywhere for Unit 3 and Unit 4. Observation showed there were no posted weekly menus within any of the units.

During an interview on 09/10/2024 at 9:11 AM, Staff J, Dietary Services Manager, stated that each day, the lunch and dinner meals were written on the blackboard in the common area between Units 1 and 2. Staff J stated that menus were not posted in the dining rooms or provided to the residents.

DIETARY MANUAL
Observation on 09/10/2024 between 8:07 AM and 10:37 AM showed four staff, responsible for food preparation for the residents, were on shift.

During an interview on 09/10/2024 at 9:11 AM, Staff J stated that they did not have a dietary manual available for use.

During an interview on 09/10/2024 at 9:16 AM, Staff K, Cook, stated that staff did not have a dietary manual available for use.

During an interview on 09/10/2024 at 1:47 PM, Staff H, Assistant General Manager, confirmed that the facility did not have a dietary manual.

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) — 11/5/24 Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(i) Giving residents opportunities for privacy, socialization, and common spaces that account for wandering behaviors;

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 16 of 16 residents (Resident 1, Resident 2, and Residents11 through Resident 23) who resided in Unit 2 were able to access an outdoor space. The facility failed to ensure 53 of 53 residents (Resident 1 through Resident 53) in all four units were able to access their own apartments without staff assistance. These failures placed all 53 residents at risk of a diminished quality of life.

Findings included...

ACCESSIBLE OUTDOOR SPACE
Review of the facility's policy titled, "Secured Outdoor Space Policy", dated 08/03/2023, showed the facility provided secured outdoor spaces for memory care residents with doors unlocked during safe daylight hours.

Review of the facility's policy titled, "Restricted Egress Policy", dated 06/01/2023, showed memory care residents were provided with a secured outdoor space for use, without staff assistance, except during inclement weather or other events that would risk residents' safety.

Observation 09/09/2024 at 1:45 PM, showed Unit 2's courtyard was locked. Observation on 09/10/2024 at 1:54 PM showed Unit 2's open-air sun porch was locked.

During an interview on 09/10/2024 at 1:45 PM, Staff L, Facility Director, stated that they did not know why Unit 2's outdoor access was unavailable to residents.

ACCESSIBLE APARTMENTS
Observation of the facility's four secured memory care units during the full inspection between 09/09/2024 at 9:00 AM and 09/13/2024 at 2:00 PM, showed the residents' apartments remained locked while unoccupied by the resident(s).

Observation on 09/10/2024 at 2:15 PM, showed Resident 8 requested the department's licensor unlock their apartment door. Staff L assisted Resident 8 and unlocked the door.

During an interview on 09/10/2024 at 2:15 PM, Staff L stated that residents did not have keys to their own apartments which were kept locked. Staff L stated that all residents required staff assistance to enter their apartments.

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 11/5/24

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the air exchange ventilation system in 3 of 3 of utility closets with mop sinks (first-floor utility closet, second-floor utility closet, and the commercial kitchen utility closet) and 4 of 4 dirty linen rooms with utility sinks (Unit 1 linen room, Unit 2 linen room, Unit 3 linen room, and Unit 4 linen room) and 4 of 4 shower rooms (Unit 1 shower room, Unit 2 shower room, Unit 3 shower room, and Unit 4 shower room) functioned correctly. These

failures placed all 53 residents at risk of breathing poor air quality, possible respiratory distress, and a diminished quality of living.

Findings included...

UTILITY CLOSETS
Observation on 09/09/2024 at 12:39 PM of the second-floor utility closet with a mop sink, showed the air exchange vent did not function. Observation on 09/09/2024 at 1:47 PM of the first-floor utility closet showed, the air exchange vent did not function. Observation 09/09/2024 at 2:35 PM of the utility closet with a mop sink in the main commercial kitchen showed, the air exchange vent did not function.

DIRTY LINEN ROOMS
Observation on 09/09/2024 at 11:50 AM of the Unit 4 dirty linen room with a utility sink showed, the air exchange vent did not function. Observation on 09/09/2024 at 12:40 PM of the Unit 3 dirty linen room showed, the air exchange vent did not function. Observation on 09/09/2024 at 1:47 PM of the Unit 2 dirty linen room showed, the air exchange vent did not function. Observation on 09/09/2024 at 2:21 PM of the Unit 1 dirty linen room showed, the air exchange vent did not function.

SHOWER ROOMS
Observation on 09/09/2024 at 11:58 AM of the Unit 4 shower room showed, the air exchange vent did not function. Observation on 09/09/2024 at 12:48 PM of the Unit 3 shower room, showed the air exchange vent did not function. Observation on 09/09/2024 at 1:55 PM of the Unit 2 shower room, showed the air exchange vent did not function. Observation on 09/09/2024 at 2:28 PM of the Unit 1 shower room, showed the air exchange vent did not function.

During an interview on 09/09/2024 at 12:48 PM, Staff L, Facility Director, stated that their heating, ventilation, and air conditioning repair person stated that the facility vents worked from a common fan. Staff L stated that they were informed that the fan may be not functioning.

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 11/5/24

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to safely store 2 of 2 ladders (a 10-foot ladder and a 16-foot ladder) on a resident accessible sun porch. The facility failed to keep 1 of 1 housekeeping cart (Cart 1) with hazardous chemicals locked while unattended and in resident areas. These failures placed all 53 residents at risk of injury due to improper ladder use and skin and eye contact with hazardous chemicals and ingesting hazardous chemicals.

Findings included...

Review of the facility's policy titled, "Safe Storage and Handling", dated 02/20/2024, showed all supplies and equipment were handled in a manner that protected residents from exposure and risk. The policy showed hazardous chemicals were either kept locked or under constant supervision.

HAZARDOUS CHEMICALS

Observation on 09/09/2024 at 12:22 PM, showed Resident 10 touched an unattended housekeeping cart in the hall outside of the dining room. The unlocked cart contained bottles of cleaning chemicals. Warning labels on the bottles showed the chemicals were hazardous to humans, harmful if swallowed, harmful if inhaled, eye and skin irritants, extremely flammable, and to keep out of the reach of children.

During an interview on 09/09/2024 at 12:32 PM, Staff O, Housekeeper, stated that they did not lock housekeeping carts. Staff O stated that the facility had not provided a key for the cart.

During an interview on 09/09/2024 at 12:34 PM, Staff L, Facility Director, stated that the housekeeping carts never had keys since their employment which began in early 2023.

EQUIPMENT STORAGE
Observation on 09/09/2024 at 2:14 PM, showed two large ladders on a resident accessible sun porch. The ladders were on their sides and leaned against a wall.

During an interview on 09/09/2024 at 2:14 PM, Staff L stated that the ladders were 10 feet and 16 feet long. Staff L stated that the ladders were on the sun porch due to insufficient storage space within the 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, WEATHERLY INN AT LAKE MERIDIAN, THE is or will be in compliance with this law and / or regulation on (Date) 11/11/24 .

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

Administrator (or Representative) — Date 11/5/24

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 observation and interview the facility failed to notified residents, staff, and visitors there was COVID in the facility. This failure placed 53 of 53 residents (Resident 1 through Resident 53) at risk for contracting and spreading a potentially life-threatening disease.

Findings included...

Observation on 09/09/2024 at 10:00 AM, showed the building was a secured memory care facility which consisted of four units, two on the first floor and two on the second floor. Each unit used its own entry door with a common area separating each unit. Observation showed that the entry door to unit two on the first floor was closed and required a keycode to enter and exit. All other unit entry doors were open to allow residents access to the common area and other units.

Observation during the facility tour on 09/09/2024 at 11:00 AM, showed an infection control cart that contained personal protection equipment next to the closed entry door to unit two. During an interview at this time, Staff H, General Manager, stated that Resident 1 tested positive for COVID. Staff H stated that Resident 1 and their roommate were both placed in isolation. Staff H stated that the facility isolated the entire unit from the other units since the residents in the unit were diagnosed with [redacted] and did not understand the need to remain in their rooms. Staff H stated that even though Resident 1 did not wander out of their room, there was always the risk that they could. This created the potential for other exposure to COVID or to possibly spreading the

infection.

During an interview on 09/13/2024 at 1:00 PM, Staff I, Director of Nurses, stated that all the families of residents residing in unit two were notified via email that a resident in the unit tested positive for COVID.

During an interview on 09/12/2024 at 1:38 PM, Collateral Contact 1 (CC1) stated that they were not informed either by email, phone call, or in person when they visited that there was COVID in the facility. CC1 stated they visited unit two accompanied by a relative, Collateral Contact 2 (CC2), whose health was compromised. CC1 stated that they would not have brought CC2 to the facility if they had known there was COVID in the building. CC1 stated that they would have worn a mask if they had known there was COVID in the unit.

During an interview on 09/12/2024 at 10:25 AM, Collateral Contact 3 (CC3), stated that they were not informed that there was COVID in the facility. CC3 stated they learned the building had COVID when they observed residents being tested. CC3 stated they did not appreciate that the facility staff did not inform visitors that the building had COVID. CC3 stated that they were aware of several families who were unhappy at not being informed there was COVID in the building. CC3 stated that their family member may have unknowingly been exposed.

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) 11/11/24 .

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

Administrator (or Representative) — Date 11/6/24

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

AMENDED
10/03/2024

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 09/27/2024 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-2690 Electronic monitoring equipment Resident requested use.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

The facility failed to ensure an agreement was documented in writing, signed by the resident's representative and updated quarterly for cameras placed in the resident's apartment. During the full inspection, the facility completed a signed camera agreement with the resident's representative.

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

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

The facility failed to ensure first aid kits were kept clearly marked and readily available. During the full inspection, the facility made clearly marked first aid kits available per the regulation.

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

(d) Provide all additional documentation as requested by construction review services;

(2) Obtain the written approval of construction review services for the new use of the room; and

The facility failed to notify Construction Review Services (CRS) when they changed the function of a fireside common room to a hospice room. During the full inspection, the facility notified CRS for approval of the change.

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:

(e) Continuing education.

The Assisted Living Facility Administrator failed to ensure they completed the required 12 hour continuing education (CE) training between birth date June 16, 2023 and birth date June 16, 2024. The facility Administrator completed the required 12 CEs on 08/31/2024, nine days prior to the full inspection.

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

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

Enclosure