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

ALJOYA THORNTON PLACE, LLC
ALJOYA THORNTON PLACE
450 NE 100TH ST
SEATTLE, WA 98125

RE: ALJOYA THORNTON PLACE License # 2040

Dear Administrator:

This letter addresses Compliance Determination(s) 27135 (Completion Date 07/27/2023) and 25309 (Completion Date 06/28/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/27/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-3100-1, WAC 388-78A-3100-2

The Department staff who did the on-site verification:
Keiko Kitano, Licensor

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

Sincerely,

Jamie Singer

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

Residential Care Services
Investigation Summary Report

Provider/Facility: ALJOYA THORNTON PLACE
License/Cert.#: 2040
Compliance Determination #: 25309
Investigator: Keiko Kitano
Investigation Date(s): 06/12/2023 through 06/28/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 84024
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
The Named Resident (NR) was found on the floor with injuries. The NR told staff that a Private Caregiver (PCG) pushed him.

Investigation Methods:

Sample:	Total residents: 22 Resident sample size: 6 Closed records sample size:
Observations:	the Assisted Living Facility's (ALF) environment, staff and residents' interaction, the named resident's room
Interviews:	administrative staff members, caregivers, residents, Collateral Contact (CC)
Record Reviews:	incident investigative documents, residents' records, the ALF's policy

Investigation Summary:
The Administrative staff members stated that when the NR's primary caretaker was out of town, the NR's family hired a PCG from an outside agency. While making a routine check, a facility's caregiver found the NR on the floor. The NR told the ALF staff that the PCG pushed him, and he fell. The NR sustained injuries from the fall and was sent to the hospital. The ALF investigated the incident and took appropriate action. Interviews and record review showed staff had not implemented their Abuse and Neglect Reporting Policy when the PCG allegedly pushed the NR. Consultation was provided.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

07/03/2023

ALJOYA THORNTON PLACE, LLC
ALJOYA THORNTON PLACE
450 NE 100TH ST
SEATTLE, WA 98125

RE: ALJOYA THORNTON PLACE # 2040

Dear Administrator:

This document references the following complaint numbers 84400, 84024.

The Department completed a full inspection of your Assisted Living Facility on 06/28/2023 and found that your facility does not meet the Assisted Living Facility requirements.

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

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

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

Jamie Singer, Field Manager
Residential Care Services

Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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

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

WAC 388-78A-2600 Policies and procedures.

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

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

The Assisted Living Facility (ALF) failed to ensure staff implemented their Abuse and Neglect Reporting Policy when a private caregiver allegedly pushed a resident. This placed the residents at risk of possible abuse from a visiting caregiver.

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

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

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

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

ALJOYA THORNTON PLACE #2040
06/28/2023
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If You Have Any Questions:
- Please contact me at (425)670-6070.

Sincerely,

Jamie Singer

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

Enclosure

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

Statement of Deficiencies	License #: 2040	Compliance Determination #25309
Plan of Correction	ALJOYA THORNTON PLACE	Completion Date
Page 4 of 9	Licensee: ALJOYA THORNTON PLACE, LLC	06/28/2023

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 06/12/2023 and 06/14/2023 of:
ALJOYA THORNTON PLACE
450 NE 100TH STREET
SEATTLE, WA 98125

This document references the following complaint numbers: 84400, 84024.

The following sample was selected for review during the unannounced on-site visit: 6 of 22 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

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

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

Jamie Singer
Residential Care Services

7/3/2023
Date

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

Administrator (or Representative) 7/10/23 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to review and update the Negotiated Service Agreement (NSA) for 1 of 1 sampled resident (Resident 2) to reflect current care and service needs. This placed Resident 2 at risk for not receiving proper care and services and a compromised health status.

Findings included...

Review of a Resident Health Evaluation and NSA (RHENSA- a combination of a Full assessment and NSA), dated 03/09/2023, showed the ALF admitted Resident 2 on [redacted] 2019 with multiple diagnoses including [redacted].

Review of a Quality Assurance Report (QAR), dated 05/24/2023, showed that a staff member found Resident 2 laying on the floor near the door to the hallway in their apartment. The QAR showed that Resident 2 told a Resident Assistant that she had been drinking alcohol and did not remember what happened. The QAR showed Resident 2 was sent to the emergency room.

Review of an After Visit Summary (AVS) from the emergency room, dated 05/25/2023, showed Resident 2 was seen for evaluation after a fall. The AVS showed the fall was related to drinking alcohol.

Review of a progress note (PN), dated 05/25/2023, showed Resident 2 told a nurse that she was consuming an excessive amount of alcohol and did not remember falling or being on the floor. The PN stated when the nurse asked whether she was feeling sad or whether there was another reason to drink an excessive amount of alcohol, Resident 2 told the

nurse, "she did not want to cry anymore."

In an interview, on 06/14/2023 at 12:50 PM, Resident 2 stated that she had recently lost a family member and had been feeling sad. Resident 2 stated that she did not want to cry and tried to not cry. When asked whether she had been drinking alcohol, Resident 2 stated that she was, but stopped drinking because she had fallen.

Review of the 03/09/2023 RHENSA showed no interventions, directives or safety plan related to Resident 2's behavior of consuming excessive alcohol.

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, ALJOYA THORNTON PLACE is or will be in compliance with this law and / or regulation on (Date) 7/10/23.

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

Administrator (or Representative) — Date: 7/10/23

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement a system that supported and promoted safe medication services for 1 of 1 sampled resident (Resident 3) who required staff assistance with medication. This resulted in Resident 3 not receiving eye drops as prescribed and placed her at risk for a compromised her health condition.

Findings included...

Review of Resident 3's Health Evaluation and Negotiated Service Agreement (HENSA, equivalent to a Full Assessment and Negotiated Service Agreement), dated 03/18/2023, showed that the ALF admitted Resident 3 on [redacted] 2021 with multiple diagnoses [redacted]. The HENSA showed Resident 3 required staff assistance with medications.

Review of the May 2023 Medication Administration Record (MAR) showed Resident 3 was prescribed multiple medications including Dorzolamide (an eye drop used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision).

Observation and interview, on 06/14/2023 at 8:15 AM, showed Resident 3's medications were kept in the medication cart in the medication section of the Wellness Office. Staff I (Resident Assistant ((RA)) stated that RAs were required to assist Resident 3 with medications. Staff I stated that RAs had been administering Resident 3's eye drops twice a day, in AM and PM.

Review of the May 2023 MAR showed, on 05/22/2023, a RA put their initials in a column for the AM dose of Dorzolamide, circled their initials and made a notation of, "Not Given" on the backside of the MAR.

In an interview, on 06/14/2023 at 2:30 PM, when asked why Dorzolamide was not given to Resident 3 on 05/22/2023, Staff G (Community Health Director) stated that she was not aware Resident 3 was not given their Dorzolamide and would investigate it.

On 06/16/2023, the Department received additional documents from Staff G, including a Quality Assurance Report (QAR). The QAR showed that on 05/22/2023, a morning shift RA was unable to locate the eye drops in the medication cart. Later that day, an evening shift RA found the drops in a medication bag that the previous evening RA used to carry medications. The QAR showed that Resident 3 missed one dose of Dorzolamide on 05/22/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ALJOYA THORNTON PLACE is or will be in compliance with this law and / or regulation on (Date) 7/10/23.

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

Administrator (or Representative) — Date 7/10/23

Statement of Deficiencies	License #: 2040	Compliance Determination # 25309
Plan of Correction	ALJOYA THORNTON PLACE	Completion Date
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WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to secure toxic chemicals in an area accessible to residents. This failure placed 22 of 22 residents in the ALF at risk for inadvertent ingestion of a toxic substance that could cause harm and compromise health.

Findings included...

Review of the undated Resident Characteristics Roster (RCR) showed the ALF had been providing care and services for 22 residents. The undated RCR showed that eight residents were identified as having dementia (a group of symptoms that affects memory, thinking and interferes with daily life) or other cognitive impairment.

Review of records showed the ALF admitted Resident 2 with a diagnosis of [redacted]

The ALF's environment observation with Staff F (Administrator/Executive Director), on 06/12/2023 at 11:15 AM, showed a spray bottle of Windex glass cleaner, belonging to a resident, sitting on a counter outside of a resident's apartment on the fifth floor. Review of the label on the spray bottle showed, "Danger: Causes serious eye damage" and "Keep Out of Reach of Children." Staff F stated that residents were not supposed to leave any chemical outside of their apartment.

Observation and interview, on 06/12/2023 at 11:55 AM, showed a door to the pantry room from the lobby on the main floor was unlocked. Observation in the pantry room showed two chemical bottles, including Cleaner Spray and Foam, sitting on the sink. There were multiple chemical bottles for housekeeping supplies, including glass and plastic cleaners and window cleaners. The label on these chemical bottles showed, "Danger" "Keep Out of Reach of Children." Observation showed multiple cans of Sterno Handy Wick fuel inside drawers under the counter. The label on the cans showed, "Danger. Harmful or Fatal if swallowed" "Keep Out of Reach of Children." Staff F stated that staff had not locked the door after leaving the room as was their expectation, and she would take full responsibility for this issue.

Statement of Deficiencies	License #: 2040	Compliance Determination # 25309
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Observation and interview, on 06/13/2023 at 9:20 AM, showed a door to the mechanical room on the second floor was unlocked. Multiple chemical supplies were stored inside the room. Staff H (Facility Director) stated that staff did not close the door all the way after they used the room.

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, ALJOYA THORNTON PLACE is or will be in compliance with this law and / or regulation on (Date) 7/10/23.

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

Administrator (or Representative) — Date 7/10/23