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

CHINA CREEK VI LLC
REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

RE: REGENCY NEWCASTLE License # 2018

Dear Administrator:

This letter addresses Compliance Determination(s) 44683 (Completion Date 07/25/2024) and 42934 (Completion Date 06/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/25/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii

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

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

Sincerely,

Laurie Anderson

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

This document was prepared by Residential Care Services for the Locator website.

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

Statement of Deficiencies	License #: 2018	Compliance Determination # 42934
Plan of Correction	REGENCY NEWCASTLE	Completion Date
Page 1 of 4	Licensee: CHINA CREEK VI LLC	06/20/2024

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

The department completed data collection for an unannounced on-site follow-up on 06/20/2024 and 06/20/2024 of:
REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

This document references the following SOD dated: 06/20/2024

The following sample was selected for review during the unannounced on-site visit: 20 of 69 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

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

Laurie Anderson — 06/27/2024

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.

This document was prepared by Residential Care Services for the Locator website.

07/03/2024

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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Negotiated Service Agreement (NSA) for 2 of 14 sampled residents (Resident 1 and Resident 9). This failure placed Resident 1 and Resident 9 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/10/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/25/2024.

Review of the facility document titled, "Care Evaluation and Service Plan Policy", dated December 2023, showed that the facility completed resident service plans to identify services to be provided to the resident. The policy showed the service plan would be revised when there was a change in services within seven days from identification of the need for more or lesser services. The policy showed that the nurse individualized the Service Plan items incorporated in the Care Evaluation form to clearly identify the resident's strengths and needs and define the respective roles and responsibilities of the resident and the staff.

RESIDENT 1
Review of Resident 1's face sheet showed that the facility admitted Resident 1 in [redacted] 2022 with a medical diagnosis of [redacted].

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Review of Resident 1's service plan (NSA), dated 02/15/2024, showed Resident 1 was not currently using the continuous positive airway pressure machine (C-PAP). The service plan showed that Resident 1 would have no adverse events related to not wearing the C-PAP. The service plan showed staff were instructed to notify the licensed nurse if Resident 9 had any adverse events related to sleep apnea and from not wearing the C-PAP machine. The service plan did not document what the signs and symptoms were considered adverse events.

During an interview on 06/20/2024 at 11:20 AM, Staff C, Registered Nurse, stated that the signs and symptoms for not wearing a C-PAP machine at night was sleepiness during the awake hours. Staff C stated that they were aware that Resident 1's service plan did not document what the signs and symptoms were of adverse effects since Resident 1 chose to not wear the C-PAP machine when asleep.

During an interview on 06/20/2024 at 11:26 AM, Staff D, CNA/Medication Aide, stated that they understood the C-PAP machine helped Resident 1 with oxygen flow. Staff D stated they did not fully understand the purpose of the C-PAP. Staff D stated that they did not know what the adverse effects or signs or symptoms were when Resident 1 did not wear the C-PAP while asleep. Staff D stated they were not taught anything about C-PAP machines in school.

RESIDENT 9
Review of the facility's Characteristics Roster showed that the facility admitted Resident 9 in [redacted] 2015. Resident 9 was admitted with medical diagnoses of: [redacted].

Observation in Resident 9's apartment on 06/20/2024 at 11:10 AM, showed Resident 9 laid in a hospital bed on top of an alternating pressure relieving mattress. Observation showed an air pump was fastened to the foot board of the bed. The air pump was in the on position. Observation showed a Roho cushion (pressure relieving cushion designed to prevent and heal skin breakdown) on the seat of the wheelchair.

Review of Resident 9's service plan, dated 06/04/2024, showed that Resident 9 was at risk for falls, with a history of past falls, due to heart disease, impaired mobility, and generalized weakness. The service plan showed Resident 9 primarily used a wheelchair for mobility. The service plan showed Resident 9 was at risk for bruising and bleeding and skin impairment. The service plan showed that Resident 9 preferred to be seated in a wheelchair for long periods of time and refused to get in bed and offload the pressure from their body to prevent skin breakdown. There was no documentation in the service plan that showed Resident 9 used an alternating pressure relieving mattress. There was no documentation that provided any instructions for the caregivers on the operation of the air mattress. There

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was no documentation in the service plan that showed Resident 9 used a Roho cushion. There were no instructions that showed the caregivers how to check to ensure Resident 9's Roho cushion was correctly inflated.

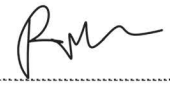
During an interview at the exit conference on 06/20/2024 at 1:04 PM, Staff B, Resident Care Coordinator, stated that they were aware the service plan did not show Resident 9 used an alternating pressure relieving air mattress and a Roho cushion.

This is an uncorrected deficiency previously cited on 04/10/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, REGENCY NEWCASTLE is or will be in compliance with this law and / or regulation on (Date) 07/15/2024 .

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



Administrator (or Representative) — Date: 07/03/2024

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: REGENCY NEWCASTLE **Provider Type:** Assisted Living Facility
License/Cert.#: 2018
Compliance Determination #: 38431 **Intake ID:** 122914
Investigator: Michelle Yip **Region/Unit #:** RCS Region 2 / Unit D
Investigation Date(s): 03/18/2024 through 04/10/2024
Complainant Contact Date(s):

Allegation(s):
Facility reported several residents and staff tested positive for COVID. Facility reports experiencing a COVID outbreak.

Investigation Methods:

Sample: Total residents: 70
Resident sample size: 9
Closed records sample size: 0

Observations: Observed facility staff practice COID isolation protocol. Observed staff donning and doffing and use of Personal Protection Equipment. Observed Alleged Victims in their apartments on isolation precautions. Observed staff to resident interactions. Observed facility's response to prevent the spread of COVID. Observed facility staff infection control practices.

Interviews: Interviews with administrative staff, Health and Wellness Director, Caregivers, Alleged Victims (Residents) and family members.

Record Reviews: Reviewed facility's Respiratory Protection Program, infection control policies and practices. 4 sampled residents records. Facility records for staff evaluated and fit tested for N95 respirator masks.

Investigation Summary:
Investigation took place during the full inspection. Facility failed to evaluate and fit test employees annually and new employees. Facility failed to educate and train staff on insolation precaution procedures and policies. Staff failed to follow infection control practice and prevent cross contamination and spread of an infectious community spread virus. Citation issued.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

This document was prepared by Residential Care Services for the Locator website.

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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

04/12/2024

Licensee: CHINA CREEK VI LLC
REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

RE: REGENCY NEWCASTLE License # 2018

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 04/10/2024 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:

This document was prepared by Residential Care Services for the Locator website.

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.

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 (253)234-6020.

Sincerely,

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

Enclosure

This document was prepared by Residential Care Services for the Locator website.

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 and complaint investigation on 03/18/2024, 03/18/2024, 03/21/2024 and 03/21/2024 of:

REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

This document references the following complaint numbers: 122914.

The following sample was selected for review during the unannounced on-site visit: 9 of 70 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

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

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.

This document was prepared by Residential Care Services for the Locator website.

Administrator (or Representative) Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to provide 9 of 9 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9) with a copy of the facility's policy on accepting Medicaid payments and keep the signed and dated Medicaid disclosure form in the residents' records. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9 at risk of being discharged and unable to reside in the facility on State [redacted] assistance.

Findings included…

Review of the facility's policy titled, "Accepting Medicaid as a Payment Source", dated July 2018, showed that the facility was required to provide each resident and their family the Medicaid eligibility information. The policy showed that the facility admitted and retained a resident if the resident completed two years of private pay and was determined to be qualified by the Department of Social and Health Service (DSHS) for Assisted Living Facility.

Review of the facility's Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 1 in [redacted] 2023, Resident 2 in [redacted] 2023, Resident 3 in [redacted] 2021, Resident 4 in [redacted] 2020, Resident 5 in [redacted] 2017, Resident 6 in [redacted] 2021, Resident 7 in [redacted] 2020, Resident 8 in [redacted] 2014, and Resident 9 in [redacted] 2018. Review of the Resident Records showed no documentation that the facility informed the

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nine residents and their families about the facility's Medicaid policy. There was no documentation that showed the facility obtained the Resident's signed and dated Medicaid notice and maintained the copy in each resident's record.

During the resident group meeting on 03/20/2024 at 3:00 PM, seven anonymous residents stated that they were unaware of the facility's policy on accepting Medicaid payments. The residents stated that they did not know the facility accepted Medicaid as a payment option.

During an interview on 03/20/2024 at 9:00 AM, Staff A, Administrator/Regional Vice President of Operations, stated that the facility had a policy of accepting Medicaid as a payment source. Staff A stated that they were responsible to inform residents about the Medicaid policy and obtain the signature on the Medicaid notice when the resident moved into the facility. Staff A stated that they had a process to inform residents of the Medicaid policy, and they did not implement it.

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, REGENCY NEWCASTLE 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-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure that 1 of 3 sampled pets (Pet 1) completed all required immunizations and 3 of 3 sampled pets (Pet 1, Pet 2, and Pet 3) were certified by a veterinarian to be free of disease transmittable to humans. These failures placed all residents at risk of contracting illnesses spread by pets.

Findings included…

This document was prepared by Residential Care Services for the Locator website.

Review of the facility's undated "Pet Policy" showed that the facility permitted pets to live on the premises. The policy showed that the facility followed the Washington Administrative Code (WAC). The policy showed that the facility required animals that lived on the facility premises received regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington State. The policy showed that the facility required the animals were certified by a veterinarian to be free of diseases transmittable to humans.

Review of the facility's pet records showed that Pet 1's rabies vaccination expired on 02/28/2024. There was no documentation that showed Pet 1's vaccination was up to date. There was no documentation that showed Pet 1, Pet 2, and Pet 3 were certified by a veterinarian to be free of infectious diseases.

Observation on 03/20/2024 at 3:57 PM showed that Pet 1 walked inside Resident 6's apartment. Observation showed there were dog dishes and dog food in the apartment. Observation showed Staff K, Medication Aide, leashed Pet 1 and walked Pet 1 out of the apartment. During an interview at this time, Resident 6 stated that they owned Pet 1 and Pet 1 moved into the facility with them. Resident 6 stated that the staff walked Pet 1 for them every day.

During an interview on 03/19/2024 at 11:00 AM, Staff L, Business Office Manager, stated that three pets (Pet 1, Pet 2, and Pet 3) resided in the facility. Staff L stated that they were aware of the WAC regulation for pets living in the assisted living facility. Staff L stated that they maintained the pet records. Staff L stated that they were unaware Pet 1's rabies vaccination was expired. Staff L stated that they were unsure if Pet 1, Pet 2, and Pet 3 were certified by a veterinarian to be free of human transmittable diseases.

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, REGENCY NEWCASTLE 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-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 document was prepared by Residential Care Services for the Locator website.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 5 of 5 sampled Staff (Staff B, Staff F, Staff J, Staff P, and Staff Q) completed the specialized training for dementia, as required. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the facility's Assisted Living Facility Resident Characteristic Roster showed 32 assisted living residents were diagnosed with [redacted].

STAFF B
Review of the facility's Employee Roster showed that the facility hired Staff B, Certified Nursing Assistant, on 11/22/2023. Review of the facility's Care Staff Schedules showed that Staff B worked in February 2024 and March 2024. Review of Staff B's employee record showed that as of 03/26/2024, 125 days after hire, there was no documentation that showed Staff B completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for dementia.

STAFF F
Review of the facility's Employee Roster showed that the facility hired Staff F, Medication Aide, on 03/03/2021. Review of the facility's Care Staff Schedules showed that Staff F worked in February 2024 and March 2024. Review of Staff F's employee record showed that as of 03/26/2024, 1119 days after hire, there was no documentation that showed Staff F completed the Washington state DSHS approved specialized training for dementia.

STAFF J
Review of the facility's Employee Roster showed that the facility hired Staff J, Certified Nursing Assistant, on 11/29/2022. Review of the facility's Care Staff Schedules showed that Staff J worked in February 2024 and March 2024. Review of Staff J's employee record showed that as of 03/26/2024, 483 days after hire, there was no documentation that showed Staff J completed the Washington state DSHS approved specialized training for dementia.

STAFF P
Review of the facility's Employee Roster showed that the facility hired Staff P, Certified Nursing Assistant, on 12/08/2022. Review of the facility's Care Staff Schedules showed that Staff P worked in February 2024 and March 2024. Review of Staff P's employee record showed that as of 03/26/2024, 474 days after hire, there was no documentation that showed Staff P completed the Washington state DSHS approved specialized training for dementia.

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STAFF Q
Review of the facility's Employee Roster showed that the facility hired Staff Q, Certified Nursing Assistant, on 12/08/2022. Review of the facility's Care Staff Schedules showed that Staff Q worked in February 2024 and March 2024. Review of Staff Q's employee record showed that as of 03/26/2024, 474 days after hire, there was no documentation that showed Staff Q completed the Washington state DSHS approved specialized training for dementia.

During an interview on 03/21/2024 at 11:00 AM, Staff L, Business Office Manager, stated that they maintained the staff credential and training documents in the employee records. Staff L stated they had a system to keep track of incomplete training and notified the corresponding supervisor. Staff L stated that they reviewed the business office computer files, and they were unable to find any records to show Staff B, Staff F, Staff J, Staff P, Staff Q, and Staff X completed the Washington state DSHS approved specialized training for dementia.

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, REGENCY NEWCASTLE 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-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

This requirement was not met as evidenced by:

This document was prepared by Residential Care Services for the Locator website.

Based on interview and record review, the Assisted Living Facility failed to ensure 5 of 5 sampled Staff (Staff B, Staff F, Staff J, Staff P, and Staff Q) completed the specialized training for mental illness, as required. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the facility's Assisted Living Facility Resident Characteristic Roster showed that the facility identified 16 residents were diagnosed with [redacted]. Review of Resident 6 and Resident 8's resident records showed a [redacted] diagnosis.

STAFF B
Review of the facility's Employee Roster showed that the facility hired Staff B, Certified Nursing Assistant, on 11/22/2023. Review of the facility's Care Staff Schedules showed that Staff B worked in February 2024 and March 2024. Review of Staff B's employee record showed that as of 03/26/2024, 125 days after hire, there was no documentation that showed Staff B completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for mental health.

STAFF F
Review of the facility's Employee Roster showed that the facility hired Staff F, Medication Aide, on 03/03/2021. Review of the facility's Care Staff Schedules showed that Staff F worked in February 2024 and March 2024. Review of Staff F's employee record showed that as of 03/26/2024, 1119 days after hire, there was no documentation that showed Staff F completed the Washington state DSHS approved specialized training for mental health.

STAFF J
Review of the facility's Employee Roster showed that the facility hired Staff J, Certified Nursing Assistant on 11/29/2022. Review of the facility's Care Staff Schedules showed that Staff J worked in February 2024 and March 2024. Review of Staff J's employee record showed that as of 03/26/2024, 483 days after hire, there was no documentation that showed Staff J completed the Washington state DSHS approved specialized training for mental health.

STAFF P
Review of the facility's Employee Roster showed that the facility hired Staff P, Certified Nursing Assistant on 12/08/2022. Review of the facility's Care Staff Schedules showed that Staff P worked in February 2024 and March 2024. Review of Staff P's employee record showed that as of 03/26/2024, 474 days after hire, there was no documentation that showed Staff P completed the Washington state DSHS approved specialized training for mental health.

STAFF Q
Review of the facility's Employee Roster showed that the facility hired Staff Q, Certified

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Nursing Assistant on 12/08/2022. Review of the facility's Care Staff Schedules showed that Staff Q worked in February 2024 and March 2024. Review of Staff Q's employee record showed as of 03/26/2024, 474 days after hire, there was no documentation that showed Staff Q completed the Washington state DSHS approved specialized training for mental health.

During an interview on 03/21/2024 at 11:00 AM, Staff L, Business Office Manager, stated that they maintained the staff credential and training documents in the employee records. Staff L stated they had a system to keep track of incomplete training and notified the corresponding supervisor. Staff L stated that they reviewed the business office computer files, and they were unable to find any records to show Staff B, Staff F, Staff J, Staff P, Staff Q, and Staff X completed the Washington state DSHS approved specialized training for mental health.

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, REGENCY NEWCASTLE 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-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to complete the required one test for tuberculosis (TB) for 2 of 2 sampled staff (Staff B and Staff H) who had a history of a negative TB test. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

STAFF B

This document was prepared by Residential Care Services for the Locator website.

Review of the facility's Employee Roster showed that the facility hired Staff B, Certified Nursing Assistant, on 11/22/2023. Review of Staff B's employee records showed that on 09/14/2023, Staff B completed an QuantiFERON-TB Gold Plus test a (blood test for TB) with negative results. There was no documentation that showed Staff B completed a one-step test for TB when they were hired.

STAFF H
Review of the facility's Employee Roster showed that the facility rehired Staff H, Dietary Manager, on 12/13/2023. Review of Staff H's employee records showed that on 05/26/2023, Staff H completed a one-step TB test and on 06/07/2023 completed a two-step TB test within 12 months of rehire. Both test results were negative. There was no documentation that showed Staff H completed a one-step test for TB when they were rehired.

During an interview on 03/19/2024 at 11:30 AM, Staff L, Business Office Manager, stated that they did not complete a TB test for Staff B after they were hired. Staff L stated that they did not complete a TB test for Staff H after they were rehired. Staff L stated that they were unfamiliar with the TB testing requirements. Staff L stated that they did not know that staff with a history of negative blood test required a one-step test for TB when hired. Staff L stated that that they did not have a system to screen and test TB for each staff when they were hired and rehired.

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, REGENCY NEWCASTLE 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-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 2 of 2 sampled staff (Staff D and Staff G) for tuberculosis (TB), as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

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STAFF D
Review of the facility's Employee Roster showed the facility hired Staff D, Aide, on 03/07/2024. Review of Staff D's employee records showed that as of 03/19/2024, 12 days after Staff D's date of employment, there was no documentation that showed Staff D completed any test for TB.

During an interview on 03/19/2024 at 11:30 AM, Staff L, Business Office Manager, stated that Staff D's employment date was 03/07/2024. Staff L stated that the facility did not complete any TB test for Staff D. Staff L stated that they were unfamiliar with the TB testing requirements. Staff L stated that they did not know that all employees were required to be tested for TB within three days of employment. Staff L stated that they did not have a system to screen and test each staff for TB when they were hired.

STAFF G
Review of the facility's Employee Roster showed the facility hired Staff G, Medication Aide, on 03/07/2024. Review of Staff G's employee records showed that as of 03/21/2024, 14 days after Staff G's date of employment, there was no documentation that showed Staff G completed a test for TB.

During an interview on 03/21/2024 at 9:49 AM, Staff L stated that the facility did not complete a TB test for Staff G.

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, REGENCY NEWCASTLE 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 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(i) A certified home care aide;

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(ii) A long-term care worker who is exempt from the seventy-hour long-term care worker basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

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:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 7 of 7 sampled care staff (Staff B, Staff C, Staff F, Staff J, Staff P, Staff Q, and Staff X) completed all required training, as required. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

FIRST AID
Review of the facility's Job Descriptions showed that the facility required all Certified Nursing Assistants (CNA) and Medication Aides maintain a current first aid certification.

STAFF B
Review of the facility's Employee Roster showed that the facility hired Staff B, CNA, on 11/22/2023. Review of the facility's Care Staff Schedule showed that Staff B worked in February 2024 and March 2024. Review of the employee records showed that as of 03/26/2024, there was no documentation that showed Staff B completed the first aid training, as required.

STAFF C
Review of the facility's Employee Roster showed that the facility hired Staff C, Medication Aide, on 11/22/2023. Review of the facility's Care Staff Schedules showed that Staff C worked in February 2024 and March 2024. Review of the employee records showed that as of 03/26/2024, there was no documentation that showed Staff C completed the first aid training, as required.

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During an interview on 03/21/2024 at 11:00 AM, Staff L, Business Office Manager, stated that they maintained staff credential and training documents in the employee records. Staff L stated they had a system to keep track of incomplete training and notified the corresponding supervisor. Staff L stated that when Staff B and Staff C provided them with their training documentation, they were unaware Staff B and Staff C did not complete the first aid training.

CONTINUING EDUCATION
Review of the facility personnel records showed that from their 2022 birthday to their 2023 birthday: Staff F completed zero hours of continuing education training approved by the DSHS; Staff J completed zero hours of continuing education training approved by the DSHS; Staff P completed zero hours of continuing education training approved by the DSHS; Staff Q completed zero hours of continuing education training approved by the DSHS; Staff X completed zero hours of continuing education approved by DSHS; Staff N completed zero hours of continuing education approved by the DSHS.

During an interview on 03/21/2024 at 9:49 AM, Staff L stated that Staff F, Staff J, Staff P, Staff Q, and Staff X did not provide any documentation that showed they completed any of the required continuing education training from their 2022 birthday to their 2023 birthday.

Plan/Attestation Statement

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_____ _____
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.

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This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility failed to complete a Washington state name and date of birth background inquiry (BGI) every two years for 3 of 5 sampled staff (Staff E, Staff N, and Staff O). This failure placed all residents at risk of potential abuse, neglect, or exploitation from caregivers and staff persons with unknown backgrounds.

Findings included…

STAFF E
Review of the facility's Employee Roster showed the facility hired Staff E, Housekeeper, on 01/24/2014. Review of Staff E's employee records showed that on 01/27/2014, the facility completed Staff E's first Washington state name and date of birth BGI, three days after Staff E was hired. The records showed that on 01/27/2016, the first BGI expired. The records showed that on 02/21/2016, the facility completed a second BGI, 25 days after the first BGI expired. On 02/21/2018, the second BGI expired. On 08/15/2018, the facility completed a third BGI, 175 days after the second BGI expired. On 08/15/2020, the third BGI expired. On 06/24/2020, the facility completed the fourth BGI. On 06/24/2022, the fourth BGI expired. On 11/22/2022, the facility completed the fifth BGI, 151 days after the fourth BGI expired.

STAFF N
Review of the facility's Employee Roster showed the facility hired Staff N, Dietary Aide Server Helper, on 12/27/2017. Review of Staff N's employee records showed that on 12/24/2017, the facility completed Staff N's first Washington state name and date of birth BGI. The records showed that on 10/29/2019, the facility completed a second BGI. On 10/29/2021, the second BGI expired. On 11/12/2021, the facility completed a third BGI, 14 days after the second BGI expired. On 11/12/2023, the third BGI expired. On 11/29/2023, the facility submitted and completed a fourth BGI, 17 days after the third BGI expired.

STAFF O
Review of the facility's Employee Roster showed that the facility hired Staff O, Activities Assistant, on 11/08/2021. Review of Staff O's employee records showed their previous Washington state name and date of birth BGI expired on 10/27/2023. The records showed that the facility completed the next BGI on 01/19/2024, 84 days after the previous BGI expired.

On 03/19/2024 at 3:00 PM, Staff L, Business Office Manager, stated that they were responsible for completion of the staff background checks for all employees. Staff L stated that they were aware the facility was required to maintain a valid Washington state name date of birth BGI for all staff. Staff L stated that when they were hired in May 2022, they were unaware there were expired staff BGIs.

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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, REGENCY NEWCASTLE is or will be in compliance with this law and / or regulation on (Date)_____ .

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_____ _____
Administrator (or Representative) Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to assess and implement nurse delegation (ND) services for 3 of 3 sampled residents (Resident 3, Resident 4, and Resident 10). These failures placed Resident 3, Resident 4, and Resident 10 at risk for medication errors and potential decline in their health.

Findings included…

Review of the facility's Disclosure of Services showed the facility used nursing assistants to administer drops, oral, and topical medications under the delegation of a Registered Nurse. The Disclosure showed that under the delegation and education of the Registered Nurse/Wellness Director, routine insulin injections would be provided by unlicensed staff.

Review of the facility's policy titled "Nurse Delegation", dated August 2018, showed that a registered nurse authorized an unlicensed person consistent with applicable law to perform tasks of nursing care in selected situations and indicated that authorization in writing. The policy showed the delegation process included nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed persons, and re-evaluating the task at regular intervals. The policy showed that the registered nurses have ultimate accountability for the management and provision of nursing care including all delegation decisions.

RESIDENT 3
Review of Resident 3's face sheet showed that the facility admitted Resident 3 in [redacted] 2023

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with a medical diagnosis of [redacted], and [redacted].

Review of Resident 3's December 2023, January 2024, February 2024, and March 2024 Electronic Medication Administration Records (eMARs) showed Resident 3 received prescription and over the counter medications. The eMARs showed staff signed off when medications were administered. The eMARs showed an order to crush all medications as needed for dysphagia. Review of the eMARs showed an order for Miconazole Antifungal External Cream, two percent topical, to be applied to the groin and private area topically twice a day for a rash.

Review of Resident 3's Care Evaluation showed that on 02/05/2024, Staff I, Wellness Director/Registered Nurse Delegator, completed an assessment of Resident 3. The evaluation showed Resident 3 required assistance with medication management. The evaluation showed the goal was that Resident 3 received medications safely and as prescribed. The evaluation showed the Medication Technicians (unlicensed staff who dispense medications and administer medications under nurse delegation) managed and administered Resident 3's oral medications as ordered, twice a day. There was no documentation in the evaluation that showed Resident 3 required nurse delegation for medications administered by unlicensed staff.

Review of Resident 3's service plan, dated 02/09/2024, showed Resident 3 required medication assistance with medication management. The service plan showed that the Medication Technicians managed and administered Resident 3's oral medications daily. There was no documentation that showed Resident 3 received nurse delegation services for medication administration.

Observation on 03/21/2024 at 9:11 AM, showed Staff U, Nursing Assistant Certified/Medication Aide dispensed and crushed all of Resident 3's AM medications and mix the medications in applesauce. At 9:20 AM, observation showed Resident 3 laid in a hospital bed with the head of the bed raised greater than 45 degrees. Observation showed Staff U used a spoon and placed the applesauce with the crushed medications into Resident 3's mouth. Observation showed Staff U applied the antifungal cream to Resident 3's groin area. Observation showed Resident 3 was unwilling and not physically capable of applying the cream to themselves.

During an interview on 03/21/2024 at 12:40 PM, Staff I stated that Resident 3 was able to take their medications without assistance prior to contracting COVID. Staff I stated that they were not aware Resident 3 required staff to administer their medications. Staff I was aware the staff applied the medicated antifungal cream to Resident 3's groin and private area. Staff I was unaware the applied ointment task required nurse delegation.

GLUCOSE MONITORING FINGER STICK NOT DELEGATED

RESIDENT 4
Review of Resident 4's face sheet showed that the facility admitted Resident 4 in [redacted] 2022

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with a medical diagnosis of [redacted] and [redacted].

Review of Resident 4's December 2023, January 2024, February 2024, and March 2024 eMARs showed an order for blood sugar checks to be done four times a day, before meals and every night at bedtime.

Review of Resident 4's Care Evaluation showed that on 02/14/2024, Staff V, Registered Nurse, completed an assessment for Resident 4. The evaluation showed that Resident 4 was alert and oriented to person, place, and time. The evaluation showed that Resident 4 displayed intact cognition, ability to make sound decisions, and displayed good judgement with decision making. The evaluation showed that Resident 4 had poor short-term memory. The evaluation showed that Resident 4 required assistance with activities of daily living which included grooming, bathing, walking, and required staff to perform blood sugar checks.

Review of Resident 4's Service Plan, dated 02/15/2024, showed Resident 4 required staff to perform blood sugar checks.

During an interview on 03/20/2024 at 1:54 PM, Resident 4 stated that they were unable to answer whether staff were nice or not as they never see the staff. Resident 4 stated that the staff avoided them. Resident 4 stated that they were independent with all their care needs, diabetic management, which included insulin administration and blood sugar checks.

Observation on 03/21/2024 at 11:02 AM, showed Staff U, used a lancet (a medical device with a sharp point, used to make a small prick in the skin) to stick Resident 4's finger to check their blood sugar. Observation showed Staff U required four attempts before they obtained enough blood to place on the test strip. Staff U then inserted the test strip into the glucometer (machine that reads a person's blood sugar level). Observation showed Staff U dialed the insulin pen to the prescribed amount of insulin per the sliding insulin order. Staff U handed the insulin pen to Resident 4 who self-injected the insulin. Resident 4 did not attempt or request to do their own finger stick to check their blood sugar level.

During an interview on 03/21/2024 at 2:49 PM, Staff C, Medication Aide, stated that "sometimes" they performed Resident 4's fingerstick and blood sugar check.

During an interview on 03/21/2024 at 3:30 PM, Staff I stated that Resident 4 was independent with blood sugar checks and insulin administration. Staff I stated that they were unaware the Med Techs performed Resident 4's blood sugar checks.

RESIDENT 10
Review of Resident 10's records showed the facility admitted Resident 10 in [redacted] 2016 with a medical diagnosis of [redacted].

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Review of Resident 10's December 2023, January 2024, February 2024, and March 2024 eMARs showed Resident 10 received: Ciclopirox Shampoo (a medication that treats dry, flaky, and itchy skin) one percent, applied topically to groin (the area between the abdomen and the thigh) folds during shower for rash caused by frictional rubbing of skin; Ketoconazole Cream (a medication that treats skin infections) two percent, applied topically to groin, every day and evening shift; Triamcinolone Acetonide Cream (a medication that reduces swelling, redness, and itching skin) 0.1 percent, applied topically to right axilla (under arm) and groin, as needed for affected area; Triple Paste Anti-Fungal External Ointment (a medication that treats fungal infections) two percent, applied topically to groin, two times a day; and Vanicream Cream (a medication that treats dry and sensitive skin), applied topically to under arms, one time a day. The eMARs showed staff signed off when the topical medications were administered.

Review of Resident 10's Care Evaluation, dated 07/05/2023, showed that Staff I completed an assessment for Resident 10. The evaluation showed Resident 10 had skin concerns. The evaluation showed Resident 10 had hand contracture and required medication technicians to apply creams and ointments.

Review of Resident 10's Service Plan, dated 07/11/2023, showed the medication technicians administered topical ointments or creams as ordered, two times or more daily for Resident 10. There was no documentation that showed Resident 10 received nurse delegation services for medication administration.

Observation on 03/21/2024 at 2:25 PM showed Resident 10 sat in a chair in their apartment. Observation showed Resident 10 with muscle stiffness and contracted right hand. During an interview at this time, Resident 10 stated that they were unable to the see the skin condition in their groin area and they were unable to apply the medication independently.

During an interview on 03/21/2024 at 2:05 PM, Staff L, Medication Aide, stated that they were aware Resident 10 was unable to see their groin area. Staff L stated that they kept Resident 10's prescribed creams and ointment in the medication cart. Staff L stated that they administered and signed off Resident 10's prescribed creams and ointments.

During an interview on 03/21/2024 at 2:45 PM, Staff I stated that in the most recent assessment, Resident 10 was physically unable to self-administer the topical medications. Staff I stated that they were unaware the administration of topical medications by medication technicians required delegation. Staff I stated that they did not delegate medication technicians the administration of Resident 10's topical medications.

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) Date

WAC 246-215-02120 Food worker cards.

(1) The permit holder and person in charge of the foodestablishment shall ensure that all foodemployees are in compliance with the provisions of chapter 69.06 RCW and chapter 246-217 WAC for obtaining and renewing valid foodworker cards.

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, interview, and record review, the facility failed to ensure 1 of 7 dietary staff (Staff M) maintained a valid Food Worker Card. This failure placed all residents at risk for foodborne illnesses.

Findings included...

Review of the facility's Job Description for Dishwasher/Dietary Aide showed that the aides were required to maintain a current food handler’s card. The document showed that staff were responsible to adhere to the policy and operating procedures.

Review of the facility’s Employee Roster showed that the facility hired Staff M, Dishwasher, on 01/17/2020. Review of the facility's dietary staff employee schedule showed that Staff M worked in February 2024 and March 2024. Review of the employee record showed that Staff M’s Washington State Food Worker Card expired on 01/20/2024.

Observations on 03/18/2024 between 11:00 AM and 1:00 PM showed that Staff M worked in the kitchen.

During an interview on 03/20/2023 at 11:00 AM, Staff H, Dietary Manager, stated that the facility maintained the employees' Food Worker Cards in the Business Office. Staff H stated that when they scheduled Staff M to work, they were unaware Staff M’s Food Worker Card

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was expired.

During an interview on 03/21/2023 at 11:00 AM, Staff L, Business Office Manager, stated that the facility required all kitchen staff maintain a valid food worker card. Staff L stated that they were unaware Staff M's Food Worker Card was expired.

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-2290 Family assistance with medications and treatments.

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

(a) By name, the family member who will provide the medication or treatment assistance or administration;

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to obtain a complete family assistance medication management plan for 1 of 1 sampled resident (Resident 7), who received family assistance with blood sugar checks and insulin injections. This failure placed Resident 7 at risk for compromised health.

Findings included…

RESIDENT 7
Observation on 03/21/2024 at 10:05 AM in Resident 7's apartment showed a weekly Pill

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Minder (a container that is used to organize medication doses) filled with medications. Observation showed several boxes of lancets and a half filled sharps disposal container (a container that places used needles and other medical-waste sharps) on the kitchen counter. Observation showed inside a cabinet drawer, there were six Pill Minder containers, with four of the containers filled with medications.

Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2020. The records showed that on 01/24/2024, the facility completed the "Assisted Living Facility Self-Medication Administration Assessment and Family Plan" for Resident 7. The records showed Resident 7 received routine and as needed oral medications, blood sugar checks, and insulin injections. The records showed Resident 7 was independent with medication administration. The records showed Resident 7's family member ordered medications and set up the Pill Minder. The assessment showed Resident 7 self-administered their oral medications, performed a fingerstick for blood sugar check, dialed the insulin pen, and self-injected their insulin. The assessment showed Resident 7 was able to dial the insulin pen and their unidentified friend dialed the insulin pen for them. There was no documentation that showed the name of Resident 7's unidentified friend. There was no documentation that showed an alternate plan if the family member or friend were unable to fulfill their duties.

During an interview on 03/21/2024 at 10:05 AM, Resident 7 stated that they were able to take the oral medications from the Pill Minder containers. Resident 7 stated that the containers were filled by a family member every month. Resident 7 stated that everyday, their blood sugar levels were checked and they received routine insulin injections. Resident 7 stated that they were unable to independently prick their finger to complete the blood sugar check. Resident 7 stated that they were unable to self-administer their insulin injection. Resident 7 stated that their friend checked their blood sugar levels and administered the insulin injections for them. Resident 7 stated that they did not know what service the facility would provide if their family member and their friend were unable to provide the medication assistance.

During an Interview on 03/21/2024 at 2:45 PM, Staff I, Wellness Director, stated that Resident 7's family provided medication management assistance. Staff I stated that in January 2024, when they completed Resident 7's self-medication administration assessment, a back-up medication management plan was not developed.

During an interview on 04/01/2024 at 4:30 PM, Staff I stated that they were aware Resident 7 received assistance with blood sugar checks and insulin injections from a friend. Staff I stated that they did not document this assistance in Resident 7's self-medication assessment.

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Negotiated Service Agreement (NSA) for 4 of 9 sampled residents (Resident 3, Resident 4, Resident 6 and Resident 7). This failure placed Resident 3, Resident 4, Resident 6, and Resident 7 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included…

MEDICAL DEVICES

RESIDENT 3
Review of Resident 3's face sheet showed that the facility admitted Resident 3 in [redacted] 2023 with a medical diagnosis of [redacted], and [redacted].

Observation on 03/20/2024 at 11:17 AM, showed Resident 3 sat on a Roho cushion

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(pressure relieving cushion designed to prevent and heal skin breakdown) in a tilt-in-space wheelchair (designed to redistribute a person's weight to reduce the pressure on the body and prevent skin breakdown by tilting the chair to various angled degrees). At the time of the observation, Resident 3 was non-ambulatory and required staff assistance for transfers. During an interview at this time, Resident 3 stated that due to contracting COVID-19, they lost their appetite and were weaker. Resident 3 stated that they required staff to transfer them from their wheelchair to the bed. Resident 3 stated that they had a chronic wound to their right heel. Resident 3 stated that they were unable to independently ambulate or maneuver their wheelchair due to wound on foot.

Observation on 03/21/2024 at 9:17 AM, showed Resident 3 required assistance from their family member and Staff U, Nursing Assistant Certified/Medication Aide (unlicensed staff who administer and dispense medications), to be reposition in bed and for the placement of heel protectors.

Review of Resident 3's Care Evaluation showed that on 02/08/2024, Staff I, Registered Nurse, Wellness Director, completed an assessment for Resident 3. The evaluation showed that Resident 3 was independent with ambulation, required assistance with wheelchair escorts to the dining room and was at risk for skin impairment. The evaluation showed that Resident 3 was at risk for "impaired skin integrity due to poor incontinence care." The evaluation showed that Resident 3 required staff assistance for transfers. The evaluation did not show Resident 3 used a Roho cushion or tilt-in-space wheelchair.

Review of Resident 3's service plan dated 02/09/2024 showed Resident 3 was independent with ambulation and required staff escort services to maneuver their wheelchair. There was no documentation that showed Resident 3 used a Roho cushion or a tilt-in-space wheelchair. There were no instructions that showed the caregivers how to check to ensure Resident 3's Roho cushion was correctly inflated. There were no instructions on how often Resident 3's wheelchair should be adjusted to relieve pressure on areas of the body to prevent skin breakdown.

RESIDENT 4
Review of Resident 4's face sheet showed that the facility admitted Resident 4 in [redacted] 2022 with a medical diagnosis of [redacted], and [redacted].

Review of Resident 4's Care Evaluation showed that on 02/15/2024, Staff V, Registered Nurse, completed an assessment for Resident 4. The Care Evaluation showed that Resident 4 used a pacemaker and used a Continuous-Positive Airway Pressure machine (C-PAP, a medical device that helps people breath at night).

Review of Resident 4's service plan, dated 02/15/2024, showed Resident 4 was independent with the set-up and use of the C-PAP machine. The service plan showed that Resident 4 used a pacemaker and was independent with the pacemaker checks.

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During an interview on 03/20/2024 at 1:54 PM, Resident 4 stated that they had a cardiac pacemaker. Resident 4 stated that they did not know who monitored their pacemaker. Resident 4 was unable to state or show whether there was an external monitoring device in the apartment. Resident 4 stated that they were diagnosed with [redacted]. Resident 4 stated they did not use a C-PAP, machine at night. Resident 4 was unable to locate their C-PAP machine.

Observation of Resident 4's apartment on 03/20/2024 at 1:54 PM, found no pacemaker monitoring device. Observation showed no visible C-PAP machine in the bedroom.

During an interview on 03/21/2024 at 11:02 AM, Staff U stated that they did not assist Resident 4 with their C-PAP machine. Staff U stated that they did not do anything with Resident 4's pacemaker.

During an interview on 03/21/2024 at 12:40 PM, Staff I stated that until about a year ago, Resident 4's friend was the Power of Attorney (POA) and coordinated the pacemaker checks and monitored the C-PAP machine. Staff I stated that there was a pacemaker monitoring device in Resident 4's apartment. Staff I stated that they found Resident 4's C-PAP in a cupboard in the apartment. Staff I stated that they did not know who managed Resident 4's pacemaker and C-PAP machine when the friend was no longer able to be Resident 4's POA and discontinued providing assistance.

MEDICATION WITH BLOOD THINNER PROPERTIES

RESIDENT 3
Review of Resident 3's December 2023, January 2024, February 2024, and March 2024 Electronic Medication Administration Records (eMARs) showed Resident 3 received 81 milligrams (mg) chewable Aspirin (a medication with blood thinner properties), one time a day, by mouth for Cerebrovascular Attack (stroke).

Observation and Interview on 03/21/2024 at 9:11 AM, showed Staff U dispensed and crushed one 81 milligram oral chewable Aspirin tablet. Staff U stated that there were no concerns with Resident 3 taking aspirin. Staff U stated that they did not need to be aware of anything related to Resident 3's aspirin use and there were no concerns with adverse effects from the aspirin. Observation on 03/21/2024 at 9:20 AM, showed Staff U administered the aspirin to Resident 3.

Review of Resident 3's Care Evaluation showed that on 02/08/2024, Staff I completed an assessment for Resident 3. There was no documentation in the evaluation that showed Resident 3 received medication which placed them at risk for bruising and bleeding easily.

Review of Resident 3's Service Plan, dated 02/09/2024, showed no documentation that Resident 3 received aspirin or was at risk for bruising and bleeding easily. There was no

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documentation that provided the care staff with guidance about the possible side effects from aspirin administration, such as increased risk for bleeding. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 6
Review of Resident 6's face sheet showed that the facility admitted Resident 6 in [redacted] 2021 with a medical diagnosis of [redacted].

Review of Resident 6's December 2023, January 2024, February 2024, and March 2024 eMARs showed Resident 6 received 81 mg of Aspirin, one time a day, by mouth for atherosclerotic heart disease.

Review of Resident 6's Care Evaluation showed that on 11/20/2023, Staff V completed an assessment for Resident 6. There was no documentation in the evaluation that showed Resident 6 received medication which placed the resident at risk for bruising and bleeding easily.

Review of Resident 6's Service Plan, dated 05/05/2023, showed no documentation that showed Resident 6 received aspirin. There was no documentation that provided the care staff with guidance about the possible side effects from aspirin administration, such as increased risk for bleeding. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 7
Review of Resident 7's face sheet showed that the facility admitted Resident 6 in [redacted] 2020 with a medical diagnosis of [redacted].

Review of Resident 7's medication orders showed Resident 7 received 81 mg Aspirin, one time a day, by mouth for atrial fibrillation.

Review of Resident 7's Care Evaluation showed that on 02/02/2024, Staff V completed an assessment for Resident 7. The evaluation showed Resident 7 was independent with medication management. There was no documentation in the evaluation that showed Resident 7 received medication which placed the resident at risk for bruising and bleeding easily.

Review of Resident 7's Service Plan, dated 02/02/2024, showed no documentation that showed Resident 7 received aspirin. There was no documentation that provided the care staff with guidance about the possible side effects from aspirin administration, such as increased risk for bleeding. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 03/21/2024 at 1:22 PM, Staff R, Certified Nursing Assistant, stated

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that the facility hired them as a caregiver. Staff R stated that caregivers were responsible for monitoring skin condition and reporting abnormal skin conditions to the licensed nurse. Staff R stated that they were unaware of any residents who were on blood thinner medications. Staff R stated that caregivers did not have access to the eMAR system. Staff R stated that they were unfamiliar with the side effects of the use of blood thinner medication.

During an interview on 03/21/2024 at 2:00 PM, Staff I stated that Resident 3, Resident 6 and Resident 7‘s service plans did not have a safety plan for taking a blood thinner medicine.

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, REGENCY NEWCASTLE 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-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess and document 1 of 1 sampled resident’s (Resident 6) use of a medical device. The facility failed to document the medical needs and possible interventions for 2 of 2 sampled residents (Resident 7 and Resident 10) with specific medical conditions. These failures placed Resident 6, Resident 7, and Resident 10 at risk of injury or harm from unidentified care needs.

Findings included…

Review of the facility’s policy titled, “Devices with Restraining Qualities Assessment”, dated

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August 2018, showed that the facility permitted the use of medical devices with restraining qualities, if the device enhanced the resident's quality of life. The policy showed that the facility required a registered nurse and/or therapist to assess the need for and the use of devices with restraining qualities. The policy showed that the facility was responsible to review the risk and benefits of use with the resident and family. The policy showed a review was required to be completed quarterly and with any significant change of condition.

MEDICAL DEVICE ASSESSMENT

RESIDENT 6
Observation on 03/20/2024 at 3:57 PM in Resident 6's apartment showed a bed with a bed enabler (medical equipment designed to provide persons with stability to get out of bed). The bed enabler was installed at the head of the bed, on the right side. Observation showed the bed enabler was securely attached to the bed. During an interview at this time, Resident 6 stated that their family installed the bed enabler when they moved into the facility two years ago. Resident 6 stated that they used the bed enabler for transfers and bed mobility every day. Resident 6 stated that the facility staff did not complete any assessment for them to use the bed enabler. The facility staff did not explain any of the risks and benefits of using a bed enabler. Resident 6 stated that they were unsure if the bed enabler was safe. Resident 6 stated that they were unaware of any safety concerns when they used the bed enabler.

Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2021. The records showed no documentation that Resident 6 used a medical device. There was no documentation that showed anyone completed an assessment with Resident 6 for the use of the medical device. There was no documentation that showed the risks and benefits for the medical device were discussed with Resident 6. The records showed no documentation that Resident 6's physician approved and ordered the medical device.

During an interview on 03/21/2024 at 2:00 AM, Staff I, Wellness Director, stated there was no documentation in Resident 6's records that showed anyone completed a bed enabler assessment. Staff I stated that the facility policy directed them to complete an assessment for residents who used a bed enabler. Staff I stated that they were unsure why a medical device assessment was not completed for Resident 6.

MEDICAL ASSESSMENT

RESIDENT 7
Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2020 with a medical diagnosis of [redacted]. The records showed Resident 7 received Levetiracetam (a medication that treats seizures), 1000 milligrams (mg), one tablet by mouth, two times a day, for seizures. The records showed that on 01/24/2024, the facility nurse completed Resident 7's assessment. There was no documentation in the assessment of Resident 7's [redacted] diagnosis and [redacted]. There was no documentation in the assessment of the signs and symptoms of Resident 7's seizures that staff needed to monitor. There

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was no documentation of the interventions required by staff if Resident 7 experienced a seizure.

RESIDENT 10
Review of Resident 10's records showed that the facility admitted Resident 10 in [redacted] 2016 with a medical diagnosis of [redacted]. The records showed Resident 10 received Pramipexole Dihydrochloride (a medication that improves stiffness, uncontrolled movements, and unsteadiness), 0.375 mg, one tablet by mouth at bedtime for epilepsy. The records showed Resident 10 received Tiagabine Hydrochloride (a medication that treats epilepsy), 16 mg, one tablet by mouth two times a day. The records showed that on 07/05/2023, the facility nurse completed Resident 10's assessment. There was no documentation in the assessment of Resident 10's [redacted] diagnosis [redacted]. There was no documentation in the assessment of the signs and symptoms of epilepsy seizures that staff to monitor. There was no documentation of the interventions required by staff if Resident 10 experienced a seizure.

During an interview on 03/21/2024 at 2:05 PM, Staff K, Medication Aide, stated that they were unaware Resident 7 had a [redacted] diagnosis and received medication for [redacted]. Staff K stated that they were unaware Resident 10 had an [redacted] diagnosis and received medications for [redacted]. Staff K stated that they were unaware of the signs and symptoms Resident 7 and Resident 10 showed when the resident experienced a seizure.

During an interview on 03/21/2024 at 2:25 PM, Staff C, Medication Aide, stated that they were unaware Resident 7 had a [redacted] diagnosis and received medication for [redacted]. Staff C stated that they were unaware Resident 10 had an [redacted] diagnosis and received medications for [redacted]. Staff C stated that they were unaware of the signs and symptoms Resident 7 and Resident 10 showed when the resident experienced seizure.

During an interview on 03/21/2024 at 2:45 PM, Staff I, confirmed that they did not have a facility policy and procedure that outlined any guidelines related to resident seizure and epilepsy management. Staff I stated that when they completed an assessment for Resident 7 and Resident 10, they did not document the residents' [redacted] or [redacted] diagnosis, the signs and symptoms, and the interventions to guide staff when a resident experienced a seizure.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the Department of a change in the assisted living facility administrator within 10 days of hire for 1 of 1 sampled staff (Staff A), as required. This failure placed all residents at risk of receiving care from unqualified staff members.

Findings included…

Review of the Department's electronic records for tracking change in administrator showed that on 03/18/2024, Staff JJ was the named Administrator of record.

Review of the “Assisted Living Facility Information Changes form” dated 03/18/2024, showed it was submitted by the facility during the first day of the Department’s inspection visit.

Review of an email dated 03/18/2024 from the Department of Social and Health Services, Residential Care Services, Business Operations and Analysis Unit (BOAU) showed the change of administrator attestation was received on 03/18/2024. The email showed a request for the facility to update the email address as the BOAU records showed the previous Administrators email address.

During the entrance conference interview on 03/18/2024 at 9:10 AM, Staff A, interim Administrator/Regional Vice President of Operations, stated that they were the administrator of record. Staff A stated that they started as the interim administrator on 03/07/2024.

During an interview on 03/19/2024 at 9:20 AM, Staff A stated that their hire date for the company was in May of 2008. Staff A stated that Staff JJ’s, previous administrator, last day as the facility administrator was 02/29/2024. Staff A stated that a new administrator started on-boarding on 03/19/2024. Staff A stated that they would remain as the administrator until the new administrator was fully on-boarded. Staff A stated that they thought the company had 30 days to submit a change of administrator attestation to the Department of Social and Health Services

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Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement the respiratory protection program (RPP) during a COVID-19 outbreak for 30 of 30 sampled staff (Staff A, Staff L, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, Staff I, Staff J, Staff K, Staff P, Staff Q, Staff R, Staff S, Staff T, Staff U, Staff V, Staff W, Staff Y, Staff Z, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, and Staff II.) 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…

Review of the Washington State Department of Health (DOH) website, titled "Respiratory Protection Program for Long-Term Care Facilities", (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program), showed that facilities were required to identify which employees would be exposed to a respiratory hazard, to fit test those employees who could potentially be exposed to a respiratory hazard, and to maintain the employees' fit test records. Facilities were required to provide initial and annual fit tests and to provide fit tested respirators to their employees.

Review of the facility's undated Respiratory Protection Program (RPP) document used for the COVID-19 Pandemic and any subsequent outbreak, showed that Staff I, Registered Nurse, Wellness Director, was the respiratory protection program administrator for the facility. The document showed that Staff A, interim Executive Director, Regional Vice President of Operations, and Staff I were responsible to train employees before they wore respirators, and annually thereafter. The document showed respirators were used to protect against transmission of SARS-COV-2 virus and other airborne diseases. The document identified the categories of employees who would be required to participate in

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the RPP, which included administrative staff, Certified Nursing Assistances (CNA), Registered Nurses (RN), Health Care Assistants/Caregivers, Maintenance staff, housekeeping staff, physical therapists, and others. The document showed that every employee required to wear a respiratory mask would be provided with a medical evaluation before they were allowed to use the mask. All designated staff would be fit-tested before use of the respirator mask. The document showed that the RPP administrator was responsible for employee training, respirator fit testing, and employee respiratory use for adherence to the rules. The document showed that the RPP administrator was responsible to maintain training records, medical evaluations, and fit testing records for all employees that used respirators.

Review of the facility's Infection Control Program Overview, dated August 2018, showed that all corporate "affiliated assisted living facilities must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections." The Infection Control Program Overview showed that the facility was to implement appropriate precautions when a resident was identified with a communicable disease.

Review of staff records for the 30 sampled staff identified as staff who received training, evaluations, and were fit tested, showed no documentation that any of the 30 sampled staff received training, medical evaluations, and were respirator fit tested.

Observation on 03/18/2024 at 9:00 AM, showed signs posted on the facility entry doors that showed the facility was experiencing a COVID-19 outbreak. The posted signs asked and for all visitors to follow infection control precautions.

During the entrance conference on 03/18/2024 at 9:10 AM, Staff A, interim Executive Director stated that the facility was currently in a COVID-19 outbreak. Staff A stated that four additional cases of COVID were reported over the weekend.

During an interview on 03/21/2024 at 12:40 PM, Staff I reported one new resident case of COVID-19. Staff I confirmed the total COVID-19 positive resident cases was 15.

Observation on 03/19/2024 at 12:45 PM, showed Staff Q, Medication Aide, wore an N95 3M respirator mask. During an interview at this time, Staff Q stated that they were not fit tested for any respirator. Staff Q stated that they tried on several types of respirator masks and wore the one that was most comfortable. Staff Q stated they did not completely understand what the fit tested entailed. Staff Q stated that recently they were given a medical evaluation form to fill out. Staff Q stated that they exercised extra precautions due to their own medical condition. Staff Q stated that they doffed (take off) outside of the resident's apartment, placed the used personal protection equipment in a hazard bag, and disposed of it in a hazard box located in the garbage room.

Observation on 03/19/2024 at 1:00 PM, showed Staff R, Certified Nursing Assistant, exited a COVID-19 positive resident's room. Staff R wore an N95 respirator mask covered with a

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non-N95 surgical mask, gloves, and a disposable gown. No face shield was observed. Observation showed Staff R doffed all Personal Protective Equipment (PPE) outside the COVID-19 positive resident's room. During an interview at this time, Staff R stated that they were not fit tested for any respirator mask.

Observation on 03/20/2024 at 11:17 AM, showed Staff J, Certified Nursing Assistant doffed the PPE outside of Resident 2's room. Resident 2 was on isolation precautions after they tested positive for COVID. Observation showed Staff J wore an N95 respirator mask, gloves, and a disposable gown. Staff J wore their own corrective lenses without any other eye protection. Observation showed Staff J did not clean their personal corrective lenses in-between resident apartments. During an interview at this time, Staff J stated that they made a mistake and should have doffed inside Resident 2's apartment. Staff J confirmed they were not fit tested for an N95 respirator mask.

Observation on 03/21/2024 at 9:07 AM, showed Staff S, Maintenance Director, and Staff T Community Relations Director, wore an N95 NIOSH respirator masks when they tested residents for COVID-19. Observation showed Staff S wore a full beard that protruded outside of the mask. During an interview at this time, Staff I stated that neither Staff S nor Staff T were fit tested for a N95 respirator mask. Staff I stated that neither staff member entered any COVID-19 positive isolation apartments. Staff I stated that the COVID-19 test results conducted by Staff S and Staff T showed one additional resident tested positive.

Observation on 03/21/2024 at 9:11 AM, showed Staff U, Certified Nursing Assistant/Medication Aide (unlicensed staff who dispense and administer medications) enter quarantined Resident 3's apartment. Observation showed Staff U administered Resident 3's medications. Observation showed Staff U wore a 3M NIOSH respirator mask, gloves, gown, and a face shield. Staff U removed the face shield outside of the room and placed it on the supply cart next to the doorway. Staff U then doffed the rest of their PPE except the N95 respirator inside of the apartment. Staff U exited the room, donned (put on) gloves and cleaned the face shield with sanitizer. Observation showed Staff U did not remove or change their mask. Staff U stated they did not have another mask to put on. During an interview at this time, Staff U stated that they were fit tested for a N95 respirator at an affiliated skilled nursing facility in November 2023 prior to their employment at the current facility. Record review found no documentation of a medical evaluation or respirator fit testing.

Observation on 03/21/2024 at 11:02 AM, showed Staff U entered Resident 4's quarantined room without was not wearing any eye protection. Observation showed Staff U used a lancet (a medical device with a sharp point, used to make a small prick in the skin) to do a finger stick to check Resident 4's blood sugar. Observation showed Staff U required for attempts before they successfully obtained enough blood to complete Resident 4's blood sugar check. Observation showed Staff U recapped the lancets before discarding them in a sharps container (a hard plastic container used to collect used medical needles and syringes). Observation showed Staff U sanitized the lancet injector and placed the glucometer (meter to read blood sugar levels) and lancet injector into a plastic zip lock bag. Observation showed Staff U doffed inside the apartment and then went to the medication cart where they sanitized the lancet injector and glucometer. Observation showed there was still blood on the lancet injector. Observation showed Staff U wore a BYD

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N95 respirator mask.

Observation on 03/21/2024 at 8:54 AM, showed Staff J wore no face shield or eye protection when they provided care for COVID-19 positive residents.

During an interview on 03/18/2024 at 4:18 PM, Staff A stated that “honestly” we don’t have any records, documentation for training, medical evaluations, and respirator fit tests for any of the staff. Staff A stated that if staff were fit tested for a respirator, the records would be expired.

During an interview on 03/19/2024 at 11:27 AM, Staff I, stated that the initial onset of the first COVID-19 positive case was 03/13/2024. Staff I stated that the facility management staff closed the main dining room and staff delivered meal trays to all residents. Staff I stated that as of 03/19/2024, there were four additional positive cases. Staff I stated that one resident was sent to the hospital for further evaluation.

During an interview on 03/21/2024 at 10:24 AM, Staff A stated that the facility did not have any records of employee respirator fit testing, medical evaluations, or training documents. Staff A stated that all new staff hired within the last six months did not complete the medical evaluations and were not fit tested for any respirator mask. Staff A stated that they handed out the medical evaluations to all the staff required to wear an N95 respirator mask.

During an interview on 03/21/2024 at 12:40 PM, Staff I stated that they and Staff W, Registered Nurse, completed the training to conduct respirator fit testing. Staff I stated that they provided all identified staff with medial evaluation forms to complete. Staff I stated that the plan was to fit test all identified staff when there was opportunity. Staff I stated “right now” were focused the current COVID outbreak.

Review of an email dated 03/29/2024 at 1:01 PM, showed that Staff I and Staff W completed a respirator fit test on 03/29/24. The email showed that Staff I and Staff W’s previous respirator fit tests were expired. There was no documentation to show Staff I or Staff W were fit tested or completed medical evaluations during the Departments on-site visit.

During an interview on 03/21/2024 at 12:40 PM, Staff I stated that the last time the staff received formal infection control and COVID policy and practices training was July of 2023. Staff I stated that they provided individual verbal instruction to each staff on infection control and COVID-19.

Plan/Attestation Statement

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