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

Mt Vernon Operations LLC
THE BRIDGE ASSISTED LIVING AT MOUNT VERNON
301 S Laventure Rd
Mount Vernon, WA 98274

RE: THE BRIDGE ASSISTED LIVING AT MOUNT VERNON License # 1826

Dear Administrator:

This letter addresses Compliance Determination(s) 60377 (Completion Date 06/06/2025) and 57056 (Completion Date 04/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/06/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-b, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2484-2, WAC 388-78A-2481-1-a

The Department staff who did the on-site verification:
Cristina Gonzalez, Nursing Consultant Institutional

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

Sincerely,

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site follow-up on 03/27/2025 of:
THE BRIDGE ASSISTED LIVING AT MOUNT VERNON
301 S Laventure Rd
Mount Vernon, WA 98274

This document references the following SOD dated: 04/08/2025

The following sample was selected for review during the unannounced on-site visit: 2 of 29 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor

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

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

Kim Ripley
Residential Care Services

04/17/2025
Date

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

Administrator (or Representative) Date

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

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

(a) Orientation and safety;

(b) Basic;

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff completed 70-hour basic training within 120 days from their date of hire for 2 of 2 staff (Staff C and H), specialty dementia and mental health training for 3 of 4 staff (Staff B, C, and H), Occupational Safety and Health Administration (OSHA) approved hands-on cardiopulmonary resuscitation (CPR) and first aid training for 4 of 4 staff (Staff B, C, D, and H). This failure resulted in Staff B, C, D, and H not having the necessary training related to their job duties and expectations and placed all 29 residents at risk for compromised care and safety.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and

Reporting System (STARS) showed that on 01/31/2025, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have the deficiency corrected by 03/17/2025.

Basic Training

Review of WAC 388-112A-0080(5) showed long-term care workers in assisted living facilities must complete the 70-hour basic training within one hundred twenty days of their date of hire.

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

Staff C, Caregiver, was hired on 08/27/2024. Staff C's file showed no record of a completed 70-hour basic training course.

Staff H, Medication Technician/Caregiver, was hired on 12/12/2023. Staff C's file showed no record of a completed 70-hour basic training course.

On 03/27/2025 at 1:49 PM, Staff C stated that they still were working on completing their basic training.

On 03/27/2025 at 1:51 PM, Staff K, Business Office Assistant, stated that Staff C and H had not yet completed their 70-hour basic training at this time.

Specialty Training

Review of WAC 388-112A-0495(4) showed if an ALF serves one or more residents with special needs, long-term care workers must complete specialty training within 120 days of their date of hire.

Review of the ALF's Resident Characteristic Roster, dated 03/27/2025, showed three residents living in the ALF had a [redacted] diagnosis and one of two sampled residents (Resident 1) had a [redacted] diagnosis.

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

Staff B, Caregiver, was hired on 07/16/2024. Staff B's file showed no record of a completed dementia or mental health training.

Staff C was hired on 08/27/2024. Staff C's file showed no record of a completed dementia or mental health training.

Staff H was hired on 12/12/2023. Staff H's file showed no record of a completed dementia or mental health training.

On 03/27/2025 at 1:56 PM, Staff K stated that Staff C and H had been registered for their specialty training but had not completed it as of yet. Staff K stated that they were unable to find Staff B's Specialty training certificates as they were not registered in their system that tracks Basic and Specialty training.

On 03/27/2025 at 1:49 PM, Staff C stated they still need to do their dementia and mental health training, but that they were now signed up for the classes.

CPR and First Aid Training

Review of WAC 388-112A-0720(2)(a) showed long-term care workers must have and maintain a valid CPR and first aid card or certificate within 30 days of their date of hire.

Review of WAC 388-112A-0710 showed CPR and first aid training must meet the guidelines established by OSHA, including mandatory hands-on skills development through the use of mannequins or trainee partners.

Review of OSHA's Best Practices Guide: Fundamentals of a Workplace First-Aid Program (https://www.osha.gov/sites/default/files/publications/OSHA3317first-aid.pdf) showed that CPR and first aid training programs should have trainees develop hands-on skills through the use of mannequins and partner practice.

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

Staff B was hired on 07/16/2024. Staff B had no record of completed CPR and first aid training.

Staff C was hired on 08/20/2024. Staff C's CPR and first aid card showed Staff C was accredited by International CPR Institute, a company that offers online CPR and First Aid training and certification. Review of the company's site showed they do not offer any hands-on CPR training.

Staff D was hired on 10/24/2024. Staff D had no record of completed CPR and first aid training.

Staff H was hired on 12/12/2023. Staff H had no record of completed first aid training.

On 03/27/2025 at 2:06 PM, Staff K stated that Staff B, C, D, and H were still on their list to receive CPR and first aid training.

This is an uncorrected deficiency for subsections (2)(b)(c)(d), previously cited on 01/31/2025.

Plan/Attestation Statement

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

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

_____ _____

Administrator (or Representative) Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 staff (Staff A, C, and D) completed a two-step skin testing to screen for tuberculosis (TB) (an infectious disease caused by bacteria that most often affects the lungs). This failure placed all 29 residents at risk of possible exposure to a communicable disease.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 01/31/2025, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have the deficiency corrected by 03/17/2025.

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

Staff A, Executive Director, was hired on 04/01/2024. Staff A's first step of TB testing was administered on 04/02/2024 and read on 04/05/2024. There was no record available for review to show the second step was completed within one to three weeks after their first test, nor was there a record available for review that showed Staff A had completed a negative TB test within a year of hire.

Staff C, Caregiver, was hired on 08/27/2024. Staff C's first step of TB testing was administered on 08/23/2024 and read on 08/26/2024. There was no record available for review to show the second step was completed within one to three weeks after their first test, nor was there a record available for review that showed Staff C had completed a negative TB test within a year of hire.

Staff D, Caregiver, was hired on 10/24/2024. Staff D's first step of TB testing was administered on 10/23/2024. There was no record available for review to show the second step was completed within one to three weeks after their first test, nor was there a record available for review that showed Staff D had completed a negative TB test within a year of hire.

On 03/27/2025 at 1:08 PM, Staff K, Business Office Assistant, stated that they weren't aware of the requirements for two-step skin testing for TB as they believed the local clinic had completed the two-step TB test because they didn't schedule staff for a second appointment during their first test. Staff K stated that they would have to send all staff, including Staff A, C, and D out to retest.

This is an uncorrected deficiency previously cited on 01/31/2025.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 staff (Staff D) had a trained professional read the results of their tuberculosis (TB) (an infectious disease caused by bacteria that most often affects the lungs) skin test 48 to 72 hours after administration of the test. This failure placed all 29 residents at risk of possible exposure to a communicable disease.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 01/31/2025, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have the deficiency corrected by 03/17/2025.

Review of the ALF's employee files showed Staff D, Caregiver, was hired on 10/24/2024. Staff D's first step of TB testing was administered on 10/23/2024. There was no record available for review to show that this test was read within 24 to 72 hours of the test.

On 01/28/2025 at 1:47 PM, Staff K, Business Office Assistant, stated that they didn't know Staff D didn't have their initial TB test read, so they hadn't scheduled Staff D to get retested and have those new results read.

This is an uncorrected deficiency previously cited on 01/31/2025.

Plan/Attestation Statement

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

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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 01/21/2025, 01/22/2025 and 01/23/2025 of:

THE BRIDGE ASSISTED LIVING AT MOUNT VERNON
301 S Laventure Rd
Mount Vernon, WA 98274

The following sample was selected for review during the unannounced on-site visit: 5 of 29 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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

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

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

Kim Ripley — Residential Care Services

02/05/2025 — Date

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

Administrator (or Representative) — Date

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

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

(a) Orientation and safety;

(b) Basic;

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff completed Orientation and Safety training for 3 of 6 staff (Staff A, B, and C), 70-hour Basic training within 120 days from their of hire for 1 of 6 staff (Staff C), Specialty dementia and mental health training for 3 of 6 staff (Staff A, B, and C), Occupational Safety and Health Administration (OSHA) approved hands-on Cardiopulmonary Resuscitation (CPR) and first aid training for 3 of 6 staff (Staff B, C, and D), and Department of Social and Health Services (DSHS) approved continuing education (CE) for 2 of 2 staff (Staff E and F). This failure resulted in Staff A, B, C, D, E, and F not having the necessary training related to their job duties and expectations and placed all 29 residents at risk for compromised care and safety.

Findings included...

Orientation and Safety Training

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

Staff A, Executive Director, was hired on 04/01/2024. Staff A's file showed no record of a completed Orientation and Safety training course.

Staff B, Med Tech/Caregiver, was hired on 07/16/2024. Staff B's file showed no record of a completed Orientation and Safety training course.

Staff C, Med Tech/Caregiver, was hired on 08/27/2024. Staff C's file showed no record of a completed Orientation and Safety training course.

On 01/22/2025 at 10:10 AM, Staff A stated that they believed they completed Orientation and Safety training with a previous employer and would look through personal records at home for the certificate of completion.

On 01/22/2025 at 2:04 PM, Staff B stated that they believed they completed Orientation and Safety training and would need to look through their paperwork at home for a certificate of completion. Staff B stated they couldn't remember when they took the training.

On 01/22/2025 at 3:53 PM, Staff C stated that they've never taken any Orientation and Safety training.

Basic Training

Review of the ALF's employee files showed Staff C was hired on 08/27/2024. Staff C's file showed no record of a completed 70-hour Basic training course within 120 days of hire.

On 01/22/2025 at 9:08 AM, Staff A stated that Staff C was still working on completing their 70-hour basic training.

On 01/22/2025 at 3:53 PM, Staff C stated that they are currently taking the basic training course, but had not yet finished it at this time.

Specialty Training

Review of the ALF's Resident Characteristic Roster, dated 01/21/2025, showed four residents living in the ALF had a [redacted] diagnosis and one of five sampled residents (Resident 3) had a [redacted] diagnosis.

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

Staff A was hired on 04/01/2024. Staff A's file showed no record of completed dementia or mental health training.

Staff B was hired on 07/16/2024. Staff B's file showed no record of a completed dementia or mental health training.

Staff C was hired on 08/27/2024. Staff C's file showed no record of a completed dementia or mental health training.

On 01/22/2025 at 10:28 AM, Staff A stated that they believed they took Specialty training with a previous employer but did not have a certificate of completion to confirm it was completed. Staff A stated they would need to look through personal records at home for their certificates.

On 01/22/2025 at 2:06 PM, Staff B stated they took the Specialty training for dementia and mental health, but were unable to remember the exact dates and would need to look through their personal records at home.

On 01/22/2025 at 3:53 PM, Staff C stated that they've never taken Specialty training on dementia or mental health.

CPR and First Aid Training

Review of OSHA's Best Practices Guide: Fundamentals of a Workplace First-Aid Program (https://www.osha.gov/sites/default/files/publications/OSHA3317first-aid.pdf) showed that CPR and first aid training programs should have trainees develop hands-on skills through the use of mannequins and partner practice.

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

Staff B was hired on 07/16/2024. Staff B had no record of a completed CPR and First Aid training.

Staff C was hired on 08/20/2024. Staff C's CPR and First Aid card showed Staff C was accredited by International CPR Institute, a company that offers online CPR and First Aid training and certification. Review of the company's site showed they do not offer any hands-on CPR training.

Staff D was hired on 10/24/2024. Staff D had no record of a completed CPR and First Aid training.

On 01/22/2025 at 3:53 PM, Staff C stated that their latest CPR and First Aid training was completed entirely online with no physical CPR or first aid skill development.

On 01/28/2025 at 1:47 PM, Staff D stated that their CPR and First Aid card expired on 09/09/2024.

Continuing Education (CE)

Review of WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?
(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.
(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:
(i) A certified home care aide;

Review of DSHS's Continuing Education Approval Process (https://www.dshs.wa.gov/altsa/faq?field_altsa_topics_value=ce) showed that once DSHS approves a CE, it is assigned a unique DSHS CE approval code and that without a DSHS CE approval code on the certificate or transcript, the CE cannot be used to meet the 12-hour CE requirement.

Staff E, Med Tech/Caregiver, was hired on 11/06/2023. Staff E had 8.7 out of 12 hours of CE's. None of the CE's were DSHS approved.

Staff F, Med Tech/Caregiver, was hired on 02/07/2023. Staff F had one out of 12 hours of CE's. None of the CE's were DSHS approved.

On 01/22/2025 at 9:15 AM, Staff A, Executive Director, stated that they had provided information about WA State CE requirements to their corporate office to determine if the CE's Staff E and F had in their files were DSHS approved.

On 01/23/2025 at 9:40 AM, Staff I, Business Office Assistant, stated that they would try

to re-print CE's with the DSHS approval code.

On 01/23/2025 at 12:32 PM, Staff A stated that they were unable to provide proof that the CE's for Staff E and F were DSHS approved.

On 01/25/2025 at 2:38 PM, Staff F stated that they had not completed any additional CE's other than what was in their file.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 6 staff (Staff A, C, and D) completed a two-step skin testing to screen for tuberculosis (TB). This failure placed all 29 residents at risk of exposure to a communicable disease.

Findings included...

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

Staff A, Executive Director, was hired on 04/01/2024. Staff A's first step of TB testing was administered on 04/02/2024 and read on 04/05/2024. There was no record available for review to show the second step was completed within one to three weeks after their first test, nor was there a record available for review that showed Staff A had

completed a negative TB test within a year of hire.

Staff C, Med Tech/Caregiver, was hired on 08/27/2024. Staff C's first step of TB testing was administered on 08/23/2024 and read on 08/26/2024. There was no record available for review to show the second step was completed within one to three weeks after their first test, nor was there a record available for review that showed Staff C had completed a negative TB test within a year of hire.

Staff D, Med Tech/Caregiver, was hired on 10/24/2024. Staff D's first step of TB testing was administered on 10/23/2024. There was no record available for review to show the second step was completed within one to three weeks after their first test, nor was there a record available for review that showed Staff D had completed a negative TB test within a year of hire.

On 01/22/2025 at 10:22 AM, Staff A stated that they had the first step TB test but not the second step. Staff A stated that the corporate ownership of the facility only required a one step TB test for employees.

On 01/22/2025 at 3:53 PM, Staff C stated that they had a TB test administered and read when they were first hired at the ALF, but did not have a second test administered. Staff C stated that the ALF's previous Business Office Manager told Staff C that the two steps in a two-step TB skin testing were administering it once and then reading the results of this first test.

On 01/28/2025 at 1:47 PM, Staff D stated that they had one TB test administered when they were first hired at the ALF and that they were not scheduled for any further TB testing after this. Staff D stated they had been previously tested for TB via a blood test over two years ago.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff D) had a trained professional read the results of their tuberculosis (TB) skin test 48 to 72 hours after administration of the test. This failure placed all 29 residents at risk of exposure to a communicable disease.

Findings included...

Review of the ALF's employee files showed Staff D, Med Tech/Caregiver, was hired on 10/24/2024. Staff D's first step of TB testing was administered on 10/23/2024. There was no record available for review to show that this test was read within 24 to 72 hours of the test.

On 01/28/2025 at 1:47 PM, Staff D stated that they did the TB testing when they were first hired, however they were unable to have the test read due to schedule conflicts.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff C) completed a Washington state name and date of birth background check and 4 of 6 staff (Staff B, C, D, and E) completed a national fingerprint background check. This failure resulted in Staff B, C, D and E working with vulnerable adults while having an unknown criminal background with potentially disqualifying crimes and placed all 29 residents at risk for harm.

Findings included...

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

Staff B, Med Tech/Caregiver, was hired on 07/16/2024. No national fingerprint background check for Staff B was available for review.

Staff C, Med Tech/Caregiver, was hired on 08/27/2024. No Washington state name and date of birth background check nor national fingerprint background check for Staff C were available for review.

Staff D, Med Tech/Caregiver, was hired on 10/24/2024. No national fingerprint background check for Staff D was available for review.

Staff E, Med Tech/Caregiver, was hired on 11/06/2023. No national fingerprint background check for Staff E was available for review.

On 01/21/2025 at 2:22 PM, Staff A, Executive Director, stated that they were unable to locate Staff C's background check. Staff A stated that the ALF has been through two previous Business Office Assistants (BOAs) since April 2024 and that previous BOAs may have had background check results in their email which is not accessible to Staff A. Staff A was unable to provide any records of a Washington state name and date of birth background check for Staff C.

On 01/22/2025 at 2:04 PM, Staff B stated that they had the receipt from IdentoGO (a private company offering fingerprint services) for the fingerprint but were unable to locate the results.

On 01/22/2025 at 1:01 PM, Staff I, BOA, stated that they accessed the DSHS background check system and were unable to locate any completed background checks under the ALF. Staff I stated that when the ALF didn't have a BOA another BOA may have completed the background checks.

On 01/22/2025 at 3:46 PM, Staff I stated that they contacted another BOA within their corporation and that BOA also did not have any background check results for the ALF's staff.

On 01/22/2025 at 3:53 PM, Staff C stated that they never had a fingerprint background check ran in Washington state nor did they remember signing a Washington state name and date of birth background check authorization form.

On 01/28/2025 at 1:47 PM, Staff D stated that they had not had a fingerprint background check appointment as of yet.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff A) completed a Washington State Name and Date background check within one business day of hire. This failure resulted in Staff A not having a completed background check and placed the safety of 29 residents at risk by allowing an employee with a potentially disqualifying background access to them.

Findings included...

Review of the ALF's employee file showed Staff A, Executive Director (ED), was hired on

04/01/2024. The most recent background check in Staff A's file was dated 06/12/2024, completed 72 days after hire.

On 01/22/2025 at 11:51 AM, Staff A stated they knew they had the Washington state name and date of birth background check but didn't realize it wasn't completed upon hire and was done late.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow their Respiratory Protection Program, a program used to prevent the spread of infectious diseases, by not ensuring 6 of 6 staff (Staff A, B, C, D, E, and F) were fit tested (a procedure that ensures a respirator fits a person's face and provides the expected level of protection) for N95 respirators (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles). This failure resulted in Staff A, B, C, D, E, and F not being fit tested for a respirator in the event of an infectious disease outbreak and placed all 29 residents, staff, and visitors at a higher risk of contracting and spreading communicable diseases.

Findings included...

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

Review of the ALF's undated Respiratory Protection Program (RPP) showed that the ALF would ensure employees required to wear respiratory protection as a condition of their employment were protected from airborne transmissible diseases through the proper fit testing and use of respirators. The RPP showed that the staff would be identified for the potential exposure to airborne diseases and provided with respirator fit testing upon hire, annually, and when there was a change that affected the quality of the respirators seal.

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

Staff A, Executive Director (ED), was hired on 04/01/2024. No N95 respirator fit testing documentation was available for review.

Staff B, Med Tech/Caregiver, was hired on 07/16/2024. Review of the ALF's Respiratory Fit Testing document showed Staff B was last fit tested on 05/26/2022, during prior employment with the ALF.

Staff C, Med Technician/Caregiver, was hired on 08/27/2024. No N95 respirator fit testing documentation was available for review.

Staff D, Med Technician/Caregiver, was hired on 10/24/2024. No N95 respiratory fit testing documentation was available for review.

Staff E, Med Tech/Caregiver, was hired on 11/06/2023. Review of the ALF's Respiratory Fit Testing document showed Staff E was last fit tested on 08/24/2023.

Staff F, Med Tech/Caregiver, was hired on 02/07/2023. Review of the ALF's Respiratory Fit Testing document showed Staff F was last fit tested on 08/23/2023.

On 01/23/2025 at 9:47 AM, Staff A stated they were never fit tested for a respirator, nor were any staff since they have been the ED for the ALF. Staff A stated that they knew fit testing must be completed upon hire and annually but that it just wasn't done.

On 01/22/2025 at 3:00 PM, Staff B stated that they had been fit tested but couldn't remember when they were tested and had no documentation to review.

On 01/22/2025 at 3:46 PM, Staff C stated that they had never been fit tested for a respirator.

On 1/28/2025 at 1:47 PM, Staff D stated that they had never been fit tested for a respirator.

Plan/Attestation Statement

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain prescribed medications in a timely manner for 1 of 7 residents (Resident 3). This failure resulted in Resident 3 missing 31 doses of a prescribed medication in a three-month period and placed Resident 3 at risk of worsening health conditions.

Findings included...

Review of the ALF's policy titled, "Medication Assistance Record," dated 11/13/2024, showed that ALF staff would ensure medication availability for each shift and manage all refills with the pharmacy.

Resident 3 was admitted to the ALF on [redacted]/2021 with multiple medical diagnoses including [redacted].

Review of an Negotiated Service Agreement (NSA), dated 12/05/2024, showed Resident 3 required ALF staff to manage their medications. The NSA showed Resident 3 would receive their medications safely and as prescribed.

Review of an Electronic Medication Administration Record (EMAR) showed Resident 3 was prescribed Isosorbide Dinitrate (a medication used to prevent chest pain resulting from not enough blood flow to the heart by widening blood vessels making it easier for

blood to flow through) one time a day.

Review of the November 2024 EMAR showed Resident 3 missed a total of 11 prescribed doses of Isosorbide Dinitrate. The MAR identified code "11" defined as medication unavailable.

Review of the December 2024 EMAR showed Resident 3 missed a total of 18 prescribed doses of Isosorbide Dinitrate. The MAR identified code "11" defined as medication unavailable.

Review of the January 2025 EMAR showed Resident 3 missed a total two prescribed doses of Isosorbide Dinitrate. The MAR identified code "11" defined as medication unavailable.

On 01/22/2025 at 1:46 PM, Staff K, Med Tech/Caregiver, stated that for residents who use an outside pharmacy, medications are to be ordered well-before running out to ensure the resident doesn't miss a dose. Staff K stated that if they don't have the medication available when it's due, they can call the pharmacy to immediately send it to the ALF.

On 01/22/2025 at 2:09 PM, Staff G, Wellness Director, stated that they had been having difficulties obtaining Resident 3's medications due to delays from Resident 3's pharmacy. Staff G stated that a resident's pharmacy should be called when they are running low on a medication to check in on the status of that medication. Staff G stated that the ALF has a local backup pharmacy to ensure residents are able to get their medications in a timely manner.

Plan/Attestation Statement

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

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

Administrator (or Representative) Date

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

(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:

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to serve resident meals that had been reviewed and approved by a dietitian for 4 of 4 weekly food services menus dated for the weeks of 12/29/2024, 01/05/2025, 01/12/2025, and 01/19/2025. These failures resulted in 29 residents receiving meals that had no dietitian oversight and placed all residents at risk for not receiving nutritionally balanced meals.

Findings included...

Review of the ALF's policy titled "Cycle Menus", revision dated 02/17/2022, showed that "AL [Assisted Living] menus must be signed off by Registered Dietitian prior to implementation".

Review of the ALF's menus dated for the weeks of 12/29/2024, 01/05/2025, 01/12/2025, and 01/19/2025 showed Staff J, Dining Services Director, had signed 4 of 4 menus.

On 01/22/2025 at 1:13 PM, Staff I, Business Office Assistant, stated that the menus are provided by the corporate office and signed by a Registered Dietitian (RD).

On 01/22/2025, at 1:15 PM, Staff A, Executive Director, stated that the menus are provided by the corporate office and are done by season; Fall/Winter and Spring/Summer.

Review of the RD signed Fall/Winter 2024-2025, Week 4, Day 1-Day 7 menu showed that the menu did not match the menu the ALF was using.

On 01/23/2025 at 10:30 AM, Staff J stated that they do not have a RD certification and that the menu with the RD signature is not the menu that is used.

On 01/23/2025 at 12:00 PM, Staff A stated that the corporate office sent the wrong menus, and they would work on getting the menus they are using approved and signed by the RD.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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;

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

(3) Ensure the facility functional program and room list are updated to reflect the change.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to notify Department of Health (DOH) Construction Review Services (CRS) prior to changing the use of 1 of 46 rooms (Room [redacted]) for resident use. This failure placed 1 of 29 residents at risk of living in an environment that does not meet the minimum basic standards required to ensure the safety and comfort of the resident.

Findings included...

Review of the Department's room list signed by Staff A, Executive Director, on 01/21/2025, showed an added room, room [redacted].

Review of the ALF's Resident Characteristic Roster, dated 01/21/2025, showed that a resident was residing in room [redacted].

Review of the Department's database showed no record of room [redacted] as a resident room

going back to 03/29/2017.

On 01/28/2025 at 2:32 PM, Staff I, Business Office Assistant, stated that when they worked at the ALF 10 years ago, room [redacted] was an office.

On 01/28/2025 at 2:41 PM, Staff H, Maintenance Director, stated that shortly after he was hired (06/22/2022), room [redacted] was changed to a resident room from an employee break room and that another staff person, who no longer works at the ALF, was supposed to have completed the paperwork for the room change.

On 01/29/2025, DOH CRS stated that they had no records of having received an application for a room change at the ALF and their last review request was for a fire alarm panel in 2018.

On 01/31/2025 at 10:31 AM, room [redacted] was observed to have a resident living in it.

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