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

WRG PHASE I EQUITIES EIGHT TOWNCENT
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

RE: FOUNTAIN COURT ASSISTED LIVING License # 1568

Dear Administrator:

This letter addresses Compliance Determination(s) 54444 (Completion Date 02/10/2025) and 51466 (Completion Date 12/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/10/2025 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-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d, WAC 388-78A-2290-4, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2474-4, WAC 388-78A-2480-1, WAC 388-78A-2620-2-a, WAC 388-78A-2620-2-b, WAC 388-78A-2660-1, RCW 70.129.080.3

The Department staff who did the on-site verification:
Claudia Allis, ALF Licensor

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

Sincerely,

Laurie Anderson

Laurie Anderson, Community 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 #: 1568	Compliance Determination #51466
Plan of Correction	FOUNTAIN COURT ASSISTED LIVING	Completion Date
Page 1 of 9	Licensee: WRG PHASE I EQUITIES EIGHT TOWNCENT	12/12/2024

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

The department completed data collection for an unannounced on-site follow-up on 12/10/2024, 12/10/2024, and 12/10/2024 of:
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

This document references the following SOD dated: 12/12/2024

The following sample was selected for review during the unannounced on-site visit: 7 of 36 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Michelle Yip, 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.

Kim Ripley for Laurie Anderson — Residential Care Services

12/23/2024 — 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)

12/27/24
Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a family medication assistance agreement had been obtained for 1 of 1 resident (Resident 5) and the agreement was documented in the resident record. This failure placed the resident at risk for missed medications and a potential for complications of their medical diagnoses.

Findings included...

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 10/15/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/29/2024.

During the entrance interview on 12/10/2024 at 10:45 AM, Staff A, Executive Director, stated that the facility had reviewed and corrected the documentation for residents who will receive family medication assistance. Staff A stated that Resident 5's medication assistance plan had been reviewed by the facility staff. Staff A stated that Resident 5's representative had not submitted a signed plan with the required components to provide family medication assistance.

Review of Resident 5's records showed no documentation of any consent; no documentation of the family plan for assistance, the medications and/or treatments be provided by the family, the schedule and frequency for family medication assistance; the name of the responsible family member and the named alternate individual who will be responsible for the plan; contact information for the family member and the named alternate; and the plan to be utilized in the event the family medication agreement is not followed..

During an interview on 12/10/2024 at 2:10 PM, Staff A stated that the facility did not have the required documentation in Resident 5's records for the family medication assistance. Staff A stated that they were unaware of the Washington Administrative Code requirements and facility expectations for resident requested family medication assistance.

This is an uncorrected citation previously cited on 10/15/2024.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 1/24/25

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

Courtney Reigel — Administrator (or Representative)

12/27/24 — 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:

(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.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 4 staff (Staff E and Staff F) completed all required training to perform their job duties and responsibilities. This failure placed all the residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 10/15/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/29/2024.

Review of facility's undated personnel records showed the facility hired Staff E, Caregiver, on 10/03/2018 and Staff F, Caregiver, on 11/08/2021.

Review of Staff E's undated personnel records showed there was no documentation that showed Staff E completed the required 12 hours of continuing education between 12/14/2022 and 12/14/2023.

Review of Staff F's undated personnel records showed there was no documentation that showed Staff F completed the required 12 hours of continuing education between 09/01/2023 and 09/01/2024.

During an interview on 12/10/2024 at 2:06 PM, Staff A, Executive Director, stated that they were aware Staff E and Staff F did not complete the required 12 hours of continuing education requirements.

This is an uncorrected citation previously cited on 10/15/2024 as to subsection (2)(e) only.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 1/24/25.

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

Courtney Rupel — 12/23/24
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 facility failed to ensure 4 of 4 staff (Staff B, Staff C, Staff D, and Staff W) 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 Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 10/15/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/29/2024.

Review of the facility's personnel staff records showed that the facility hired Staff B, Medication Technician/Caregiver, on 07/24/2024. Review of Staff B's personnel records showed no documentation that Staff B was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff B 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 C, Medication Technician/Caregiver, on 08/12/2024. Review of Staff C's personnel records showed no documentation that Staff C was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff C 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, Care Associate, on 07/23/2024. Review of Staff D's personnel records showed no documentation that Staff D was screened for tuberculosis within three days of hire.

Review of the facilities staff schedule showed that Staff D 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 W, Cook, on 12/04/2024. Review of Staff W's personnel records showed no documentation that Staff W was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff W worked in the facility, prepared resident meals, and was allowed direct access to residents.

During an interview on 12/10/2024 at 2:00 PM, Staff A, Executive Director, stated that when Staff B, Staff C, Staff D, and Staff W were hired the facility did not screen Staff B, Staff C, Staff D, and Staff W for tuberculosis.

This is an uncorrected citation previously cited on 10/15/2024.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 1/24/25.

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

Administrator (or Representative) — Date 12/27/24

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain current veterinarian pet records for 4 of 4 pets (Pet 1, Pet 2, Pet 3, and Pet 4) that resided in the facility. This failure placed the residents at risk of contracting illnesses from unvaccinated or unhealthy pets living in the facility.

Findings included...

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 10/15/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/29/2024.

Review of the facility's document titled, "Disclosure of Services", showed the facility permitted pets with the condition stated in their pet policy. Review of the facility's document titled "Pet policy", undated, showed that pets must maintain a regular veterinary examination and immunizations. The pet policy showed that pets must be free of diseases transmittable to humans.

Review of the facility's pet binder showed there were 4 pets that lived in the facility: 3 cats and 1dog. Review of the records showed no documentation that Pet 1, Pet 2, Pet 3, and Pet 4 had received a current veterinarian certificate that verified they were free of diseases transmittable to humans.

Review of the records showed no documentation that Pet 1, cat; Pet 2, cat; Pet 3, dog; and Pet 4, cat had received a current veterinarian health examination.

During an interview on 12/10/2024 at 1:40 PM, Staff A, Executive Director, stated that they were aware of the pets who needed updated health examinations and health certifications.

This is an uncorrected citation previously cited on 10/15/2024.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 1/24/25.

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

Administrator (or Representative) — Date: 12/27/24

RCW 70.129.080 Mail and telephone -- Privacy in communications. The resident has the right to privacy in communications, including the right to:

(3) Have reasonable access to the use of a telephone where calls can be made without being overheard.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide reasonable access for 39 of 39 facility residents to a telephone where phone calls could be made without being overheard. This failure violated the resident's right to privacy.

Findings included...

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 10/15/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/29/2024.

On 12/10/2024 at 11:00 AM an observation of the facility environment showed a seating area at the end of the 2nd floor hallway. The seating area consisted of 2 chairs, a small table, and a landline telephone. During the observation an un-named Resident seated themselves and made an outgoing phone call. The Resident's conversation was audible throughout the hallway.

On 12/10/2024 at 1:30 PM, Staff A, Executive Director, stated the facility had not implemented a system to provide residents with access to a telephone located in an area that allowed for privacy. Staff A reported they were aware the facility had to provide residents with access to a phone that allowed for privacy. Staff A stated that they had submitted a request to install a phone line in a location which provided privacy for telephone communication on 12/10/2024.

This is an uncorrected citation previously cited on 10/15/2024.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 1/25/24.

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

Administrator (or Representative) — Date: 12/27/24

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

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 10/07/2024, 10/07/2024, 10/09/2024 and 10/09/2024 of:
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

The following sample was selected for review during the unannounced on-site visit: 7 of 34 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Michelle Yip, ALF Licensor
Laurie Anderson, Community Field Manager

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

10/28/2024
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.

Courtney Rye
Administrator (or Representative)

11-1-24
Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain and document a family medication assistance agreement for 1 of 1 resident (Resident 5). This failure placed Resident 5 at risk for missed medications and potential for complications of their medical diagnoses.

Findings included...

Review of Resident 5's records showed no documentation of any consent. The records showed no documentation of the planned family assistance, no documentation of which medications the family would assist, and no documentation of the frequency for family medication assistance. The records showed no documentation of the name of the responsible family member or the named alternate individual responsible for the plan.

There was no contact information for the family member or the named alternate. There was no documentation of an alternate plan to be used in the event the family medication agreement was not followed.

During the entrance interview on 10/07/2024 at 10:45 AM, Staff A, Executive Director, stated that Resident 5 received family assistance with medication services. Staff A stated that Resident 5 did not sign a family medication assistance agreement. Staff A stated that Resident 5's representative did not submit a signed plan to provide family medication assistance.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) ~~Dec 10th, 2024~~ Nov, 29th 2024 QR

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

Administrator (or Representative) — Date: 11-1-24

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

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

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

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State Name and Date of Birth Background check for 1 of 6 staff (Staff F). This failure placed all 34 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

Review of Staff F's undated personnel records showed the facility hired Staff F, Caregiver, on 11/08/2021. Further review of the records showed documentation that

Staff F completed a Washington State Name and Date of Birth background check on 11/02/2021 and expired on 11/02/2023. Staff F's personnel record showed no documentation that the facility completed a new name and date of birth background check.

Review of the facility undated document titled, "DSHS Survey Roster", showed Staff F provided unsupervised direct care to residents 345 days without a valid Name and Date of Birth background check.

During an interview on 10/11/2024 at 2:55 PM, Staff A, Executive Director, stated that the facility staff did not notice Staff F's background check expired. Staff A stated that the facility staff did not submit an updated Washington State Name and Date of Birth background check in November 2023 for Staff F, as required.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) Dec 16th, 2024 Nov 29th 2024 CR

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

Administrator (or Representative) — Date: 11-1-2024

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:

(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.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 6 staff (Staff C, Staff D, Staff E and Staff F) completed all required training to perform their job duties

and responsibilities. This failure placed all the residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff C (Med tech/caregiver) on 08/12/2024; Staff D (caregiver) on 07/23/2024; Staff E (caregiver) on 10/03/2018; and Staff F (caregiver) on 11/08/2021.

Cardio-Pulmonary Resuscitation and First Aid

Review of Staff C's personnel records showed no documentation that Staff C completed the required cardio-pulmonary resuscitation and first aid training.

Review of Staff D's personnel records showed no documentation that Staff D completed the required cardio-pulmonary resuscitation and first aid training.

Continuing Education
Review of Staff E's personnel records showed no documentation that Staff E completed the required 12 hours of continuing education between 12/14/2022 and 12/14/2023.

Review of Staff F's personnel records showed no documentation that Staff F completed the required 12 hours of continuing education between 09/01/2023 and 09/01/2024.

During an interview on 10/11/2024 at 2:25 PM, Staff A, Executive Director, stated that they were unaware Staff B and Staff C did not complete cardio-pulmonary resuscitation and first aid training. Staff A stated that they were unaware Staff E and Staff F did not complete the required 12 hours of continuing education requirements.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on
(Date) ~~Dec 10th, 2024~~ Nov 29th, CR

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

Administrator (or Representative) — Date: 11-1-24

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 facility failed to ensure 3 of 6 staff (Staff B, Staff C, and Staff D) were screened for Tuberculosis (TB), as required. This failure placed all 34 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 B, Med Tech/Caregiver, on 07/24/2024. Review of Staff B's personnel records showed no documentation that Staff B was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff B 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 C, Med Tech/Caregiver, on 08/12/2024. Review of Staff C's personnel records showed no documentation that Staff C was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff C 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, Care Associate, on 07/23/2024. Review of Staff D's personnel records showed no documentation that Staff D was screened for tuberculosis within three days of hire. 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 10/11/2024 at 3:00 PM, Staff A, Executive Director, stated that the facility did not screen Staff B, Staff C, and Staff D for tuberculosis when hired.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) ~~Dec 10th 2024~~ Nov 29th, 2024 -CR

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

Administrator (or Representative) 11-1-24 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 facility failed to ensure 3 of 3 sampled staff (Staff B, Staff C, and Staff D) completed a medical evaluation and fit test in compliance with the infection control regulations. This failure placed 34 residents at risk of illness, disability, or death from a potentially life-threatening infectious disease.

Findings included...

The Centers for Disease Control and Prevention (CDC), the national public health agency for the United States, developed guidelines for infection prevention and control practices in healthcare settings including assisted living facilities. 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 respiratory infections, such as coronavirus disease 2019 (COVID-19), in healthcare settings.

Review of the CDC website "Transmission-Based Precautions" at (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 including a fit-tested National Institute for Occupational Safety and Health (NIOSH)-approved N95 or higher-level respirator for healthcare personnel.

Review of the DOH publication, "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31, 2022, showed specific guidelines for a Respiratory Protection Program (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 employee identified as potentially

being exposed to respiratory hazard. The publication showed that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

Review of the DSHS Dear Provider Letter, "Provider Responsibilities for Provision of Personal Protective Equipment (PPE), Respiratory Protection Program (RPP), and changes to Department of Health RPP Resources", dated 09/14/2023, showed the guidelines for long-term care facilities (LTCF) and employer responsibilities for respiratory protection and RPP. The letter showed that LTCF providers were required to supply PPE to staff who provided care to residents with known or suspected communicable disease. The letter also showed that employers were responsible to identify respiratory hazards in the workplace, provide appropriate PPE and follow regulations pertaining to respiratory protection.

Review of the facility's policy titled, "Respiratory Protection Program for COVID -19 Prevention at Fountain Court Senior Living", update April 2023, showed that all employees designated to use N95 respirators would be fit-tested, annually, before using any respirator. The policy showed that all employees designated to use N95 respirators would be evaluated for medical clearance before being fit-tested for the use of a respirator. The policy showed that the categories of employees who were included in this program include: Certified Nurse Assistants, Registered Nurses, Health care assistants/caregivers, Maintenance staff, housekeeping staff, and administrative staff. The policy showed that all employees designated to use N95 respirators would be fit-tested before using their respirator.

Review of the facility personnel records showed the following: There was no documentation of a medical clearance and no documentation of N95 respirator fit testing for Staff B, Med tech/caregiver, with a hire date of 07/22/2024. There was no documentation of N95 respirator fit testing for Staff C, Med tech/caregiver, with a hire date of 08/12/2024. There was no documentation of a medical clearance and no documentation of N95 respirator fit testing for Staff D, Caregiver, with a hire date of 07/23/2024.

During an interview on 10/11/2024 at 2:10 PM, Staff A, Executive Director, stated that they were unaware of the facility RPP policy and N95 fit testing requirements. Staff A stated they were aware staff who may be required to be fit tested had not completed the medical clearance and fit testing requirements.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on
(Date) ~~Dec 10th 2024~~ Nov 29th, 2024 -dl

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

Administrator (or Representative) — Date 11-1-24

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain current veterinarian pet records for 3 of 3 pets (Pet 1, Pet 2, and Pet 3) that resided in the facility. This failure placed all 34 residents at risk of contracting illnesses from unvaccinated or unhealthy pets living in the facility.

Findings included...

Review of the facility's Disclosure of Services showed the facility permitted pets with the condition stated in their pet policy. Review of the facility's undated document titled, "Pet policy", showed that pets must maintain a regular veterinary examinations and immunizations. The pet policy showed that pets must be free of diseases transmittable to humans.

Review of the facility's pet binder showed there were three pets that lived in the facility: two cats and 1dog. Review of the records showed no documentation that Pet 1 (cat), Pet 2 (cat), and Pet 3 (dog), received a current veterinarian certificate that verified they were free of diseases transmittable to humans.

Review of the records showed no documentation that Pet 1, Pet 2, and Pet 3 received a current veterinarian health examination.

Review of the records showed that Pet 1's vaccines expired on 03/06/2023. The records

showed no documentation Pet 2 received a rabies vaccine.

During an interview on 10/10/2024 at 11:40 AM, Staff A, Executive Director, stated that they were unaware of the pets who needed updated health examinations, health certifications and vaccinations.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) Dec 10th, 2024 Nov 29th, 2024 -CR

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

Administrator (or Representative) — Date: 11-1-24

RCW 70.129.080 Mail and telephone -- Privacy in communications. The resident has the right to privacy in communications, including the right to:

(3) Have reasonable access to the use of a telephone where calls can be made without being overheard.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide access for 34 of 34 facility residents (Resident 1 through Resident 34) to a telephone where phone calls could be made without being overheard. This failure violated all 34 residents right to privacy.

Findings included...

On 10/09/2024 at 11:24 AM, observation of the facility environment showed a seating area at the end of the second-floor hallway. The seating area consisted of two chairs, a small table, and a landline telephone. Observation showed an un-named Resident seated themselves and made an outgoing phone call. The resident's conversation was audible throughout the hallway.

On 10/10/2024 at 11:40 AM during an observation of the resident dining room, an unidentified

resident stated that they did not have a personal cell phone and did not have a landline phone in their room. The unidentified resident stated that the facility had provided hallway telephones. The unidentified resident stated that the phones were located "out in the open" and were not private.

During an interview on 10/11/2024 at 1:35 PM, Staff T, Activities Director, stated that they were not aware the facility was required to provide residents with a telephone in a location that allowed for private conversations.

On 10/11/2024 at 2:31PM, Staff A, Executive Director, stated that there were no residents that asked about a phone. Staff A stated that residents may have talked to the previous administrator. Staff A reported they were unaware the facility was required to provide residents with access to a phone that allowed for privacy.

Plan/Attestation Statement

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(Date) ~~Dec 10th, 2024~~ Nov 29th, 2024-CR

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

Administrator (or Representative) — Date: 11-1-2024

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in

writing an initial agreement to use electronic monitoring, the duration of use, and quarterly reevaluations of electronic surveillance for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk for potential violation of their rights.

Findings included...

During the entrance interview on 10/07/2024 at 10:45 AM, Staff A, Executive Director, stated that Resident 1 used electronic monitoring devices in their room. Staff A stated that Resident 1 did not sign any facility consent form to use electronic monitoring. Staff A stated that Resident 1's representative signed a copy of the facility's electronic monitoring policy when Resident 1 admitted to the facility on [redacted]/2024.

Observation on 10/08/2024 at 11:13 AM, showed a one-inch-wide strip of paper tape on Resident 1's apartment door. The paper tape signage read "Electronic Monitoring in Use".
Review of Resident 1's records showed no documentation of any consent, no documentation of the duration of usage, and no documentation of a quarterly review for continued use.

During an interview on 10/09/2024 at 2:40 PM, Staff A stated that the facility did not have the required documentation in Resident 1's records for the request to use electronic monitoring. Staff A stated that they were aware of the Washington Administrative Code requirements and facility expectations for resident requested electronic monitoring devices.

Plan/Attestation Statement

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(Date) ~~Dec 10th, 2024~~ Nov 29th, 2024

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Administrator (or Representative) — Date: 11-1-24

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

(1) The assisted living facility must:

(c) Provide, and tell staff persons of a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms;

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

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

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

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain 1 of 1 emergency disaster manual that provided information and operating procedures to be used by facility staff during emergencies and disasters, as required. This failure placed all 34 residents at risk for illness, injury, and potential loss of life in the event of an emergency or disaster.

Findings included...

Review of an undated red three ring binder, identified as the facility's "Emergency and Disaster Manual", showed: no information that instructed staff of their responsibilities in an emergency; no instructions on how to contact emergency personnel; no instructions on the procedure for evacuation of residents; no details that outlined alternative resident accommodations, when needed; no instructions that outlined the facility's emergency communication plan; and no instructions on how much emergency water needed to be stored.

During an interview on 10/07/2024 at 10:05 AM, Staff A, Executive Director, stated that the facility's emergency manual was outdated and had not been updated for many years.

Observation on 10/07/2024 at 12:15 PM showed the facility's emergency water was stored in the storage room. Observation showed an opened cardboard box contained pouches of water. Each pouch contained 125 milliliters of water. Observation of the label on the cardboard box showed there was a total of 1.5 liters of water. During an interview at this time, Staff I, Maintenance Director, stated that the water storage was all the emergency water the facility currently stored. Staff I stated that the Culinary Director was responsible for keeping track of the water storage.

During an interview on 10/08/2024 at 9:56 AM, Staff H, Culinary Director, stated that

they were responsible to keep track of the water storage. Staff H stated that they were unaware of the number of assisted living resident that resided in the community. Staff H stated that the number of assisted living resident changed as residents moved in or out of the facility. Staff H stated that they did not know how much water they should store for emergency. Staff H stated that they were unaware there was not enough emergency water in storage for their assisted living residents.

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) — 11-1-24 Date

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

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

(a) Exclusively for the individual resident; or

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

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update 3 of 7 sampled residents' (Resident 2, Resident 3, and Resident 6) Negotiated Service Agreement (NSA). This failure placed Resident 2, Resident 3, and Resident 6 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

RESIDENT 2
Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2020 with medical diagnoses of [redacted]. The records showed that on 07/29/2024, the facility completed Resident 2's assessment and service plan. The assessment showed that Resident 2 required assistance with medication administration.

Review of Resident 2's July 2024, August 2024, September 2024, and October 2024 Medication Administration Records (MARs) showed that staff monitored and documented Resident 2's blood glucose levels daily.

Review of Resident 2's Service Plan, updated 07/29/2024, showed documentation that Resident 2 used a continuous blood glucose monitor. There was no documentation that provided care staff with guidance about the maintenance of a continuous glucose monitor (CGM) device. There were no instructions for staff about how to use the CGM to monitor blood glucose levels. There were no instructions for staff about what actions were needed if Resident 2 experienced any issues or side effects from the CGM's placement on Resident 2's body. There were no instructions for staff about where and when to document the start of the CGM. There were no instructions about when a new CGM was to be replaced by the Registered Nurse (RN).

RESIDENT 3
Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 08/13/2024, the facility completed Resident 3's assessment. The assessment showed that Resident 3 required assistance with medication administration. The records showed Resident 3 started hospice care service on 09/23/2024.

Review of Resident 3's July 2024, August 2024, September 2024, and October 2024 MARs showed that Resident 3 received Aspirin (a medication with blood thinning property), 81 Milligrams (mg), one time a day, by mouth.

Review of Resident 3's Service Plan, dated 08/13/2024, showed no documentation that Resident 3 received Aspirin. There was no documentation that provided care staff with guidance about the possible side effects from daily Aspirin usage, such as bleeding and bruising. There were no instructions for staff about what actions were needed if Resident 3 experienced any side effects. There was no documentation that showed the hospice care agency information, the hospice care service schedules, and the coordination of care with the hospice agency.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2021. The records showed that on 06/17/2024, the facility completed Resident 6's assessment. The assessment showed Resident 6's medical diagnosis included [redacted]. The assessment showed that Resident 6 required assistance with insulin administration.

Review of Resident 6's July 2024, August 2024, September 2024, and October 2024 MARs showed that Resident 6 received Lantus insulin (a medication that lowers the blood sugar levels), 20 units, subcutaneously (under the skin), two times a daily.

Review of Resident 6's Service Plan, dated 06/17/2024, showed no documentation that provided care staff with guidance about the possible side effects from daily insulin usage, such as high and low blood sugar levels. There were no instructions for staff about what actions were needed if Resident 6 experienced any side effects.

During an interview on 10/09/2024 at 11:30 AM, Staff S, Registered Nurse, stated that residents' service plans were updated when the resident experienced changes in care needs. Staff S stated that Resident 2, Resident 3, and Resident 6's service plans were not updated to include all areas of assistance required.

Plan/Attestation Statement

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(Date) ~~Dec 10th, 2024~~ Nov 29th, 2024 CR

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

Administrator (or Representative) — Date: 11-1-24

WAC 388-78A-2170 Required assisted living facility services.

(2) The assisted living facility must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement:

(e) Nutritious snacks - Providing nutritious snack items on a scheduled and nonscheduled basis, and providing nutritious snacks in accordance with WAC 388-78A-2300 .

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide nutritious snacks to 34 of 34 residents (Resident 1 through Resident 34), as required. This failure placed all 34 residents at risk of a decreased quality of life.

Findings included...

NUTRITIOUS SNACKS
Review of the facility's undated "Resident Handbook" showed that the facility provided meals three times a day and snacks available throughout the day. The document showed that there was "a fridge upstairs" that contained snacks.

Observation on 10/09/2024 between 7:00 AM and 2:00 PM showed an upright refrigerator and freezer in the Activity Room on the second floor. Observation showed the refrigerator and freezer were empty. There were no snacks or beverages in the refrigerator or freezer.

During an interview on 10/09/2024 at 2:05 PM, Staff A, Executive Director, stated that they thought the culinary staff was responsible to fill finger-food type of snacks in the refrigerator and freezer, in the afternoon, every day. Staff A stated that they did not have a list of snacks to be placed in the appliances. Staff A stated that they did not have a schedule of when the refrigerator and freezer were to be filled. Staff A stated that they were unaware there were no snacks available.

During an interview on 10/09/2024 at 2:15 PM, Staff T, Cook, stated that they were unaware the refrigerator and freezer in the Activity Room was emptied. Staff T stated they refilled the refrigerator and freezer twice a week and that there was not on a regular schedule of when to fill the appliances. Staff T stated that on days when they were short of staff, they were too busy to refill the refrigerator and freezer.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 11-1-24

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530 , and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(b) At 41 F (5 C) or less.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to monitor food temperatures to ensure the food temperature of the cold holding foods were at or below 41 degrees Fahrenheit. The facility failed to ensure 9 of 32 sampled staff (Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff P, Staff Q, and Staff R) maintained a valid food work card. These failures placed all 34 residents at risk for food-borne illness.

Findings included...

COLD HOLDING FOOD TEMPERATURE
Review of the facility's document titled, "Culinary Services, Food Temperatures, Storage and Freshness of Foods", dated November 2020, showed the facility followed the Washington State Food Codes and other applicable state standards. The policy showed no instructions for checking the temperature of the cold foods, prior to serving.

Review of the facility's undated document titled, "Food Temperature Chart" showed the

facility instructed staff to discard daily products (including egg products, cheese, and hard cheese) when the food was held above 40 degrees Fahrenheit for two hours.

Observation on 10/08/2024 at 11:50 AM showed individual containers of cold foods sat on a stainless-steel cold holding station, was located adjacent to the stove inside the kitchen. Observation showed that Staff U, Cook, measured the temperatures of four cold holding foods (Swiss cheese, cheddar cheese, turkey slices, and salami). All temperature measurements read between 42 degrees Fahrenheit and 43 degrees Fahrenheit. During an interview at this time, Staff U stated that they measured the food temperatures when they took the cold foods out from the walk-in refrigerator and placed the cold foods inside the cold holding station between 9:00 AM and 9:30 AM this morning. Staff U stated that the facility required them to keep the cold foods below 40 degrees Fahrenheit. Staff U stated that when the stove was turned on for cooking, the cold foods were unable to maintain the required cold holding temperatures. Staff U stated that the lid of the cold holding station was frequently opened during lunch time which raised the cold food holding temperatures above the required range.

Observation on 10/09/2024 at 11:30 AM showed that Staff V, Cook, measured the temperatures of four cold holding foods (cheddar cheese, turkey slices, salami, and egg salad). All temperature measurements read between 42 degrees Fahrenheit and 43 degrees Fahrenheit. During an interview at this time, Staff V stated that they used the refrigerator thermometer to keep track the cold holding station's temperature. Staff V stated that they took the cold foods out from the walk-in refrigerator in the morning and left the cold foods inside the cold holding station after the lunch time. Staff V stated that the facility required them to keep the cold foods below 40 degrees Fahrenheit. Staff V stated the cold holding station was located very closed to the stove and when the stove was turned on for cooking, the cold foods were unable to maintain the required cold holding temperatures.

During an interview on 10/09/2024 at 2:05 PM, Staff A, Executive Director, stated that they were unaware the cold foods kept in the cold holding station did not maintain the cold holding temperatures as required.

FOOD WORKER CARDS
Review of the facility's Caregiver Job Description showed that the caregiver's duties and responsibilities included serving meals and snacks to residents.

Review of the facility's employee roster showed that the facility hired Staff I, Maintenance Director, on 10/07/2019; Staff J, Medication Technician, Caregiver, on 07/06/2023; Staff K, Dishwasher, Dietary Aide, on 02/21/2024; Staff L, Medication Technician, Caregiver, on 03/21/2024; Staff M, Caregiver, on 05/07/2024; Staff N, Caregiver, on 06/28/2024; Staff P, Medication Technician, Caregiver, on 09/18/2023; Staff Q, Lead Cook, on 08/31/2021; and Staff R, Caregiver, on 05/28/2024.

Review of the facility's personnel documents showed that as of 10/07/2024, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff P, Staff Q, and Staff R did not have a valid Food

Worker Card.

During an interview on 10/09/2024 at 2:00 PM, Staff A, Executive Director, state that the culinary staff and caregivers served meals to residents. Staff A confirmed that Staff I assisted to serve meals in the dining room. Staff A stated that the culinary staff and caregivers were required to hold a valid Food Worker Card. Staff A stated that they did not have a system to keep track of the staff's Food Worker Card. Staff A stated that they were unaware Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff P, Staff Q, and Staff R did not have a valid Food Worker Card.

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: 11-1-24

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;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to post 1 of 1 Assisted Living Facility license (the current license) in the facility. This failure placed all 34 residents at risk of being uninformed about the facility licensure status and any conditions on the license.

Findings included...

Observation on 10/07/2024 between 9:30 AM and 2:23 PM, showed the facility's assisted living facility (ALF) license posted on the wall behind the front desk. Observation showed the posted ALF license expired in August 2024. There was no current ALF license posted.

During an interview on 10/07/2024 at 2:23 PM, Staff G, Business Office Manager, stated that they were unaware the posted ALF license expired. Staff G stated that they were unsure where to find the current facility's ALF license in the premise.

Plan/Attestation Statement

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

CR — 11-1-24

Administrator (or Representative) — Date

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility failed to provide a lockable storage area for 3 of 8 sampled residents (Resident 3, Resident 6, and Resident 8). This failure violated Resident 3, Resident 6, and Resident 8's rights to have a lockable storage area for their personal belongings.

Findings included...

Resident 3
Observation of Resident 3's room on 10/09/2024 at 7:28 AM, showed a door with a cylinder lock included in the kitchenette cabinets was installed. Observation showed the cabinet door was left unlocked. During an interview at the same time, Resident 3 stated that they did not have the key for the lock on the cabinet door. Resident 3 stated that they preferred to have lockable storage.

Resident 6
Observation of Resident 6's room on 10/08/2024 at 3:35 PM, showed a door with a cylinder lock included in the kitchenette cabinets was installed. Observation showed the cabinet door was left unlocked. During an interview at the same time, Resident 6 stated that they did not have the key for the lock on the cabinet door. Resident 6 stated that

they preferred to have lockable storage.

Resident 8
Observation of Resident 8's room on 10/08/2024 at 3:00 PM, showed a door with a cylinder lock included in the kitchenette cabinets was installed. Observation showed the cabinet door was left unlocked. During an interview at the same time, Resident 8 stated that they did not have a key for the lock. Resident 8 stated they needed lockage storage that would be used to keep some cash and personal items in their room.

During an interview on 10/09/2024 at 2:30 PM, Staff A, Executive Director, stated that a lockable storage space was installed in each apartment. Staff A stated that they were unaware Resident 3, Resident 4, and Resident 8 did not hold the key for the lockable storage in their rooms.

Plan/Attestation Statement

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

CRyn — 11-1-2024

Administrator (or Representative) — Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

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

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to document in the assessment that 1 of 1 sampled resident (Resident 3) was assessed to safely use a medical device. This failure placed Resident 3 at risk of injury from improper use of a medical device.

Findings included...

Observation of Resident 3's apartment on 10/09/2024 at 7:28 AM, showed a quarter-length bed rail attached at the head of the bed, on the right side. Observation showed the bed rail was partially covered with a fibric cover. Observation showed the bed rail was securely fastened to the bed frame with a 2-inch gap between the mattress and the bed rail. Observation showed Resident 3 laid in bed. Observation showed Resident 3 used the bed rail to reposition themselves in bed.

Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 08/13/2024, the facility completed Resident 3's assessment. The assessment showed Resident 3 required assistance with transfers. The assessment showed no documentation that Resident 3 used a bed rail. There was no record of a physician order for bed rail use. There was no record of a physical therapist evaluation for bed rail use. There was no documentation that showed the facility explained the risks and benefits to the resident and family. There was no documentation that instructed staff about the safe monitoring of bed rail use.

During an interview on 10/09/2024 at 1:40 PM, Staff S, Registered Nurse, stated that they were aware Resident 3 used a bed rail. Staff S stated that Resident 3 was recently admitted to hospice care. Staff S stated that when Resident 3 had the bed rail installed about two weeks ago, they did not complete Resident 3's bed rail assessment. Staff S stated that they did not receive a physician order, and they did not explain the risks and benefits of bed rail use to Resident 3 and their representative. Staff S stated that they did not update Resident 3's service plan.

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: 11-1-24

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to report to the Department when of 2 of 2 sampled residents (Resident 9 and Resident 10) were relocated to other rooms within the facility, after the residents' apartments were damaged from flooding. This failure placed Resident 9 and Resident 10 at risk of a diminished quality of life.

Findings included...

During an interview on 10/07/2024 at 10:05 AM, Staff A, Executive Director, stated that in August 2024, a flooding incident happened in Resident 10's apartment. The incident required staff to relocate Resident 10 to another unit in the community. Staff A stated that they were unfamiliar with the Department's reporting requirement for these types of incidents. Staff A stated that at time of the occurrence, they did not report the flooding incident to the Department.

Observation on 10/09/2024 at 11:50 AM showed two apartments: Apartment [redacted] and Apartment [redacted] were under construction. Observation of Apartment [redacted] showed the carpeted flooring, and the kitchenette were removed from the unit. Observation of Apartment [redacted] showed that the carpet flooring, the kitchenette, and the bathroom vanity were removed from the unit. Observation of Apartment [redacted] showed that a contractor had repaired the dry wall. During an interview at this time, Staff I, Maintenance Director, stated that Apartment [redacted] was located directly underneath Apartment [redacted]. Staff I stated that the flooding happened in Apartment [redacted] in August 2024. Staff I stated that the water went down from Apartment [redacted] to Apartment [redacted], which caused water damage in the two units. Staff I stated that the water damage to the two units required immediate evacuation of the two residents that resided in the units. Staff I stated that the two involved residents were relocated to two other apartments.

During an interview on 10/09/2024 at 11:50 AM, Staff A stated that the flooding incident happened on 08/09/2024 and involved two residents, Resident 9 and Resident 10, in Assisted Living. Staff A stated that they immediately evacuated Resident 9 and Resident 10 from the two damaged units and relocated them to other units in the facility. Staff A stated that as of 10/08/2024, they had not reported the flooding incident to the Department.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on
(Date) ~~Dec 10th, 2024~~ Nov 29th, 2024 -CR

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

Administrator (or Representative)

11-1-24
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

10/25/2024

WRG PHASE I EQUITIES EIGHT TOWNCENT
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

RE: FOUNTAIN COURT ASSISTED LIVING # 1568

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/15/2024 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-2970 Garbage and refuse disposal. The assisted living facility must:

(1) Provide an adequate number of garbage containers to store refuse generated by the assisted living facility:

(c) Cleaned and maintained to prevent:

(i) Entrance of insects, rodents, birds, or other pests;

(ii) Odors; and

(iii) Other nuisances.

The Assisted Living Facility failed to ensure the garbage was completely disposed of in the dumpsters located in the outside garbage area. During the full inspection, the facility cleaned up the outside garbage area.

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

The Assisted Living Facility failed to ensure the exhaust air vent in one of the housekeeping/chemical room, with a wet mop sink, provided proper air flow and ventilation to the outside. During the full inspection, the facility fixed the faulty component of the exhaust air vent.

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