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

CASCADE LIVING GROUP - KENT LLC
ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY
24121 116TH AVE SE
KENT, WA 98030

RE: ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY License # 1993

Dear Administrator:

This letter addresses Compliance Determination(s) 31544 (Completion Date 10/24/2023) and 27309 (Completion Date 08/11/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/24/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2466-1, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2484-1, WAC 388-78A-2140-5, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-7, WAC 388-78A-2610-1, WAC 388-78A-2610-2-d, WAC 388-78A-2170-1, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3090-1-a

The Department staff who did the on-site verification:

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

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

Sincerely,

Laurie Anderson, Field Manager

Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for the unannounced on-site full inspection on 07/19/2023, 07/20/2023, 07/21/2023, 07/25/2023, 07/26/2023, 07/27/2023 and 07/27/2023 of:

ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY
24121 116TH AVE SE
KENT, WA 98030

The following sample was selected for review during the unannounced on-site visit: 9 of 47 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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

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

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

Residential Care Services

Date

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

Administrator (or Representative) Date

WAC 388-78A-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 submit a request for a Washington State Name and Date of Birth Background check for 1 of 6 staff (Staff F, Care Associate) prior to Staff F having unsupervised contact with facility residents. This failure placed all 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 on 03/23/2009. Further review of the records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 02/18/2021 and expired on 02/18/2023. Staff F's personnel record showed no documentation that showed the facility completed a new name and date of birth background check.

Review of facility document titled 'DSHS Survey Roster', undated, showed Staff F provided unsupervised direct care to residents 153 days without a valid Name and Date of Birth background check.

During an interview on 07/20/2023 at 1:55 PM, Staff A, Administrator, stated that the facility did not notice Staff F's background check expired. Staff A stated that the facility did not submit an updated Washington State Name and Date of Birth background check in February 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, ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY 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-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;

(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 facility failed to ensure 2 of 6 staff (Staff E, Care Associate and Staff F, Care Associate) 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 E on 08/13/2021 and Staff F on 03/23/2009.

Review of Staff F's undated personnel records showed no documentation Staff F completed Orientation and Safety training. Further review showed no documentation Staff F completed 12 hours of annual continuing education training.

Review of Staff E's undated personnel records showed no documentation Staff E completed cardiopulmonary resuscitation (CPR) certification and first aid training. Further review showed no documentation Staff E had completed 12 hours of annual continuing education training.

During an interview on 07/27/2023 at 3:10 PM, Staff A, Administrator, confirmed that Staff

E and Staff F had not completed training 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, ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY 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:

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 6 staff (Staff B, LPN/Licensed Practical Nurse; Staff C, Med Tech; Staff E, Care Associate; and Staff F, Care Associate) were screened for Tuberculosis (TB) as required. This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included…

Review of the facility's personnel staff records showed that the facility hired Staff B on 05/30/2023. 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 on 03/27/2023. 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 E on 08/13/2021. Review of Staff E's personnel records showed no documentation that Staff E

was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff E 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 F on 03/23/2009. Review of Staff F's personnel records showed no documentation that Staff F was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff F worked in the facility and was allowed direct access to residents.

During an interview on 07/27/2023 at 3:00 PM, Staff A, Administrator, confirmed that when Staff B, Staff C, Staff E, and Staff F were hired, the facility did not screen any of them for tuberculosis.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY 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-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:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(5) Appropriate behavioral interventions, if needed;

(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in 2 of 9 sampled residents (Resident 3 and Resident 4) Negotiated Service Agreements (NSA), the

care needs and interventions required to meet the health and safety of each resident. This failure placed Resident 3 and Resident 4 at risk of compromised health related to unmet care needs.

Finding included...

RESIDENT 3
Review of Resident 3's June 2023 and July 2023 Medication Administration Record (MAR) showed that Resident 3 received 0.5 milligrams (mg) Lorazepam (anti-anxiety medication used to treat anxiety and sleep problems), one tablet, by mouth, every 8 hours as needed for anxiety (intense, excessive, and persistent worry and fear about everyday situations). The MAR provided no documentation about the signs and symptoms of any side effects related to medication used.

Review of Resident 3's plan titled "WA - Cascade Level of Care - Assisted Living - V2", dated 05/15/2023, showed diagnoses of [redacted]. The plan contained no documentation that provided guidance to staff about the signs and symptoms or behaviors associated with Resident 3's anxiety. The plan provided no instructions for staff to follow when Resident 3 exhibited any of the signs or symptoms of anxiety. Further review showed no documentation about the side effects of the medication given to Resident 3 to treat their anxiety.

Review of Resident 3's service plan, dated 05/15/2023, showed Resident 3 received "cognitive/behavioral support/mental health" assistance as needed. The plan showed Resident 3 experienced episodes of agitation or anxiety triggered by fears of imaged (sic) medical issues. The plan documented that staff were to listen and reassure Resident 3 they were safe. Staff were to observe and report all changes in cognition, activities, appetite, Activities of Daily Living (ADL)'s, sleep patterns, mood behavior to the Licensed Nurse (LN). The LN reported to the Medical Doctor (MD). The nurses provided nursing oversight and communicated with the Primary Care Physician (PCP) and other outside agencies. Further review of the service plan showed no guidance for the care staff about any specific behaviors exhibited by Resident 3 for anxiety. The service plan showed no instructions for staff about what actions were needed to engage and redirect Resident 3 when anxious.

Review of Resident 3's undated "Progress Notes" showed that from 05/19/2023 through 07/06/2023, Resident 3 demonstrated several behaviors related to their anxiety. The notes documented that in May 2023, Resident 3 verbalized concerns about not having enough clothes; was observed pacing in dining room and left without eating meal; unable to keep still; required redirection to their room; observed in their room playing with toilet water and playing with stool; looked at meal tray and licked fingers; wandered around building; asked repetitive questions and searched for something. In June 2023, Resident 3 ate meals in their apartment frequently; intake of food and liquids decreased/refused; refused medications; remained in bed frequently; observable 'shakiness'; 'jitters'; found standing in hallway, remained standing in hallway for 6 hours, refused to go to dining room or return to apartment; went outside of facility unaccompanied at 8:10 PM and required redirection from staff to return to building. For July 2023, Resident 3 showed signs of increased anxiety; remained in their room; remained in bed; refused medications; observed poor

intake of meals and fluids".

Observation on 07/26/2023 at 11:00 AM, showed Resident 3 in their apartment. Resident 3 was in bed, with bed linens pulled up and tucked under their chin. Resident 3 faced the wall with the room lights turned off and the window blinds pulled closed. Observation showed a covered breakfast tray and two covered juice glasses sat on the bedside tray table located near the window. The table was located away from Resident 3's bedside, out of Resident 3's reach. The meal was uneaten.

During an interview on 07/27/2023 at 11:00 AM, Resident 3 spoke in a whispery voice with halting speech (slow and hesitant speech). During the interview, observation showed Resident 3 rocked their body forward and back while rubbing their hands and picking at the threads of the blanket. Resident 3's eyes remained closed during the interview. Resident 3 stated that they did not have clothes on. Resident 3 stated, "she came to help me, but she left…I don't have pants on…I don't have enough clothes". When asked if they felt safe in the facility, Resident 3 stated "no…they give me too many pills…I'm thirsty but they told me not to drink water…".

During an interview on 07/27/2023 at 12:05 PM, Staff G, Licensed Practical Nurse, Wellness Director, stated that Resident 3 "wasn't always like that…". Staff G stated that a lot of times, (Resident 3) ate in the dining room and visited with family and other residents. Staff G stated that after getting dressed, sometimes Resident 3 took their clothes off. Staff G stated that Resident 3's behaviors, such as pacing, wringing their hands, repetitive questions and confusion, made other residents uncomfortable. Staff G stated that at those times, other residents did not want to share their dining table with Resident 3. Staff G stated that Resident 3 does not ask for their anxiety medication, staff just give it to Resident 3 when staff noticed Resident 3 was anxious. Staff G confirmed that Resident's 3's service plan did not document any individualized 'cognitive/behavioral support/mental health' plan which provided caregivers with guidance and interventions for Resident 3's behaviors related to anxiety.

RESIDENT 4
Review of Residents 4's Service Plan, dated 02/13/2023, showed Resident 4 received "cognitive/behavioral support/mental health" assistance as needed. The service plan showed no documentation about when and how Resident 4 was allowed to leave the facility. There was no documentation that provided staff with guidance about the behaviors Resident 4 exhibited related to possible elopement (when a resident leaves the facility without permission or supervision). There were no instructions for staff about what actions to take when Resident 4 presented with exit seeking behaviors. The plan provided no information on what actions staff were to take if Resident 4 successfully eloped.

Review of Resident's 4 undated "Progress Notes" showed that Resident 4 attempted to leave the community on 06/07/2023. The notes documented that staff suggested resident move to memory care because of their exit seeking behaviors. The notes documented that the facility asked the family to consider options. The facility continued to follow the service plan, with follow up with the family as needed. Further review of Resident 4's service plan showed that the plan was not updated to show Resident 4 was an exit seeker (a person

who attempts to escape a home or facility) and at risk for elopement.

During an interview on 07/27/2023 at 11:02 AM, Collateral Contact 1 (CC1), Resident Representative, stated that about a year ago, when Resident 4 was found wandering in the stairwell and unaware of their location, Resident 4 moved from the second floor of the facility to the first floor in the same facility. CC1 further stated that during the year 2020, they received several calls from the facility about Resident's 4 wandering and exit seeking behaviors. CC1 stated that they did not see any documentation in Resident 4's service plan that addressed how the facility managed Resident 4's wandering and elopement attempts.

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, ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY 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.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow the Centers for Disease Control (CDC) and the Washington State Department of Health established guidelines on respiratory protection program (RPP) for 17 of 24 staff who have direct contact with residents (Staff B, Nurse; Staff C, Med Tech; Staff D, Care Associate; Staff F, Care Associate; Staff G, Wellness Director; Staff K, Care Associate; Staff N, Nurse; Staff O, Care Associate; Staff Q, Care Associate; Staff R, Care Associate; Staff S, Care Associate; Staff T, Care Associate; Staff U, Care Associate; Staff V, Med Tech; Staff Y, Care Associate; Staff AA, Care Associate; and Staff BB, Nurse) to reduce the potential spread of infectious diseases. This failure placed all residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included…

The 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 coronavirus disease 2019 (COVID-19) in healthcare settings.

Review of the CDC website, titled "Transmission-Based Precautions" (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html), showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission 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, titled "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31, 2022, showed specific guidelines for RPP that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and annual fit tests for any employee identified as potentially being exposed to respiratory hazard. The publication also stated that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

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

Review of the facility's document titled "Emergency & Disaster Manual COVID Policies & Procedures subject: RESPIRATORY PROTECTION PLAN", dated 03/21/2023, showed that the Chief Wellness Officer and the Vice President of Human Resources were responsible for the administration of the RPP and each was designated as a Respiratory Program Administrator (RPA). The document showed that the facility Executive Director and department heads were responsible for monitoring the ongoing and changing needs for respiratory protection. The document further showed that it applied to all associates who could potentially be exposed to airborne respiratory illnesses during normal work operations, and during non-routine or emergency situations.

Review of the facility's undated "Employee List" showed that the facility hired Staff B on 05/30/2023, Staff C on 03/07/2023, Staff D on 07/21/2022, Staff F on 03/23/2019, Staff G on 12/13/2021, Staff K on 02/10/2000, Staff N on 10/30/2001, Staff O on 07/29/2002, Staff Q on 07/29/2002, Staff R on 12/30/2004, Staff S on 02/13/2006, Staff T on 06/14/2006, Staff U on 01/04/2015, Staff V on 11/20/2008, Staff Y on 08/23/2019, Staff AA on 03/09/2022, and Staff BB on 11/02/2022.

Review of the facility's RPP documentation showed there was no medical evaluation

clearance records for Staff B, Staff C, Staff D, Staff F, Staff G, Staff K, Staff N, Staff R, Staff S, Staff Y, Staff AA, and Staff BB. Further review showed there was no fit test records documentation for Staff B, Staff C, Staff D, Staff F, Staff K, Staff N, Staff R, Staff S, Staff U, Staff AA, and Staff BB. Additionally, the documentation showed that Staff O, Staff Q, Staff T, and Staff V were all last fit tested on 03/24/2022. There was no documentation that showed Staff O, Staff Q, Staff T, and Staff V completed their annual fit testing in 2023. The records showed an undated respirator fit test record for Staff G.

During an interview on 07/20/2023 at 9:50 AM, Staff A, Executive Director, stated that the corporate staff were the RPA. Staff A stated that they were aware of the fit test requirements for all care staff. Staff A further stated that they were aware the facility had not completed fit testing for all staff that were required to be fit tested.

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, ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY 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-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (Resident 9) with a medical device was assessed to safely and properly use the device. The facility also failed to ensure Resident 9 or their representative were aware of the safety risks associated with the use of the lift. This failure placed Resident 9 at risk of potential injury from unsafe or inappropriate use of a medical device.

Findings included…

Review of the Department of Social and Health Services "Dear Provider" letter, dated 05/15/2013 showed that the assisted living facility would complete a resident assessment to identify the need for a medical device. The letter also stated that the facility would

document the need for a medical device. The letter also stated that the facility would document the need in the resident's negotiated service agreement and provide the resident or representative with information on the safety risk associated with the medical device.

Record review of Resident 9's facility assessment, dated 01/24/2023, showed that Resident 9 used a mechanical lift (sit to stand lift) for all transfers. There was no documentation that showed an assessment was completed to assess Resident 9's ability to safely use the lift. There was no documentation that showed the facility discussed the safety risks associated with the medical device with Resident 9 or their representative.

During an interview on 07/26/2023 at 10:54 AM, Resident 9 stated that they used the lift to get into and out of bed, as well as to their wheelchair and toilet. Resident 9 further stated that staff were required to assist Resident 9 when they used the device. Observation during the interview at this same date and time, showed a sit to stand lift in Resident 9's bathroom.

During an interview on 07/27/2023 at 4:05 PM, Staff G, Wellness Director, stated that they were aware that Resident 9 used a sit to stand lift device. Staff G stated that staff utilized the lift to transfer Resident 9. Staff G further stated that they were unaware that this type of medical device required an assessment to identify Resident 9's need for the lift. Staff G also stated that they were unaware the facility needed to provide safety information to Resident 9 or their representative for use of the lift.

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, ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY 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-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 9 of 47 residents (Resident 4, Resident 6, Resident 9, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, and Resident 16) with cognitive deficits, did not have access to hazardous cleaning supplies. This failure placed the residents at risk of harm and injury had they accessed and ingested the hazardous chemicals.

Findings included…

Observation during the environmental tour on 07/19/2023 at 1:08 PM showed an unlocked housekeeping cart in the second-floor hallway, in front of apartment 203. Observation showed there was no staff member present in the hall. Observation of the cart showed it contained cleaning chemicals which included: a one quart (qt) bottle of Foamy Q&A, an acid disinfectant cleaner, and a one qt bottle of Airlift, a deodorant concentrate. The Foamy Q&A warning label stated, "Corrosive. Causes irreversible eye damage or skin burns. May be fatal if swallowed". The Airlift warning label stated, "May cause mild eye and skin irritation. May be harmful if swallowed. Inhalation of product mist may cause respiratory irritation".

Observation on 07/27/2023 at 10:37 AM showed an unlocked housekeeping cart in the first-floor hallway, in front of apartment 102. Observation showed the cart contained the same chemicals previously observed on 07/19/2023 on the second floor of the facility. This cart also contained a 121-ounce (oz) bottle labeled disinfecting bleach.

During an interview on 07/19/2023 at 1:08 PM, Staff H, Plant Operations Manager, and an unidentified housekeeper both stated that there was no key available to lock the housekeeping carts. Staff H further stated that they instructed the staff to keep the housekeeping carts locked.

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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide 47 of 47 residents with clean living environment in the common areas of the facility. This failure placed all 47 residents at risk for diminished quality of life and potential of contracting an infectious illness from unclean living conditions.

Findings included…

During the environmental tour on 07/19/2023 at 12:30 PM, observations throughout the facility showed the common area hallways were carpeted. Observations showed the carpets were significantly stained with multiple dark brown and black stains that varied in size.

During an interview on 07/20/2023 at 12:15 PM, Anonymous Resident 17 stated that they had lived at the facility for 2.5 years. Anonymous Resident 17 stated that the facility did not have the carpet professionally cleaned in all these years. Anonymous Resident 17 stated that the scent of the dirty carpet continued to worsen every day. Anonymous Resident 17 stated that the housekeeping staff used strong scented sprays to cover the worsening smell of the dirty carpet. Anonymous Resident 17 stated that the scented sprays caused nasal irritation. Anonymous Resident 17 further stated that they constantly wore a mask due to the irritation. Observation during this interview showed resident wore a mask.

During an interview on 07/21/2023 at 1:12 PM, Resident 10 stated that the carpets in the hall leading to their apartment were constantly dirty. Resident 10 stated that they were embarrassed by the stained carpet.

During an interview on 07/26/2023 at 10:31 AM, Staff I, Housekeeper, stated that the facility did not clean the carpets consistently. Staff I stated that when carpets were cleaned, the residents quickly made them dirty again.

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

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

08/25/2023

CASCADE LIVING GROUP - KENT LLC
ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY
24121 116TH AVE SE
KENT, WA 98030

RE: ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY # 1993

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 08/11/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

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

Kent, WA 98032

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

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

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

(1) The assisted living facility must:

(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:

The facility's Emergency & Disaster Manual showed that the community was equipped with an emergency back-up generator that powered the common area heating, lighting and any (orange) electrical outlets in the event of a power outage. The facility Executive Director and Maintenance Director both stated that at this time, the facility did not have a back-up generator. The Executive Director stated that plans were already in place to install a back-up generator.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

Three facility staff (two housekeepers and one care associate) were unable to explain the facility's mandated reporter policy for incidents when resident abuse or neglect was suspected. The Executive Director (ED) stated that when new staff were hired, the facility provided staff education on the mandated reporting requirements. The facility's policy explained the staff requirements for any witnessed abuse or neglect, or if there was reasonable cause to suspect abuse or neglect. The ED stated the facility would schedule an immediate in-service training for all staff on the facility's mandated reporting policy.

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

Licensors found several resident records were filed together with other resident charts and documents. Licensors informed facility Executive Director and Wellness Director of misplaced resident records. Facility staff returned resident records to their appropriate files and charts.

WAC 388-78A-2600 Policies and procedures.

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

(r) When receiving and responding to resident grievances consistent with RCW 70.129.060 ; and

The facility did not implement their grievance policy to acknowledge or respond promptly to resident and resident representative concerns. The facility received multiple resident and representative grievances about dirty mop heads washed in residential laundry machines and worn out, dirty carpet conditions throughout the building. During the time of the inspection the Administrator and Wellness Director initiated a plan to respond to resident and resident representative grievances.

WAC 388-78A-2370 Dementia care.

(1) The assisted living facility must, to the fullest extent reasonably possible, obtain for each resident who has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7):

(a) Information regarding the resident's significant life experiences, including:

(i) Family members or other significant relationships;

(ii) Education and training;

(iii) Employment and career experiences;

(iv) Religious or spiritual preferences;

(v) Familiar roles or sources of pride and pleasure.

(b) Information regarding the resident's ability or inability to:

(i) Articulate his or her personal needs; and

(ii) Initiate activity.

(c) Information regarding any patterns of resident behavior that express the resident's needs or concerns that the resident is not able to verbalize. Examples of such behaviors include, but are not limited to:

(i) Agitation;

(ii) Wandering;

(iii) Resistance to care;

(iv) Social isolation; and

(v) Aggression.

(2) The assisted living facility, in consultation with the resident's family or others familiar with the resident, must evaluate the significance and implications of the information

obtained per subsection (1) of this section and integrate appropriate aspects into an individualized negotiated service agreement for the resident.

The facility did not evaluate and obtain sufficient personal information for each residents' assessment, used to determine a base line of the resident's care needs and personal preferences. Establishment of base line provides guidelines to staff to determine when there is a change in residents' condition and cognitive functioning. Staff A, Administrator and Staff G, Heath Services Director, stated all resident assessments would be updated with the information needed to establish base line of functioning.

You Are Not:

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

You May:

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

In Addition, You May:

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

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

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

If You Have Any Questions:

• Please contact me at (253)234-6020.

Sincerely,

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

Enclosure