STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Road SE
Salem, OR 97317

RE: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY License # 1995

Dear Administrator:

This letter addresses Compliance Determination(s) 30761 (Completion Date 10/10/2023) and 27993 (Completion Date 08/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/10/2023 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-2480, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2510, WAC 388-78A-3090-1-a

The Department staff who did the on-site verification:
Faith Le, NCI
Erin Steinbrenner, Nursing Consultant Institutional

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies License #: 1995 Compliance Determination # 27993
Plan of CorrectionNORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY Completion Date
 Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING 08/17/2023

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

The department completed data collection for an unannounced on-site follow-up on 08/14/2023 and 08/14/2023 of:
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following SOD dated: 08/17/2023

The following sample was selected for review during the unannounced on-site visit: 8 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Faith Le, NCI
Erin Steinbrenner, Nursing Consultant Institutional
Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

08/29/2023
Date

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

Administrator (or Representative) 9/1/2023 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.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 13 sampled staff (Staff H) were screened for tuberculosis (TB) within three days of employment. This failure placed all 55 residents at risk of exposure to tuberculosis.

Findings included...

Review of records showed the ALF hired Staff H on 05/18/2023. Staff H's records showed no documentation of TB screening.

Interview, on 08/14/2023 at 11:40 PM, Staff C (Assistant Executive Director) stated Staff H had not been tested for TB and confirmed she continued to work as a caregiver. Staff C stated Staff H was still trying to coordinate with the Wellness Nurse to receive her TB test.

This is an uncorrected deficiency previously cited on 06/26/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 9/30/23 .

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

Administrator (or Representative) 9/1/23 Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 13 sampled staff (Staff J) had the necessary training to provide care and services to residents with dementia. This placed 31 residents with dementia living in the ALF at risk of harm and unmet care needs from untrained staff.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-112A-0400 - What is specialty training and who is required to take it? (4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (b) Dementia specialty training as described in WAC 388-112A-0440.

Review of an undated Resident Characteristics Roster (RCR), showed the ALF provided care and services to 55 residents of which 12 lived in the secured memory care and had a diagnosis of [redacted]. Review of the RCR showed an additional 19 residents with a diagnosis of [redacted] who received care and services in the unsecured section of the ALF.

Review of staff records showed the ALF hired Staff J (Caregiver) on 06/12/2019. Record review showed Staff J did not have the required Dementia Specialty Training.

Interview, on 08/14/2023 at 10:58 AM, Staff C (Assistant Executive Director) stated Staff J was unable to attend the recent class and would take the next scheduled dementia training.

This is an uncorrected deficiency previously cited on 06/26/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 9/30/23 .

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

Administrator (or Representative) 9/1/23 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 Assisted Living Facility (ALF) failed to ensure the environment was well-maintained, safe, and sanitary. This failure placed 55 of 55 residents at risk for injury, infection and a decreased quality of life.

Findings included...

Observations on 08/14/2023 at 11AM showed the following:

- There were white bleach stains on the carpet in front of the central elevator.
- The south common laundry room on the 4th floor had no paper towels available in the dispenser.
- The south common laundry room on the 3rd floor had no soap available in the dispenser.
- The south common laundry room on the 3rd floor had no handle on the dryer.
- Outside of room 102 in the Memory Care Unit was a waist high faceplate with a hole in it.

In an interview, on 08/14/2023 at 11:50 AM, Staff C (Assistant Executive Director) stated that the ALF recently hired a Maintenance Director to try to get all the environmental issues resolved.

This is an uncorrected citation previously cited on 06/26/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 9/30/23 .

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

Administrator (or Representative) Date 9/1/2023

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

07/03/2023

Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Road SE
Salem, OR 97317

RE: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY License # 1995

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 06/26/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• 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.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

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 (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 and complaint investigation on 06/06/2023 and 06/09/2023 of:
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following complaint numbers: 83760.

The following sample was selected for review during the unannounced on-site visit: 11 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Erin Steinbrenner, Nursing Consultant Institutional
Scottie Sindora, ALF Licensor
Faith Le, NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer 7/3/2023
Residential Care Services Date

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

Administrator (or Representative)

July 8, 2023
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.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 8 of 13 sampled staff (Staff C, D, E, F, G, H, I and M) were screened for tuberculosis (TB) within three days of employment. This failure placed all 55 residents living in the ALF at risk of exposure to tuberculosis.

Findings included...

Review of records showed the ALF hired Staff C on 04/17/2023. Staff C's records showed no documentation of TB screening.

Review of records showed the ALF hired Staff D on 05/26/2023. Staff D's records showed no documentation of TB screening.

Review of records showed the ALF hired Staff E on 05/07/2019. Staff E's records showed no documentation of TB screening.

Review of records showed the ALF hired Staff F on 04/30/2019. Staff F's records showed no documentation of TB screening.

Review of records showed the ALF hired Staff G on 05/20/2023. Staff G's records showed no documentation of TB screening.

Review of records showed the ALF hired Staff H on 05/18/2023. Staff H's records showed no documentation of TB screening.

Review of records showed the ALF hired Staff I on 05/17/2023 Staff I's records showed no

documentation of TB screening.

Review of records showed the ALF hired Staff M on 04/14/2023. Staff M's records showed no documentation of TB screening.

Interview, on 06/07/2023 at 12:40 PM, Staff A (Executive Director) stated TB testing is managed by the wellness nurse and the ALF had recently run out of supplies. Staff A stated there was not a backup plan to test new hires at an alternative testing location.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) July 31, 2023.

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

Administrator (or Representative) July 8, 2023 Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 2 of 13 sampled staff (Staff F and J) had the necessary training to provide care and services to residents with dementia. This placed 37 residents with dementia living in the ALF at risk of harm and unmet care needs from untrained staff.

Findings included...

Review of an undated Resident Characteristics Roster (RCR), showed the ALF provided care and services to 55 residents of which 13 lived in the secured memory care and had a diagnosis of [redacted] Review of the RCR showed an additional 19 residents with a diagnosis of [redacted] who received care and services in the unsecured section of the ALF.

Review of staff records showed the ALF hired Staff F (Memory Care Medication Aide) on 04/30/2019. Record review showed Staff F did not have the required Dementia Specialty Training.

Review of staff records showed the ALF hired Staff J (Caregiver) on 06/12/2019. Record review showed Staff J did not have the required Dementia Specialty Training.

In a joint interview, on 06/07/2023 at 12:40 PM, with Staff A (Executive Director), Staff C (Assistant Executive Director and Staff O (Regional Director of Operations), Staff A confirmed the ALF did not have these documents in the staff records. Staff O stated they had found a new qualified trainer and would schedule the required specialized dementia training for staff.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date): July 31, 2023 .

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

Administrator (or Representative) July 8, 2023 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 Assisted Living Facility (ALF) failed to ensure a system was in place to keep a well-maintained, safe, and sanitary environment. This failure placed 55 of 55 residents at risk for injury, infection and a decreased quality of life.

Findings included...

Observations during the environmental tour, on 06/06/2023 at 10:30 AM, with Staff A (Executive Director) and Staff C (Assistant Executive Director) showed the following:

The north common laundry room on the 4th floor had no paper towels or soap available in the dispensers. There were white bleach stains on the carpet in front of the central elevator. The south common laundry room on the 4th floor had no paper towels available in the dispenser. The south common laundry room on the 3rd floor had no soap available in the dispenser. The south common laundry room on the 3rd floor had no handle on the dryer. The deck outside of the Hospitality Room on the 3rd floor had cobwebs, pollen, leaves, and dirt covering the floor. The top caulking on the large vent outside room 335 was mostly peeled off with spots of black on it. The Therapy Room door showed a cut hole in it with no doorknob in place. The north common laundry room on the 3rd floor had no paper towels or soap available in the dispensers. The north common laundry room on the 2nd floor had no paper towels or soap available in the dispensers. The south common laundry room on the 2nd floor had no paper towels or soap available in the dispensers. In the Memory Care Unit (MCU) there was a cracked outlet faceplate in the dining room, another cracked outlet faceplate by room 110, and a missing outlet faceplate by room 114. Outside of room 102 was a waist high faceplate with a hole in it. The exterior of the ALF, behind the kitchen, showed the dumpster was propped open with a stick.

In an interview, on 06/06/2023 at 10:43 AM, Staff A stated that the ALF currently had no Maintenance Director and utilized the Corporate Maintenance Director (MCD). Staff A stated that the MCD oversaw several buildings and would come to the ALF as needed.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) JULY 31, 2023 .

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

Maire L. Blaine — Administrator (or Representative)

JULY 8, 2023 — Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living

facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record reviews, the Assisted Living Facility (ALF) failed to ensure the residents, or their representatives signed the Negotiated Service Agreement (NSA) at least annually for 5 of 12 sampled residents (Residents 1, 3, 8, 10 and 12). This placed Residents 1, 3, 8, 10 and 12 at risk for receiving care, or not receiving care and services that had been agreed upon.

Findings included...

Review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2017 with multiple diagnoses. Review of Resident 1's Resident Service Plan (RSP-- equivalent to a Negotiated Service Agreement), dated 02/23/2023, showed no signature from the resident or the resident representative.

Review of a Face Sheet showed the ALF admitted Resident 3 on [redacted]/2020 with multiple diagnoses. Review of Resident 3's RSP, dated 03/28/2023, showed no signature from the resident or the resident representative.

Review of a Face Sheet showed the ALF admitted Resident 8 on [redacted]/2023 with multiple diagnoses. Review of Resident 8's RSP, dated 04/19/2023, prior to Resident 8's move-in date, showed no signature from the resident or resident representative.

Review of an undated Resident Characteristic Roster showed an admission date for Resident 10 of [redacted]/2022. Review of Resident 10's RSP, dated 11/04/2022, showed no signature from the resident or the resident representative.

Review of a Face Sheet showed the ALF admitted Resident 12 on [redacted]/2020 with multiple diagnoses. Review of Resident 12's RSP, dated 12/01/2022, showed no signature from the resident or the resident representative.

In an interview, on 06/08/2023 at 10:55 AM, Staff P (Registered Nurse) stated the RSP's are completed by the Assisted Living (AL) or Memory Care (MC) directors, who set up meetings with the families to obtain signatures. Staff P was unaware of the location of the signed RSPs and stated they were likely stored in the Executive Director's office.

In a joint interview, on 06/09/2023 at 11:43 AM, Staff A, Executive Director, stated she had provided all requested signed service plans that had resident or resident representative signatures and confirmed she did not have signed RSP's for Residents 1, 3, 8, 10 and 12. Staff O (Regional Director of Operations) agreed the service plan should be reviewed and signed by the resident or the resident representative, regardless if a resident

is on waived services or not.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) JULY 31, 2023.

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

Administrator (or Representative) — Date: July 8, 2023

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:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(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.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete an Assessment for 3 of 12 sampled residents (Residents 4, 8 and 9) within 14 days of Resident 4, 8 and 9's move-in date and failed to complete an assessment related to care and safety needs with the placement of a bed side rail for 2 of 12 sampled residents (Residents 9 and 10). This placed Residents 4, 8, and 9, at risk of harm by care staff unfamiliar with unassessed care needs and Residents 9 and 10 at risk for improper use of equipment, injury and entrapment.

Findings included...

Resident 4

Record review of a Face Sheet, undated, showed the ALF admitted Resident 4 on [redacted]/2023 with multiple medical conditions to include dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Record review of the Resident Characteristic Roster, dated 06/06/2023, showed Resident 4 lived in the secured Memory Care Unit (MCU).

In an interview, on 06/07/2023 at 11:15 AM, Staff K (Medication Aide) stated that Resident 4 was admitted to the assisted living portion of the ALF but was not there long and moved to the MCU "about a month ago." Staff K stated that Resident 4 moved to the MCU because of increasing behaviors.

Record review showed Resident 4 had a Pre-Admission Assessment dated 04/27/2023. Review of Resident 4's records showed no evidence of a 14-Day Assessment completed after move-in.

Request was made to Staff Q (Assisted Living Director), on 06/07/2023 at 3:00 PM and 06/08/2023 at 9:15 AM, for a copy of Resident 4's 14-Day Assessment. No documents were received.

Resident 8

Review of a Face Sheet, undated, showed the ALF admitted Resident 8 on [redacted]/2023. Review of a Service Plan, dated 04/19/2023, showed Resident 8 to have a primary medical condition of diabetes (a disorder in which the body has high sugar levels for prolonged periods of time).

Review of an Assessment, dated [redacted]2023, indicated this was the "initial assessment" under the category of assessment type. This initial Assessment was dated 42 days after Resident 8's move-in date.

In an interview, on 06/08/2023 at 11:00 AM, Staff P (Registered Nurse) confirmed she did not have an initial Assessment for Resident 8 completed within 14 days of admission. Staff P acknowledged the Assessment, dated [redacted]/2023, was completed the same day as requested by the Department Representative.

Resident 9

Review of a Face Sheet showed the ALF admitted Resident 9 on [redacted]/2022 with multiple diagnoses to include [redacted] and [redacted]

Review of an Assessment, dated [redacted]/2023, indicated this was the "initial assessment" under the category of assessment type. This initial Assessment was completed more than seven months after Resident 9's move-in date.

In an interview, on 06/08/2023 at 10:55 AM, Staff P confirmed she did not have an initial Assessment for Resident 9 completed within 14 days of admission. Staff P acknowledged the assessment, dated [redacted]/2023, was completed the same day as requested by the Department Representative.

Observation, on 06/09/2023 at 10:20 AM, showed a quarter length bed rail was installed on the left side of Resident 9's bed.

During an interview, on 06/08/2023 at 11:10 AM, Resident 9 confirmed the bed rail was installed when he moved in the ALF.

Record review of an assessment, dated [redacted]/2023, showed "No" had been selected for Support/Restraint assessments. Resident 9 had not been assessed of their ability to safely use side rails. There was no documentation to show Resident 9 was aware of the risks and benefits of side rail use.

During an interview, on 06/09/2023 at 9:50 AM, with Staff P stated she was unaware Resident 9 had a side rail installed on his bed and would follow up.

Resident 10

Review of a Resident Characteristic Roster (undated) showed the ALF admitted Resident 10 on [redacted]/2022.

Observation, on 06/08/2023 at 11:50 AM, showed two mobility bed rails attached to the right and left sides of Resident 10's bed, measured to be approximately 32 inches from the top of the rail to the mattress and approximately 14 inches in width.

During an interview, on 06/08/2023 at 11:55 AM, Resident 10 stated the bed rails had been in place since she moved into the apartment.

Record review of an Assessment, dated 02/03/2023, showed "No" was selected for any support or restraints used by Resident 10. Resident 10 had not been assessed of their ability to safely use side rails. There was no documentation to show Resident 10 was aware of the risks and benefits of side rail use.

During an interview, on 06/09/2023 at 9:50 AM, with Staff P stated she was unaware Resident 10 had a side rail installed on his bed and would follow up.

This is a repeat citation previously cited on 05/11/2021.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) July 31, 2023.

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

Administrator (or Representative) July 8, 2023 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 observation, and interview, that Assisted Living Facility (ALF) failed to ensure 1 of 2 Medication Technicians (Staff R) in the Memory Care Unit (MCU) practiced infection control while passing medications. This failure placed 14 of 14 residents in the MCU at risk for illness.

Findings included...

An observation, on 06/07/2023 at 07:55 AM, showed Staff R in the MCU passing medications to residents. Staff R signed off the medications using the computer then took the medication cup to the Activity Room and assisted a non-sampled resident to take their medications. Staff R returned to the medication cart, discarded the empty medication cup in the trash, unlocked the medication cart, and removed a set of bingo-packed medications. Staff R pulled medications for another resident, including crushing the medications and adding a spoonful of apple sauce. Staff R took the medication cup to a non-sampled resident in the Dining Room and assisted the resident. Staff R returned to the medication cart, signed off the given meds on the computer, and filled another medication cup for a third resident. At one point a small pink pill dropped onto the medication cart. With a bare hand Staff R picked the pill up and dropped into the medication cart. Staff R took this medication cup to a non-sampled resident's room where the resident asked for assistance with toileting. Staff R set the medication cup on a nightstand and assisted the resident to the bathroom. At no time during the passing of medications, or before assisting the resident with toileting, did Staff R wash her hands or use sanitizer.

In an interview, on 06/07/2023 at 3:30 PM, Staff A (Executive Director) stated that all staff should be washing, or sanitizing, their hands before giving any care or passing medications.

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Administrator (or Representative) July 8, 2023 Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

(b) Together for each resident and physically separated from other residents' medications;

(c) Separate from food or toxic chemicals;

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

(e) In environments recommended on the medication label.

This requirement was not met as evidenced by:

Based on observation, and interview, the Assisted Living Facility (ALF) failed to ensure 1 of 1 medication carts in the Memory Care Unit (MCU) was locked and medications were stored securely. This failure placed 14 of 14 residents with dementia (a group of symptoms that affects memory, thinking and interferes with daily life) at risk for ingesting unprescribed medications and increased health issues.

Findings included...

An observation, on 06/06/2023 at 11:34 AM, with Staff A (Executive Director) and Staff C (Assistant Executive Director) showed an unattended medication cart parked in the MCU common hallway by the dining room. The lock to the medication cart was open and the drawers were able to be pulled open. Staff R (Medication Technician) was observed in the dining room, assisting a resident with medications. The medication cart remained unlocked

until 11:39 AM which, during the time the cart was unlocked, four residents walked past the unlocked medication cart. Observation at 11:39 AM showed Staff R had moved to the kitchenette, next to the dining room, when Staff C approached and reminded Staff R that the medication cart was unlocked.

An observation, on 06/07/2023 at 7:55 AM, showed Staff R at the medication cart in MCU. Staff R finished pouring medications into a medication cup, returned the medication cards to the drawer of the cart, then took the medication cup into the dining room where she assisted a resident with medications. Staff R did not lock the medication cart when she left and returned to the cart at 7:59 AM. During that time, three residents walked by, or gathered near the unlocked medication cart.

In an interview, on 06/06/2023 at 11:34 AM, Staff A stated that the medication cart should always be locked.

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Administrator (or Representative) 7/8/2023 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, interview, and record review, the Assisted Living Facility (ALF) failed to ensure a system was in place to secure hazardous chemicals for 1 of 3 housekeeping carts, 2 of 6 common laundry rooms in Assisted Living (AL), and 1 of 1 common bathrooms in the Memory Care Unit (MCU). This failure placed 55 of 55 residents at risk for illness and

increased health issues.

Findings included...

Record review of the Resident Characteristic Roster (RCR), updated on 06/06/2023, showed the ALF had 41 residents living in the AL portion of the ALF with 19 residents identified with a diagnosis of [redacted] and one resident identified with behaviors. The RCR showed that of the 14 residents living in the MCU, all 14 had a diagnosis of [redacted] and 10 residents were identified as having behaviors.

An observation and interview, on 06/06/2023 at 10:30 AM, showed the north common laundry room on the 4th floor. In an unlocked cabinet was a bottle of dishwashing detergent. The label on the bottle stated, "do not ingest" and "keep out of reach of children." Staff A (executive Director) stated that the laundry detergent should not be there.

An observation and interview, on 06/06/2023 at 10:35 AM, showed the south common laundry room on the 4th floor. Sitting on top of the sink counter was a 28-ounce (oz) bottle of rust remover. The label on the bottle stated, "Harmful is swallowed, eye irritant, vapor may be harmful, do not mix with other household cleaners or chemicals including bleach, as toxic fumes may result. Keep out of reach of children." Staff A stated that the bottle should be locked up.

An observation and interview, on 06/06/2023 at 11:10 AM, showed an unattended housekeeping cart in the hallway of the north 2nd floor hallway. Sitting on top of the cart was a spray bottle of blue liquid with a hand-written label that stated "multi-surface cleaner." The door to the cart was unlocked, half open, and contained a bottle of bleach and a bottle of disinfectant deodorant. The lower shelf of the housekeeping cart was not contained and had a spray can of stainless-steel cleaner, a box containing chemical-coated steel wool pads, rug shampoo, and container of scrubbing bleach powder. Staff A stated that all housekeeping carts should be locked at all times.

An observation and interview, on 06/06/2023 at 11:25 AM, showed the common bathroom in the MCU. In an unlocked cabinet next to the toilet was a bottle of hair cleanser and two bottles of "Peri-Fresh." All bottles stated to "keep out of reach of children." Staff A stated that this was the main common bathroom used by residents in the MCU and these items should be locked.

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Administrator (or Representative) July 8, 2023 Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(1) Resident identifying information, including resident's:

(a) Name;

(b) Birth date;

(c) Move-in date; and

(d) Sleeping room identification.

(2) Current name, address, and telephone number of:

(a) Resident's primary health care provider;

(b) Resident's representative, if the resident has one;

(c) Individual(s) to contact in case of emergency, illness or death; and

(d) Family members or others, if any, the resident requests to be involved in the development or delivery of services for the resident.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure a system was in place for 4 of 12 sampled residents (Residents 2, 8, 10, and 11) to have completed informational Face Sheets placed in their medical records. This failure placed Residents 2, 8, 10 and 11 at risk for delayed treatment in an emergency.

Findings included...

Record review of Resident 2's Medical Record showed no evidence of any page containing the resident's vital statistics (date of birth, medical conditions), name of emergency contact, or name of the resident's Primary Care Physician.

Record review of Resident 8's Medical Record showed a Face Sheet to contain minimal information. Review of a Face Sheet showed Resident 8's name, room number, move-in date and phone number. Further review showed no evidence of any page to contain Resident 8's vital statistics, name of emergency contact, or name of the resident's Primary Care Physician.

Record review of Resident 10's Medical Record showed a Face Sheet to contain the resident's name and date of birth and no information containing the resident's vital statistics, name of emergency contact, or name of the resident's Primary Care Physician.

Record review of Resident 11's Medical Record showed no evidence of any page containing the resident's vital statistics, name of emergency contact, or name of the resident's Primary Care Physician.

In an interview, on 06/08/2023 at 10:52 AM, Staff P (Registered Nurse) stated the Face Sheet was entered electronically by the receptionist at the time of a resident's admission and the neighborhood director added the face sheet to the resident's chart. Staff P did not know why there was not a face sheet or completed face sheet for Resident's 2, 8, 10 or 11 and agreed it should be available for reference in the event of an emergency.

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Administrator (or Representative) July 8, 2023 Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service

agreement; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to coordinate care and services with the home health provider for 1 of 1 sampled resident (Resident 2) on physical therapy services, and with the physician for 1 of 1 sampled resident (Resident 3) when she refused to have her weight monitored as ordered. This placed Resident 2 and Resident 3 at risk for compromised safety and health complications.

Findings included...

Resident 2

Review of an undated Resident Data Sheet and Resident Service Plan (RSP equivalent to a Negotiated Service Agreement), dated 02/17/2023, showed the ALF admitted Resident 2 on [redacted]/2023 with multiple medical conditions to include Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning).

Review of a home health provider's Therapy Note Report, dated 06/01/2023, showed Resident 2 was receiving physical therapy services.

Resident 2's RSP showed no information and did not identify Resident 2 was receiving physical therapy.

In an interview, on 06/09/2023 at 11:45 AM, Staff P (Registered Nurse) acknowledged Resident 2 had was receiving physical therapy and confirmed it was not documented in the RSP.

Resident 3

Review of a RSP, dated 06/06/2023, showed the ALF admitted Resident 3 on [redacted]/2020 with multiple medical conditions.

Review of the electronic Medication Administration Record (eMAR), for April, May, and June of 2023, showed a physician's order for weekly weight checks with instructions to notify the physician with changes. The eMARs showed Resident 3 had been refusing weekly weight checks through April, May and June of 2023.

Review of Resident 3's records showed no documentation to show the ALF had notified

Resident 3's physician of her refusing weekly weight checks.

In an interview, on 06/09/2023 at 11:40 AM, Staff P acknowledged Resident 3 had refused weight checks, and she confirmed the facility had not followed up with Resident 3's physician of the refusals.

This is a repeat citation previously cited on 05/11/2021.

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Administrator (or Representative) July 8, 2023 Date

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

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(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.

(9) For the purpose of consenting to video electronic monitoring without an audio component, the term "resident" includes the resident's representative.

This requirement was not met as evidenced by:

Based on observation, record review and interview, the Assisted Living Facility (ALF) failed to ensure 1 of 1 resident (Resident 1) who had a video camera in her apartment completed an evaluation and signed consent for the monitoring equipment. This placed Resident 1 at risk of violation of privacy.

Findings included...

Review of a Resident Service Plan (RSP equivalent to a Negotiated Service Agreement), dated 02/23/2023, showed the ALF admitted Resident 1 on [redacted]/2020 with multiple medical conditions. The RSP showed Resident 1's family had installed a camera in her apartment.

Observation and interview, on 06/07/2023 at 1:40 PM, showed an electronic video camera mounted to Resident 1's windowsill, pointing towards the front door of her apartment. Resident 1 reported her family installed the video camera.

A review Resident 1's records did not include documentation evaluating the need for, the duration of or consent of electronic monitoring.

In a joint interview, on 06/06/2023 at 10:45 AM, Staff A (Executive Director) and Staff C (Assistant Executive Director) reported Resident 1 had a video camera inside her apartment. An evaluation and signed consent for the use of electronic monitoring equipment for Resident 1 was requested.

Staff A stated in a follow up interview, on 06/09/2023 at 12:20 PM, the ALF had been unable to provide an evaluation and signed consent for electronic monitoring.

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Administrator (or Representative) — Date: JULY 8, 2023

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;

This requirement was not met as evidenced by:

Based on observation and interview the Assisted Living Facility (ALF) failed to ensure 1 of 1 observed dishwashing staff (Staff T) followed handwashing protocol, a system was in place for the kitchen to have a designated food preparation sink, and a sanitizing procedure for manual washing equipment. This failure placed 55 of 55 residents at risk for illness and increased health issues.

Findings included...

NOTE: Washington Administrative Code (WAC) 246-215-02310 Hands and arms-When to wash (FDA Food Code 2-301.14).
Food employees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:
(5) After handling soiled equipment or utensils.

WAC 246-215-04325 Equipment—Designated food preparation sinks.
Food establishments must have designated food preparation sinks that are:
(3) Not used for handwashing, utensil washing, or other activities that could contaminate food.

WAC 246-215-04565 Equipment—Manual and mechanical ware washing equipment, chemical sanitization—Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114).
A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under WAC 246-215-04710(3) must meet the requirements specified under WAC 246-215-07220, must be used in accordance with the EPA-registered label use instructions, and must be used as follows:
(6) If a chemical sanitizer is generated by a device located on-site at the food establishment, it must be used as specified in subsections (1) through (4) of this section and must be produced by a device that: (b) Complies with 40 C.F.R. 152.500 Requirement for Devices and 40 C.F.R. 156.10 Labeling Requirements.

Observation during the food service and kitchen tour, on 06/08/2023 at 11:25 AM showed Staff T (Dishwasher) using a three-compartment sink to clean multiple loads of dirty dishes/pots and pans. Staff T was observed not wearing gloves. Staff T continually went back and forth from handling dirty dishes and clean dishes without washing his hands or putting on gloves during throughout the observation. A sink at the back of the kitchen had dishes and utensils with food particles inside and around the sink.

Further observation showed the three-compartment sink consisted of three separate basins, each basin was labeled "Wash", "Rinse" or "Sanitize", and served a specific purpose according to that label. A dispenser was set up to dilute and distribute concentrated detergent into the wash basin and sanitizer cleaning products into the sanitizing basin. Regular testing is required for the sanitizing basin to ensure the correct solution was created.

In a joint interview, on 06/08/2023 at 11:40 AM, when asked for the sanitizing solution to be tested, Staff T says he didn't know how. Staff U (Server) performed the test with the test strip that showed the concentration level was below 200 PPM (parts per million). Staff U was unsure if the concentration level was correct and says the concentration level may need to be around 300-400 PPM, but couldn't confirm her conclusions. Staff U could not find the facility or manufacturer's instructions to verify the test results. Staff T and Staff U did not know if the facility had records of sanitizing procedures.

In a follow-up interview, on 06/08/2023 at 1:10 PM, Staff S (Dining Services Manager) confirmed that Staff T was not following proper sanitary procedures when washing dishes and stated he needed to buy dishwashing gloves. Staff S stated the commercial dishwasher had been broken and confirmed there were no records showing the facility has a sanitizing procedure for the 3-compartment sink method system. With the commercial dishwashing machine being broken, and the 3-compartment sink is being utilized for cleaning all dishes, Staff S stated the facility did not have a system to ensure the kitchen had a designated food preparation sink.

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