STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Cascade Living Group - Shelton, LLC
Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

RE: Alpine Way Retirement Apartments License # 2141

Dear Administrator:

This letter addresses Compliance Determination(s) 61052 (Completion Date 06/12/2025) and 57103 (Completion Date 04/16/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/12/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-3-d, WAC 388-78A-2320-3-e, WAC 388-78A-2160, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3100-4, WAC 388-78A-2100-2-b-i, WAC 388-78A-3090-1-c, WAC 388-78A-2474-1, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-2, WAC 388-78A-2130-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2305-2, WAC 388-78A-24642-1, WAC 388-78A-2600-2-a, WAC 388-78A-2600-2-i, WAC 388-78A-2600-2-r, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-d, WAC 388-78A-2140-5, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2620-2-a, WAC 388-78A-2620-2-b, WAC 388-78A-2260-1, WAC 388-78A-2260-2-d, WAC 388-78A-2610-1, WAC 388-78A-2610-2-d

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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

The department completed data collection for the unannounced on-site full inspection on 03/28/2025 and 04/02/2025 of:

Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

The following sample was selected for review during the unannounced on-site visit: 9 of 78 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2141	Compliance Determination # 57103
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 2 of 52	Licensee: Cascade Living Group - Shelton, LLC	04/16/2025

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.

Cory Cisneros
Residential Care Services

04/24/2025
Date

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

Administrator (or Representative)

4/24/2025
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.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 4 of 4 residents (Resident 6 [R6], Resident 4 [R4], Resident 1 [R1], and Resident 12 [R12]) received medication administration from medication technicians within their scope of practice. This failure placed all four residents at risk of receiving unsupervised nursing services by unqualified and untrained medication technicians.

Findings included...

Revised Code of Washington (RCW) 18.79.260, "Registered Nurse- activities allowed- delegation of tasks... (3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient (a) The delegating nurse shall:
(i) Determine the competency of the individual to perform the tasks;
(ii) Evaluate the appropriateness of the delegation;

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.

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Residential Care Services

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(i) Determine the competency of the individual to perform the tasks;
(ii) Evaluate the appropriateness of the delegation;

(iii) Supervise the actions of the person performing the delegated task; and
(iv) Delegate only those tasks that are within the registered nurse's scope of practice.
(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.
(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) or (f) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

Record review of the Washington State Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2025", undated, under the section titled, "medication assistance vs [versus] medication administration", showed the distinction between these two ways for individuals to receive medication was critical in determining to delegate to long term care workers or not. Medication assistance described ways to help an individual take their medication and does not need delegation. Medication administration was the way an individual received their medication from an authorized person. The task must be delegated if it was for a long-term care worker to complete. Under the section titled, "what is medication administration", showed when the client or resident was not functionally able and/or not cognitively aware they receive medication, the long-term care worker that was authorized with delegation of the medication. The long-term care worker must be delegated for each task to administer. Under the section titled, "medication assistance continued", showed for medication assistance to take place the client or resident must be both functionally able to get the medication where it needs to go (the last step) as in put it in their mouth, or apply the ointment to their own body, and they must be cognitively aware that they receive medications.

Record review of the facility's, "Disclosure of Services Required by Revised Code of Washington 18.20.300", undated, under the section titled, "intermittent nursing services", showed the facility did not have nursing assistances that provided authorized nursing services under delegation of a registered nurse. Under the section titled, "help with medications", showed the facility assisted residents with administration of their oral, topical, eye, ear, or nasal medications. The facility did not use nursing assistances under delegation of a registered nurse to administer drops, oral, and topical medications.

R6

Record review of R6's Move In Record, dated 03/06/2025, showed R6 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R6's customized service plan, dated 10/31/2024, located in the caregiver's service plan binder, under the section titled, "medication management", showed licensed staff (who were aware of resident's abilities with medications" were to consult with the pharmacy and health care provider to oversee mediation program. Staff were to order, store, and deliver medications per healthcare providers orders and licensed nurse instructions. Staff were to report any changes in needs or ability to the

licensed nurse. R6 had difficulties with speech and required extra time to find words or responded to yes/no questions. R6 talked in "word salad" (a metaphorical expression used to describe confused or unintelligible mixtures of seemingly random words and phrases that was often associated with neurological or mental disorders when speech becomes disorganized or lacks comprehensive meaning).

Record review of R6's, "encounter notes", dated 03/27/2025, showed it was a note from the hospice registered nurse (RN) visit with R6 on 03/27/2025 at 10:01 AM. The note showed R6 no longer talked and just mumbled occasionally. Staff reported that R6 experienced several syncope episodes on 03/24/2025, 03/25/2025, and 03/26/2025 that resulted in R6 not eating lunch and required to be laid down in bed.

Record review of R6's Medication Administration Record (MAR), dated 03/01/2025 through 03/31/2025, showed R6 had prescribed medication orders for acetaminophen (medication to help treat mild pain, discomfort, or elevated body temperature) one tab every four times daily, haloperidol (a prescribed medication to help treat mental conditions, behaviors, or emotional instability) one tablet by mouth/sublingually (under the tongue)/rectally up to every four hours as needed for agitation, morphine sulfate (a prescribed medication to help treat severe pain to provide comfort) IR (instant relief) take half tablet by mouth every three hours as needed for pain or shortness of breath. Review of the administrations of the medications showed all R6's administrations were administered by medication technicians. Staff DD, Medication Technician, administered R6's haloperidol on 03/14/2025, 03/19/2025, and 03/21/2025. Under the section titled, "pass notes", showed Staff DD did not document what route R6 received their haloperidol when they administered the medication.

In an interview on 03/31/2025 at 1:57 PM, R6 was lying in bed. R6 was asked if they took medications, R6 said random things that was difficult to understand. R6 was unable to answer the question if they took medications.

In an observation and interview on 03/31/2025 at 3:28 PM, Staff BB, Medication Technician, stated R6 took them medications crushed and mixed with pudding. Staff BB stated they had to spoon feed R6 their crushed medications. Staff BB stated R6 opened their mouth when the spoon was placed in front of their mouth when Staff BB was asked if R6 was aware that they took medications. At 4:22 PM, Staff BB spoon fed R6 their medications. R6 was noted to spit out chunks of the medication from their mouth, despite Staff BB encouraging R6 to take a drink of water to swallow the medication down. R6 did not verbalize anything to Staff BB during the medication administration.

R1

Record review of R1's Move In Record, dated 03/06/2025, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R1's customized service plan, dated 11/01/2024, under the section titled, "mediation management", showed R1 used the facility preferred pharmacy. Staff ordered, stored, and delivered R1 their medications per healthcare providers orders and licensed nurse instructions.

Record review of R1's MAR, dated 03/01/2025 through 03/31/2025, showed R1 took aspirin (medication to help with blood thinning and heart health) daily, atorvastatin calcium (prescribed medication to help lower cholesterol in the blood), donepezil (a prescribed medication to help decrease the progress of memory loss) daily, ferrous sulfate (medication to help increase iron in the blood and body) daily, lidocaine patch (a medicated patch that is put on the skin to help with pain and discomfort) that was put on every morning and then removed after 12 hours in the evening, lisinopril (a prescribed medication to help lower high blood pressure) daily, metformin (a prescribed medication to help lower high blood sugar levels in the blood) two times daily, and quetiapine fumarate (a prescribed medication to help treat instability in mood and behaviors) daily. Review of the administrations showed medication technicians administered R1's medications 29 of 31 days of administration.

In an interview on 04/01/2025 at 11:30 AM, R1 stated they did not take medication every day. R1 stated they were sick, when they were asked if they took medications.

R4

Record review of R4's Move In Record, dated 03/06/2025, showed R4 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R4's customized service plan, dated 10/31/2024, located in the caregiver's service plan binder, under the section titled, "medication management", showed staff ordered, stored, and delivered R4's medications per healthcare providers orders and licensed nurse instructions.

Record review of R4's MAR, dated 03/01/2025 through 03/31/2025, showed R4 took clonidine (prescribed medication to help lower high blood pressure) two times daily, donepezil daily at bedtime, losartan potassium (a prescribed medication to help lower high blood pressure) daily at bedtime, sertraline (prescribed medication to help treat mood disorder that causes excessive sadness or feeling of anxiousness) daily in the evening, simvastatin (a prescribed medication to help treat high cholesterol levels in the blood) daily in the evening, acetaminophen as needed, and hydroxyzine (a prescribed medication to help treat feeling of anxiousness, fear, excessive worrying) as needed.

Review of administration showed 29 of 31 days a medication technician had administered R4's medications to them.

In an interview on 03/31/2025 at 2:57 PM, R4 stated they did not take medication and only when they needed it. R1 stated they did not routinely take any medications or vitamins.

R12

Record review of R12's Move In Record, dated 04/11/2025, showed R12 moved into the facility on [redacted]/2023.

Record review of R12's customized service plan, dated 03/11/2025, under medication management, showed R12 used the facility preferred pharmacy. Staff ordered, stored,

and delivered medications per healthcare providers orders and licensed nurse instructions. R12 was on hospice services.

Record review of R12's MAR, dated 03/11/2025 through 03/31/2025, showed R12 had multiple medical diagnoses that included [redacted] and [redacted]. R12 had an order to crush their medications due to swallowing difficult per hospice. R12 took oral medication that included dexamethasone (prescribed steroid medication to help reduce swelling) daily for cancer pain, lorazepam (prescribed medication to help reduce anxiety and restlessness) two times daily, quetiapine fumarate daily for agitation or delirium (a condition when a person experiences confusion or disorientation), haloperidol every two hours as needed for anxiety that started on 03/29/2025, lorazepam concentrate solution every two hours as needed for restlessness and anxiety that started on 03/29/2025, and morphine sulfate take every two hours as needed for pain or shortness of breath that started on 03/29/2025.

Review of the administrations showed medication technicians administered R12's medications 15 of 20 days of administration.

In an interview on 03/31/2025 at 3:01 PM, Staff N, Nurse, stated that the licensed nurses administered the resident's treatments, wound care, insulin administration, and applications of creams. Staff N stated the medications technicians administered the resident's oral medications.

In an observation and interview on 03/31/2025 at 3:28 PM, Staff BB stated they administer medication crushed and spoon fed them to multiple residents as they would smear the medications on them or they were unable to take the medications independently.

In an interview on 04/01/2025 at 2:43 PM, Staff EE, Medication Technician, stated they administered crushed medications mixed with yogurt to multiple medications in the memory care locked unit. Staff EE stated they also administer medications that included morphine, Ativan (prescribed medication to help reduce feeling of worrying, anxiousness, or provide comfort and relaxation) or lorazepam, and other narcotics to residents that were end of life comfort care. Staff EE stated they did administer R12 their end of life medication leading up to them passing away on [redacted]/2025.

In an interview on 04/02/2025 at 12:17 PM, Staff B, Registered Nurse Wellness Director, stated all the licensed nurses that work administer residents topicals, eye drops, blood sugar checks, and insulin injections. The medications technicians administer resident's oral medications. All resident's orders that were listed on the MAR were to be administered by the medication technician and the treatment administration record were administered by the licensed nurses.

Statement of Deficiencies	License #: 2141	Compliance Determination # 57103
Plan of Correction	Alpine Way Relirement Apartments	Completion Date
Page 7 of 52	Licensee: Cascade Living Group - Shelton, LLC	04/16/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/30/25.

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

Administrator (or Representative) Tracey Hunter Date 4/24/25

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record, review the facility failed to provide the care and services as agreed upon in the residents customized service plan (facility's version of the negotiated service agreement) for 2 of 5 assisted living residents (Resident 6 [R6] and Resident 5 [R5]). This failure resulted in residents not receiving specialized care as agreed upon and placed both residents in the facility at risk for unmet care needs and service needs.

Findings included...

Record review of the facility's Disclosure of Services Required by Revised Code of Washington 18.20.300, undated, under section titled, "services/care", showed the assisted living must provide the care and services according to what was agreed on in the residents negotiated service agreement.

Record review of the facility's wellness policies and procedures titled, "customized service plan", dated "09/2011", showed all residents living at the assisted living licensed rooms would have a customized service plan based upon their needs to ensure the resident's needs could be safely met within the community.

R6

Record review of R6's Move In Record, dated 03/06/2025, showed R6 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted] and [redacted].

Plan/Attestation Statement

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Administrator (or Representative) Date

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R6

Record review of R6's Move In Record, dated 03/06/2025, showed R6 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R6's order, dated 03/13/2025, showed "wound care geri legs and sleeve [material used to cover and protect the skin]to be worn when patient up in wheelchair daily".

Record review of R6's customized service plan, dated 10/31/2024, located in the caregiver's binder, showed geri sleeves and geri legs were to be applied every morning and removed every night at bedtime that was put in place on "03/13". Under the section titled, "supportive devices", showed on 01/27/2023 staff were to ensure supportive device was in place and notify LN (licensed nurse) if not working or needs repair. Fall mat to the floor beside R6's bed, while R6 was in bed.

Record review of R6's, "encounter notes", dated 03/27/2025, showed it was a note from the hospice registered nurse visit with R6 on 03/27/2025 at 10:01 AM. The note showed R6 had a skin tear to the left shin. R6 had geri sleeves and legs ordered and were available, but not in use. R6's skin was fragile and bruised easily. Staff continued to forget to apply sleeves, despite they were visibly in the room.

Record review of R6's Treatment Administration Record, dated 03/01/2025 through 03/31/2025, showed R6 had an order for geri sleeves/arms with the directions for care staff to apply geri sleeves to arms and legs every morning before R6 got up into the wheelchair everyday and to remove the geri sleeves at bed time. The order started on 03/13/2025. Review of administration on 03/31/2025, showed R6's geri sleeves were put on their arms and legs as documented by Staff I, Licensed Practical Nurse. On 03/28/2025, Staff N, Nurse, documented that R6's geri sleeves were put on R6's arms and legs that morning.

Record review of R6's Treatment Administration Record, dated 04/01/2025 through 04/11/2025, showed R6 had an order for geri sleeves/arms with the directions for care staff to apply geri sleeves to arms and legs every morning before R6 got up into the wheelchair everyday and to remove the geri sleeves at bed time. Review of administrations showed R6's geri legs on 04/01/2025 AM were signed off by Staff I that they were put on R6. There was a note within the order that showed "suspended 01 April 2025 to 27 April 2025: unsuspend when product arrives". Review of administration on 04/01/2025, showed Staff I documented that R6 had the geri sleeves on.

In an observation on 03/28/2025 at 12:32 PM, R6 was up in the wheelchair sitting at a dining room table being assisted with lunch. R6 wore a short sleeve shirt with their arms exposed with no geri sleeves on. R6 wore pants, with lower legs exposed without any geri legs on.

In an observation on 03/31/2025 at 11:22 AM, in the assisted living assisted dining room, R6 was up in their wheelchair sitting at a dining room table. R6 wore a coral-colored dress with their arms exposed without any geri sleeves on. R6 did not have any geri legs on as their legs were exposed and could observed the discoloration to their shins and the scabbed area on their right shin. At 1:57 PM, R6 was in their room lying in bed. On the ground under the bed was a blue fall mat. R6 did not have any geri sleeve on when they were lying in bed. At 4:00 PM, upon walking into R6's room the blue fall mat was under R6's bed. Staff G, Care Associate, stated the blue fall mat was to be beside the bed and not under the bed. Staff G had assisted R6 transfer into their wheelchair with Staff H, Care Associate. Staff G and Staff H did not put on R6's geri sleeves or geri legs before Staff H wheelchair R6 in their wheelchair down to the

assisted dining room for dinner.

In an observation on 04/01/2025 at 12:31 PM, R6 was sitting upright in their wheelchair in the assisted living assisted dining room being assisted with eating for lunch. R6 was observed to not have geri sleeves on both arms.

In an observation on 04/02/2025 at 10:59 AM, R6 was lying in their bed. R6's blue fall mat was under R6's bed and not beside it. At 11:33 AM, R6 was up in their wheelchair sitting at a dining room table waiting for lunch to be served. R6 lower legs were exposed, as their pant leg was pushed up to mid-calf area. R6 did not have any geri legs on their legs.

R5

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R5's, "Service Plan Report", dated 10/29/2024, showed ambulation and transfer section indicated R5 was a one-person escort to and from meals, used footrests when transporting R5 and remove after so R5 could pedal around. The falls section showed ensure equipment controls such as drinks and remotes were within reach at bedside. The diet section showed R5 was supposed to receive a nutritional supplement or high calorie snack provided between meals for weight maintenance. The eating meals section showed R5 required hands on assistance to complete meal "at times needs assistance, use new adaptive silverware and drink cups, wash and allow dry in residents room." Give health shake three times a day with meals. The document had been signed by Collateral Contact 2 (CC2), R5's resident representative, Staff A, Executive Director, Staff B, Registered Nurse, Wellness Director, and the Business Office Manager.

In an observation on 03/28/2025 at 12:32 PM, in the assisted living assisted dining room, R5 sat in their tilt n space wheelchair (a specialized wheelchair that allowed the entire seat to tilt backward which helped improve posture and alleviate pressure) with their footrests on. R5 ate independently with a normal silver spoon and fork. R5 had dropped food from their silverware when they tried to put a bite of food in their mouth.

In an observation on 03/31/2025 at 4:20 PM, in the assisted living assisted dining room, R5 sat up in their tilt n space wheelchair with the footrests on with R5's feet rested on the ground in front of the footrests. R5 was getting set up for dinning and noted that R5 had a normal silver fork and spoon on the table where they sat.

In an observation and interview on 04/01/2025 at 12:00 PM, in the assisted living dining room, R5 sat in their tilt n space wheelchair with the footrests on. It was noted that R5 had a normal silver fork and spoon on the table where they sat. Staff Z, Care Associate, said R5 was mostly independent with eating, but their hand shook at times. Staff Z said they had to physically feed R5 at times. Staff Z said they were about to assist R5 with eating their meal. Staff Z said they had been unsure if R5 was supposed to use an adaptive cup or silverware during their meals. Staff Z said historically R5 had used silverware that rotated to prevent spillage, but they thought R5 ate better with regular silverware. At 12:10 PM, R5 had been observed to have their head down and shoulders hunched

forward. R5's hand visibly shook as they attempted to bring the spoon to their mouth. At 12:11 PM, R5 dropped their tapioca pudding cup on the floor. At 12:12 PM, Staff Z brought R5 another pudding cup of dessert. At 12:14 PM, it appeared as if R5 had tried to get a bite of tapioca pudding from the cup. R5's spoon missed the cup and R5 motioned the spoon forward multiple times on the napkin that had been placed on their lap. Staff Z approached R5 and physically fed R5 their pudding. After R5 finished their dessert Staff Z stated that they did not take the footrests off of R5's tilt n space wheelchair while they ate.

In an observation and interview on 04/02/2025 at 11:32 AM, in the assisted living dining room, R5 sat in their tilt n space wheelchair with their footrests on. R5 had a normal silver fork and spoon on the table where they sat. The Department inquired with Staff AA, Dining Services Associate, if R5 used adaptative silverware. Staff AA had been observed to go into the drawer and retrieved a grey spoon and fork with thick bottoms. Staff AA had been observed to replace the normal spoon and fork with the adaptative silverware.

In an observation and interview on 04/02/2025 at 10:36 AM, R5 sat up right in their tilt n space wheelchair inside of their room. Staff P, Medication Technician, provided R5's their ensure (health shake) with a straw. Staff P also provided R5 a container of vanilla ice cream and said they needed to get R5 a spoon. Staff P left the room and returned with a regular spoon that they provided to R5. Staff P said they thought R5's adaptative silverware was stored in the Willow dining room. Staff P looked inside of R5's cupboard above the kitchenet and repeated they thought the adaptive silverware might be in Willow. Staff P said it depended on the day if R5 needed physical assistance with eating. R5 had been observed to struggle to put the spoon inside of the ice cream container. R5 repeatedly missed the container and melted ice cream got on their pants. Staff P had been observed to get a shirt protector and placed a towel on R5's lap. At 10:43 AM, Staff P had been observed to start physically assisting R5 to eat their ice cream until it was finished. Staff P said they had been unsure if R5 was supposed to receive their ensure shake in-between meals or during meals. Staff P said they had intentions to put R5's ensure in a red cup with a lid and straw but had been unsure where the extra cups were located. At 10:51 AM Staff P placed R5's ensure cup on the kitchenet counter, which was out of reach of R5 and exited the room.

In an interview on 04/02/2025 at 11:12 AM, Staff I, Licensed Practical Nurse, looked at their computer and said that R5 had two orders for health shakes. Staff I said R5 was supposed to get a health shake three times a day if they ate less than 50% of their meal. Staff I said the other order said offer R5 a health shake three times a day with meals. Staff I said the facility staff were offering R5 their health shake in between meals. Staff I said R5's adaptative silverware should be in the Willow dining room.

In an interview on 04/01/2025 at 9:15 AM, CC2 confirmed R5 used a tilt and space wheelchair. CC2 said the facility purchased R5 adaptative silverware to use at mealtimes. CC2 said R5 had good days and bads days in regard to independently eating.

In an interview on 04/01/2025 at 12:23 PM, Staff U, Medication Technician and Staff V, Care Associate, confirmed R5 used a tilt n space wheelchair. Staff U and Staff V said they were supposed to take the footrests off R5's tilt n space wheelchair. Staff U said they took the footrests off during mealtimes.
Staff U said yesterday on 03/31/2025 they noticed R5 had a difficult time eating

independently and helped feed them their lunch. Staff U and Staff V said R5 used adaptative silverware that turned to prevent spillage.

This is a recurring deficiency previously cited on 05/02/2024.

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 4/24/25

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;

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to secure potentially hazardous supplies accessible to memory care residents in 4 of 4 locations within the facility (Resident 1's [R1] bathroom, Resident 4's [R4] bathroom, Ever Fit Room, and Assisted Living Resident Laundry Rooms). This failure placed 78 of 78 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 03/28/2025, showed there were four residents that resided on the assisted living side of the facility that were documented to have Dementia (a group of brain disorders that affect a person's memory, ability to reason, and thinking)/Alzheimer's(a progressive brain condition that effects a person's ability to

independently and helped feed them their lunch. Staff U and Staff V said R5 used adaptative silverware that turned to prevent spillage.

This is a recurring deficiency previously cited on 05/02/2024.

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(1) The residents' characteristics and needs;

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

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to secure potentially hazardous supplies accessible to memory care residents in 4 of 4 locations within the facility (Resident 1's [R1] bathroom, Resident 4's [R4] bathroom, Ever Fit Room, and Assisted Living Resident Laundry Rooms). This failure placed 78 of 78 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 03/28/2025, showed there were four residents that resided on the assisted living side of the facility that were documented to have Dementia (a group of brain disorders that affect a person's memory, ability to reason, and thinking)/Alzheimer's(a progressive brain condition that effects a person's ability to

think, reason, and perform activities of daily living needs) /Cognitive impairment. The roster showed 26 of 27 residents that resided in the locked memory care area of the facility were documented to have Dementia/Alzheimer's/Cognitive impairment.

R1

Record review of R1's Move In Record, dated 03/06/2025, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

In an observation on 03/31/2025 at 3:25 PM, inside R1's unlocked bathroom in the unlocked stand up shower stall, there were three bottles that were sitting on the shelf. One of the bottles was 28 fluid ounce dark blue that showed Suave Men citrus & sandal wood scent daily clean shampoo. The men's shampoo had multiple ingredients that included sodium benzoate (a chemical compound commonly used as a preservative) and sodium C12-13 Pareth sulfate (a cleansing agent used to help mix water and oil for effective cleaning and lather). Another bottle that was four fluid ounces of cleanse no-rinse foam cleaner, and the other bottle was 27 fluid ounce Kirkland body wash. The Kirkland bottle had handwritten in black marker " [Resident initials] 407". The body wash had multiple ingredients that included sodium hydroxide (a highly corrosive, white, waxy, colorless solid, that can cause severe burns to the eyes, skin, digestive system or lungs resulting in permanent damage or death in high concentrations).

In an observation on 04/01/2025 at 2:16 PM, inside R1's bathroom in the shower on the shelf were the same three bottles observed the day prior that included the blue bottle of men's suave shampoo, Kirkland body wash, and bottle of no-rinse foam cleaner all unlocked.

R4

Record review of R4's Move In Record, dated 03/06/2025, showed R4 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

In an observation on 03/31/2025 at 2:53 PM, inside R4's bathroom on the shelf and countertop was a large bottle full of green liquid with the label "Listerine fresh burst antiseptic mouthwash". On the back of the mouth wash bottle showed it had multiple ingredients that included eucalyptol (a colorless liquid that is used as an antibacterial agent that kills germs that can be toxic if consumed by mouth) and methyl salicylate (a topical analgesic and anti-inflammatory agent and if ingested is very poisonous). The label showed, "keep out of reach of children, if more than used for rinsing is accidentally swallowed, get medical help or contact a poison control center right away." On the counter was a tube of crest toothpaste and a white container of "dove" deodorant all unlocked and accessible to residents. In R4's shower was a large 27.7 fluid ounce bottle of Pantene pro-v repair and protect shampoo that was unlocked. The label showed the shampoo had multiple ingredients that included sodium benzoate and sodium lauryl sulfate (a chemical that is used to help remove oily substances and create foam).

Ever fit Room

In an observation on 03/28/2025 at 10:01 AM, the doors to the Ever fit room had been

propped open. On the counter by the sink there was a container of great value disinfecting wipes.

In an observation on 04/02/2025 at 12:45 PM, the doors to the Ever fit room had been propped open. On the counter by the sink there was a container of great value disinfecting wipes.

Assisted Living Resident Laundry Rooms

In an observation on 03/28/2025 at 9:45 AM, the unlocked laundry room located across from room 149 showed in an unlocked cabinet was 103 fluid ounces of Downy free and gentle laundry detergent (laundry soap) and 31 fluid ounces of Tide simply all in one (laundry soap).

In an observation on 03/31/2025 at 2:11 PM, the unlocked laundry room located across from room 127 showed in an unlocked cabinet were three rectangular pods with an unknown blue substance inside of them. In a refresh water bottle half the container had been filled with an unknown blue liquid substance.

In an observation on 04/01/2025 at 1:11 PM, the unlocked laundry room located across from room 127 showed in an unlocked cabinet were three rectangular pods with an unknown blue substance inside of them. In a refresh water bottle half the container had been filled with an unknown blue liquid substance.

In an interview on 04/01/2025 at 1:12 PM, Staff Q, Housekeeper, said chemicals in the facility were supposed to be stored in a locked cart or locked storage room. Staff Q said sometimes for convenience the residents stored their laundry detergents inside of the laundry rooms. Staff Q said all chemicals inside of the memory care unit should be in a locked closet or locked drawer.

In an interview on 04/01/2025 at 2:32 PM, Staff O, Care Associate, stated chemicals, shampoo, soaps, or anything that is not edible were to be locked up in the residents rooms in their lockable closet or the lockable drawer in the bathroom.

In an interview on 04/02/2025 at 10:43 AM, Staff L, Care Associate, stated all memory care residents supplies that included, shampoo, toothpaste, mouth wash were to be locked up in the their closest, or in the lockable drawer in the bathroom. Staff L stated no supplies were to be left out in the residents bathroom or room for them to access without staff present.

In an interview on 04/02/205 at 11:01 AM, Staff M, Care Associate, stated all of the memory care resident's bathroom supplies were to be locked up in their lockable closet or in the lockable drawer in the bathroom.

Plan/Attestation Statement

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Administrator (or Representative) Tracy Hunter Date 4/24/25

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(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 complete ongoing assessments focused on residents identified problems for 1 of 2 sampled resident (Resident 5 [R5]). This failure placed R5 at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included...

Record review of the facility policy titled, "Transfer & Positioning Devices", dated "11/2023", showed residents who wished to use positioning devices as a mobility aid would be assessed for safety. Examples included side rail and customized position wheelchair devices. The procedure section showed an order from the resident's physician would be needed, a complete transfer device safety assessment, update the customized service plan, and reassess and meet with the resident or resident's representative annually or more frequently as needed to review the continued use of the devices.

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R5's, "Service Plan Report", dated 10/29/2024, showed under supportive devices that R5 used half of a side rail on the right side of their bed. Under

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Findings included...

Record review of the facility policy titled, "Transfer & Positioning Devices", dated "11/2023", showed residents who wished to use positioning devices as a mobility aid would be assessed for safety. Examples included side rail and customized position wheelchair devices. The procedure section showed an order from the resident's physician would be needed, a complete transfer device safety assessment, update the customized service plan, and reassess and meet with the resident or resident's representative annually or more frequently as needed to review the continued use of the devices.

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R5's, "Service Plan Report", dated 10/29/2024, showed under supportive devices that R5 used half of a side rail on the right side of their bed. Under

ambulation and transfer section showed R5 used a wheelchair. The document had been signed by Collateral Contact 2 (CC2), R5's resident representative, Staff A, Executive Director, Staff B, Registered Nurse, Wellness Director, and the Business Office Manager.

Record review of R5's, "Transfer/Positioning/Alarm Device Assessment & Consent", dated 03/18/2021, showed the type of device was a tilt and space wheelchair (a specialized wheelchair that allowed the entire seat to tilt backward which helped improve posture and alleviate pressure). The reason for the request indicated balance deficit and instability of trunk and or limbs. "The device will be documented on the resident's service plan and evaluated at least annually." The documented was signed by the facility nurse on 03/18/2021.

In an observation on 04/01/2025 at 1:05 PM, R5's bed had a half side rail that was located on the right-hand side of their bed. R5's tilt and space wheelchair had been located next to their bed.

In an interview on 04/01/2025 at 9:15 AM, CC2 confirmed R5 used a tilt and space wheelchair.

In an interview on 04/01/2025 at 12:23 PM, Staff U, Medication Technician and Staff V, Care Associate confirmed R5 used a tilt and space wheelchair. Staff V confirmed R5 used a side rail.

In an interview on 04/02/2025 at 12:17 PM, Staff B, said they requested their staff complete annual assisted device assessments on any device that could cause harm. Staff B said they did not complete an updated assessment on residents who used tilt and space wheelchairs often unless they saw an issue such as a weight change or the resident's position did not appear right.

In an interview on 04/02/2025 at 1:23 PM, Staff B acknowledged their facility policy indicated assisted device assessments should be completed annually. Staff B acknowledged that R5's last tilt and space assessment had been completed in 2021.

Record review of R5's file on 03/31/2025, showed there had been no "Transfer/Positioning/Alarm Device Assessment & Consent" assessment to review related to R5's half side rails on the right side of their bed.

Statement of Deficiencies	License #: 2141	Compliance Determination # 57103
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 16 of 52	Licensee: Cascade Living Group - Shelton, LLC	04/16/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/30/25.

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

Administrator (or Representative) Trudy Hunter Date 4/24/25

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 1 of 5 assisted living residents (Resident 6 [R6]) care areas reviewed. This failure placed R6 at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained adaptive equipment.

Findings included...

Record review of the facility's Disclosure of Services Required by Revised Code of Washington 18.20.300, undated, under the section titled, "housekeeping", showed the assisted living facility must maintain resident livings quarters and areas residents may use in a safe, clean, and comfortable condition.

Record review of R6's customized service plan, dated 10/31/2024, located in the caregiver's binder, under the section titled, "supportive devices", showed on 01/27/2023 staff were to ensure R6's supportive device was in place and to notify the LN (licensed nurse) if not working or needed repair. Fall mat was to be on the floor beside R6's bed, while R6 was in bed.

In an observation on 03/31/2025 at 1:57 PM, inside R6's room, under the bed was a blue fall mat. On the end of one side of the blue fall mat, the blue material was ripped that exposed yellow foam that was inside.

In an observation on 04/02/2025 at 1:10 PM, inside R6's room, under the bed was R6's fall mat. The end of the fall mat's blue wipeable material was ripped and exposed yellow foam that was inside. At 4:00 PM, Staff G, Care Associate, picked up R6's blue fall mat that was on the ground under the bed. When Staff G picked the fall mat up, one of the sides had exposed yellow foam. The blue material had been ripped and was loose from the yellow foam material of the fall mat.

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In an interview on 04/04/2025 at 1:23 PM, Staff A, Executive Director and Staff B, Registered Nurse Wellness Director, stated they did not have knowledge that R6's blue fall mat had been ripped with foam exposed. Staff B confirmed that foam being exposed would be an infection prevention control matter and the mat needed to be repaired.

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Administrator (or Representative) 4/24/25 Date

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

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

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

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 3 staff (Staff D and Staff E) completed their facility orientation training within the required time. The facility failed to ensure 1 of 2 new staff (Staff C) completed their dementia and mental health specialty certificates. The facility failed to ensure 2 of 5 staff (Staff D and Staff E) completed and maintained their CPR (Cardiopulmonary Resuscitation, chest compressions and rescue breaths to restart a person's breathing and heartbeat), and first Aid Card. The facility failed to ensure 2 of 4 staff (Staff D and Staff C) maintained their Washington state Department of Health credentials. These failures placed 78 of 78 residents at risk of being improperly cared for by untrained and unlicensed staff.

Findings Included...

In an interview on 04/04/2025 at 1:23 PM, Staff A, Executive Director and Staff B, Registered Nurse Wellness Director, stated they did not have knowledge that R6's blue fall mat had been ripped with foam exposed. Staff B confirmed that foam being exposed would be an infection prevention control matter and the mat needed to be repaired.

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Findings Included…

Washington Administrative Code (WAC) 388-112A-0060 “What are the training and certification requirements for volunteers and long-term care workers in assisted living facilities and assisted living facility administrators? (1) The following chart provides a summary of the training and certification requirements for a volunteer, an administrator or designee, and a long-term care worker in an assisted living facility that showed for an licensed practical nurse, home care aid, nursing assistant registered under the section titled, “required credentials”, showed must maintain in good standing the certification or other professional role listed in WAC 388-112A-0090.”

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed?
There are two types of orientation training: Facility orientation training and long-term care worker orientation training.
“(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.”
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. (b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire. (c) The form of the first-aid or CPR card or certificate may be electronic or printed. “

WAC 388-112A-0400 “(1) Specialty training refers to approved curricula that meets the requirements of Revised Code of Washington 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450. (b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement. (c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (b) Dementia specialty training as described in WAC 388-112A-0440; (4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (b) Dementia specialty training

as described in WAC 388-112A-0440; and (5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire. (6) For long-term care workers who have completed the 75-hour training and do not have a specialty training certificate that indicates completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs."

WAC 388-112A-0490 "What are the specialty training requirements for applicants, resident managers, administrators, and other types of entity representatives in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities. (3) If an assisted living facility serves one or more residents with special needs, the assisted living facility administrator or designee must complete specialty training and demonstrate competency within one hundred twenty days of date of hire. (4) If a resident develops special needs while living in an assisted living facility, the assisted living facility administrator or designee has one hundred twenty days to complete specialty training and demonstrate competency, or demonstrate proof of specialty training."

Record review of untitled and undated facility document that was a list of employees, showed Staff C, Care Associate, started employment at the facility on 11/14/2024, Staff D, Nurse, started employment at the facility on 10/30/2024, and Staff E, Care Associate, started employment at the facility on 01/14/2025.

Record review of the facility's policy titled, "long term care worker training requirements (Washington)", dated "September 2011" showed the following grid explains the on-going licensing and training requirements to maintain active employment with our community. The grid showed licensed nurses were to obtain CPR only within 30 days of employment and must maintain valid card. All other care associates were to obtain CPR and first aid both within 30 days of employment and must maintain valid card. Staff were to complete specialty trainings for dementia and mental health within 120 days of hire.

Record review of the facility's wellness policies and procedures titled, "care associate orientation and ongoing training", dated "09/2011", showed the facility would provide standard employee orientation as required by applicable regulations. Each new associate would receive general community and safety orientation prior to working independently in the community accordance with applicable laws. Documentation of all training for the associate would be maintained in the associate's confidential file.

Record review of the facility's document titled, "[facility name] continuing care community new employee required documents", undated, showed that all staff that required to take the mental health and dementia training were to complete the training by 120 days after being hired.

On 03/28/2025 at 12:23 PM, the Department requested Staff D, Staff E, and Staff C's, employees file for review that included their facility orientation, copy of credentials, all certificates of training for review.

On 03/28/2025 at 2:31 PM, the following staff records were requested to review that included Staff C's CPR and First Aid card, and current credentials, Staff D's facility

orientation for review, and Staff E's CPR and First Aid card for review.

Facility orientation

Record review on 03/28/2025 of Staff D's employee file showed there was no facility orientation completed for review.

Record review of Staff E's "associate orientation/training checklist", dated 03/18/2025, showed it was completed 63 days after Staff E was hired at the facility.

In an interview on 04/01/2025 at 3:38 PM, Staff A, Executive Director, stated they did not have a completed facility orientation for Staff D for review.

Credentials

Staff D

Record review of Staff D's State of Washington Department of Health Credential Verifications, dated 10/24/2024, showed Staff D's Licensed Practical Nurse credentials were to expire on 03/31/2025.

Record review of Staff D's State of Washington Department of Health Credential Verifications, dated 04/01/2025, showed Staff D's Licensed Practical Nurse credentials were expired.

Staff C

Record review of Staff C's State of Washington Department of Health Credential Verifications, dated 01/23/2025, showed Staff C's nursing assistant registration expired on 03/21/2025.

Record review of the State of Washington Department of Health Database on 03/28/2025 at 2:38 PM, showed Staff C's nursing assistant registration was expired.

In an interview on 03/31/2025 at 3:09 PM, Staff A, Executive Director, stated all staff credentials were tracked by the business office.

Specialty Training

On 03/28/2025 at 12:23 PM, the Department requested Staff C's, Care Associate, employee file for review that included all certificates of training for review.

Record review on 03/28/2025 of Staff C's employee file, showed there was no mental health or dementia specialty training certificates for review. Staff C should have completed their mental health and dementia specialty training certificates by 03/14/2025.

CPR/1st aid

Record review of Staff D's Basic Life Support CPR card, dated 01/31/2023, showed the CPR card was to be renewed by 01/2025.

Record review of Staff E's CPR and First Aid card, dated 02/24/2019, showed it expired on 02/24/2021.

In an interview on 04/01/2025 at 1:12 PM, Staff HH, Concierge, stated Staff D worked Sunday through Wednesday night shift as the only licensed nurse for the assisted living and memory care areas of the facility.

In an interview on 03/31/2025 at 3:15 PM, Staff B, Registered Nurse Wellness Director, stated Staff D and Staff E did not have a valid CPR and first aid card on file for review. Staff B acknowledged that Staff D and Staff E CPR and First Aid cards were expired.

In an interview on 04/01/2025 at 2:27 PM, Staff J, Business Office Manager, said that Staff S, Receptionist, had been responsible to manage the employee's files. Staff J said the facility staff referenced the "New Employee Required Documents" form to know when specific requirements were due.

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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/30/25.

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

Administrator (or Representative) — Date 4/24/2025

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

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(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

Record review of Staff E's CPR and First Aid card, dated 02/24/2019, showed it expired on 02/24/2021.

In an interview on 04/01/2025 at 1:12 PM, Staff HH, Concierge, stated Staff D worked Sunday through Wednesday night shift as the only licensed nurse for the assisted living and memory care areas of the facility.

In an interview on 03/31/2025 at 3:15 PM, Staff B, Registered Nurse Wellness Director, stated Staff D and Staff E did not have a valid CPR and first aid card on file for review. Staff B acknowledged that Staff D and Staff E CPR and First Aid cards were expired.

In an interview on 04/01/2025 at 2:27 PM, Staff J, Business Office Manager, said that Staff S, Receptionist, had been responsible to manage the employee's files. Staff J said the facility staff referenced the "New Employee Required Documents" form to know when specific requirements were due.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(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 facility failed to update the customized service plan (facility's version of the negotiated service agreement) for 2 of 9 residents (Resident 4 [R4] and Resident 5 [R5]) when they had a change in condition and behaviors. The facility failed to complete an NSA within 30 days following admission to the facility for 2 of 4 newly admitted residents (Resident 3 [R3] and Resident 9 [R9]). These failures placed all residents at risk of unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's wellness policies and procedures titled, "customized service plan", dated "10/2021", showed all residents living in the assisted living licensed rooms would have a customized service plan based upon their needs and preferences for services delivery, agreed upon by the community as well as by coordination of outside services, to ensure the resident's needs can be safely met within the community. The resident and/or resident's responsible party would be notified of the charges associated with services reflected in the customized service plan that was reviewed prior to move in, within 14 days following the move-in date, and every six months thereafter, or with a significant change in condition. A copy of the customized service plan would be maintained in the wellness record and made available for associate's reference. A copy of the customized service plan signature page was placed in the resident's administrative record in the business office, as well as the wellness record. Signatures may be completed electronically. Temporary service plans (TSP) were implemented when there was a change of condition that required monitoring or change in care tasks and services on a temporary basis. The TSP would be made available for associates to read and follow. TSPs that became long term in nature would be incorporated into the customized service plan.

Update Service Plan

R4

Record review of R4's Move In Record, dated 03/06/2025, showed R4 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R4's emergency department discharge summary, dated [redacted]/2025, , showed R4 was diagnosed with [redacted] and [redacted]. Under the section titled, "education materials", showed rehydration was the replacement of body fluids, salts, and minerals or electrolytes that were lost during dehydration. Dehydration was when there was not enough fluid or water in the body that could cause

by but not limited to, not drinking enough fluid. Symptoms of mild dehydration included thirst, dry lips and mouth, dry skin, and dizziness, whereas severe dehydration included increased heart rate, confusion, and not urinating. Rehydration can occur by drinking certain fluids and intravenously per the health care provider.

Record review of the caregiver's service plan binder on 04/01/2025, showed the current customized service plan for R4 was dated 10/31/2024. There was nothing documented on R4's service plan that showed R4 had a recent hospital stay that resulted in R4 being dehydrated and the need to encourage fluids.

In an observation and interview on 03/31/2025 at 2:45 PM, R4 was in their room. R4 was observed to have dry cracked lips and mouth. R4 frequently rubbed their lips with their hand side to side. It was observed on multiple occasions when R4 talked their upper lip would get caught curled up on the upper top teeth from their mouth being dry. R4 stated they were so thirsty and entered the bathroom and got some water from the sink for their mouth. R4 was able to talk clearer after they moistened their mouth with water.

In an interview on 04/01/2025 at 2:23 PM, Staff O, Care Associate, stated that R4 often rubs her mouth a lot and become dry. Staff O stated R4 was unable to tell the staff that they were thirsty.

In an interview on 04/02/2025 at 11:10 AM, Collateral Contact 1 (CC1), Spouse of R4, stated R4 had a difficult time remembering what they want or need. R4 recently when out to the hospital for dehydration that required R4 to get two bags of fluid when R4 was in the emergency room. CC1 stated they put the small refrigerator in R4's room on Saturday 03/29/2025 and put bottles of water and Gatorade in there for the staff to offer to R4 to drink.

In an interview on 04/02/2025 at 10:43 AM, Staff L, Care Associate, stated R4's mouth dries out fast and needed to be encouraged to drink fluids often. Staff L stated they were to offer R4 during activities and after activities.

In an observation and interview on 04/02/2025 at 11:05 AM, Staff R, Life Enrichment Director, brought R4 back into the locked memory care unit. Staff R told Staff M that R4 needed something to drink as their mouth was very dry.

Assessment

Record review of R4's hard medical chart on 04/02/2025 at 1:00 PM, showed there was no temporary service plan completed for R4's recent hospitalization and dehydration on [redacted]/2025 for review.

In an interview on 04/02/2025 at 12:17 PM, Staff B, Registered Nurse Wellness Director, stated a TSP should have been completed for when R4 was seen at the emergency department for dehydration. Staff B stated all TSP's were filed under the assessment tab in the residents medical hard chart for review.

R5

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and

[redacted].

Record review of R5's, "Service Plan Report", print dated 04/01/2025, showed it was the most updated service plan for R5. The communication section showed R5 could make themselves understood, and to give R5 time to express themselves. The cognitive/behavioral support/mental health section showed R5 had episodes of hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not actually there) or delusions (a false belief that conflicted with reality despite evidence to the contrary). The diet section showed on 08/30/2023 R5 was to have a nutritional shake or high calorie snack provided between meals for weight maintenance.

Record review of the caregiver's service plan binder on 04/02/2025, showed the current customized service plan for R5 was signed by facility staff members from 11/02/2024 - 03/08/2025 and the print date on the document showed it was printed out on 10/29/2024. The communication section showed R5 could make themselves understood, and to give R5 time to express themselves. The cognitive/behavioral support/mental health section showed R5 had episodes of hallucinations or delusions. The diet section showed on 08/30/2023 R5 was to have a nutritional shake or high calorie snack provided between meals for weight maintenance. The eating meals section showed on 09/30/2022 that R5 was supposed to be given health shake three times a day at meals.

Record review of R5's, "Progress Notes", dated 02/23/2025, showed Staff N, Nurse, wrote R5 was extremely confused, R5 had a transient thought process (disruption in one's thoughts), and had been combative with staff.

Record review of R5's, "Progress Notes", dated 03/16/2025, showed Staff N, wrote care staff attempted to assist R5 to lay down and R5 slapped the care staff in the face.

In an interview on 04/01/2025 at 12:23 PM, Staff U, Medication Technician said R5 Parkinson's caused their hands to have random movements which they thought frustrated R5. Staff U said if the facility staff knew R5 was frustrated they would verbally inform one another during rounds.

In an observation and interview on 04/02/2025 at 10:36 AM, Staff P, Medication Technician, provided R5 their ensure (health shake) with a straw. Staff P said they had been unsure if R5 was supposed to receive their ensure shake in-between meals or during meals. Staff P said they had heard R5 had been combative. Staff P then said maybe not combative but more angry and feisty. Staff P said R5's demeanor had been new, and it would be considered a behavior. Staff P went into R5's service plan binder for caregivers to review that was at the nurse's station and confirmed that R5 being angry and feisty had not been documented in R5's service plan.

In an interview on 04/02/2025 at 11:12 AM, Staff I, Licensed Practical Nurse, looked at their computer and said that R5 had two orders for health shakes. Staff I said R5 was supposed to get a health shake three times a day if they ate less than 50% of their meal. Staff I said the other order said offer R5 a health shake three times a day with meals. Staff I said the facility staff were offering R5 their health shake in between meals. Staff I said they had not experienced R5 becoming combative with facility staff. Staff I said residents acted different with morning shift workers compared to evening shift workers. Staff I said R5 had not had negative behaviors with day shift workers.

Staff I said R5 had been very confused but R5's demeanor could be affected by the facility staff's approach.

In an interview on 04/02/2025 at 12:17 PM, Staff B, Registered Nurse/ Wellness Director, said if a resident had behaviors, it should be documented in the service plan to review. Staff B said when a resident's service plan had been updated then they put the updated copy into the resident's binder and flag it, so facility staff knew to review the information and sign off on it. Staff B said service plans were living documents and could change often. Staff B said they encouraged the facility staff to write in the service plan as needed.

Record review of the caregiver's service plan binder on 04/02/2025, showed the current customized service plan for R5 was signed by facility staff members from 11/02/2024 - 03/08/2025 and the print date on the document showed it was printed out on 10/29/2024. The communication section showed R5 could make themselves understood, give R5 time to express themselves. The cognitive/behavioral support/mental health section showed R5 had episodes of hallucinations or delusions. There was nothing documented on R5's service plan that showed R5 had combative with staff and interventions staff should try when R5 had been combative.

In an interview on 04/02/2025 at 1:23 PM, Staff B expressed understanding that R5's most updated service agreement had not been placed inside of the caregiver's service plan binder for staff to review. Staff B expressed understanding there had been a discrepancy of when the facility staff were to offer R5 their health shake.

30 Day Service Plan

R3

Record review of R3's, "Move In Record", dated 03/06/2025, showed R3 moved into the facility on [redacted]/2024 with multiple medical diagnosis that included [redacted].

Record review on 03/31/2025 at 11:00 AM, of R3's administrative file from the business office, showed there was only one customized signed service plan, dated 12/19/2024, completed and signed for R3 for review.

Record review of an untitled and undated document that was provided on 04/03/2025 at 12:43 PM, showed R3 had a 14-day level of care assessment completed on 01/07/2025. The list did not show there was a customized service plan completed on that day.

R9

Record review of R9's Move In Record, dated 03/06/2025, showed R9 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Record review on 03/31/2025 at 11:00 AM, of R9's administrative file from the business office, showed there was only one customized signed service plan, dated 02/11/2025, completed and signed for R9 for review.

Record review of an untitled and undated document that was provided on 04/03/2025 at 12:43 PM, showed R9 had a level of care assessment completed on 02/26/2025. The list did not show there was a customized service plan completed on that day.

In an interview on 04/01/2025 at 11:41 AM, Staff B, Registered Nurse Wellness Director, stated they did not complete a 30-day service plan.

In an interview on 04/02/2025 at 12:17 PM, Staff B stated for all new residents they complete a customized service plan upon admission to the facility, at 14 days and then every six months or if there was a change of condition with the resident. Staff B stated once an update has been made to the service plan, the prior service plan would not be able to be printed for review.

As of 04/07/2025 at 5:00 PM, the facility was unable to provide a customized service plan for R3 and R9 that was completed within 30 days of admission for review.

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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/30/25 .

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

Tracy Hunter 4/24/25

Administrator (or Representative) Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 5 long term staff (Staff F, Staff G, Staff C) had their food handlers cards. This failure placed 78 of 78 residents at risk of for food-borne illnesses due to receiving improperly handled food.

Findings included...

Washington Administrative Code (WAC) 246-217-015 "(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

Record review of an untitled and undated document that was provided on 04/03/2025 at 12:43 PM, showed R9 had a level of care assessment completed on 02/26/2025. The list did not show there was a customized service plan completed on that day.

In an interview on 04/01/2025 at 11:41 AM, Staff B, Registered Nurse Wellness Director, stated they did not complete a 30-day service plan.

In an interview on 04/02/2025 at 12:17 PM, Staff B stated for all new residents they complete a customized service plan upon admission to the facility, at 14 days and then every six months or if there was a change of condition with the resident. Staff B stated once an update has been made to the service plan, the prior service plan would not be able to be printed for review.

As of 04/07/2025 at 5:00 PM, the facility was unable to provide a customized service plan for R3 and R9 that was completed within 30 days of admission for review.

Plan/Attestation Statement

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Administrator (or Representative) _____ Date _____

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Based on interview and record review the facility failed to ensure 3 of 5 long term staff (Staff F, Staff G, Staff C) had their food handlers cards. This failure placed 78 of 78 residents at risk of for food-borne illnesses due to receiving improperly handled food.

Findings included...

Washington Administrative Code (WAC) 246-217-015 “(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section.”

WAC 246-217-025 (1)(8)"(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee... (8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials."

WAC 246-217-035 (1) (5)(c)"(1) All initial cards are valid for two years from the date of issuance...(5) The card shall be approximately three inches by five inches in size and contain the following information: (c) Printed (or typed written) name and signature of the food service worker."

Record review of the facility's wellness policies and procedures titled, "care associate orientation and ongoing training", dated "09/2011", showed food handler's training was required for any associate preparing food. Documentation of all training for the associate would be maintained in the associate's confidential file.

On 03/28/2025 at 12:23 PM, the Department requested Staff F, Staff G, and Staff C's food worker cards in the employees file for review.

Record review of untitled and undated facility document that was a list of employees, showed Staff F, Care Associate, started employment at the facility on 12/27/2022.

Record review of Staff F's Washington State Food Worker Card, dated 03/29/2025, showed it had valid dates from 03/29/2025 through 03/29/2027. This was completed 822 days after the required time.

Record review of untitled and undated facility document that was a list of employees, showed Staff G, Care Associate, stated employment at the facility on 03/29/2022.

Record review of Staff G's Washington State Food Worker Card, dated 03/29/2025, showed it had valid dates from 03/29/2025 through 03/29/2027. This was completed 1,080 days after the required time.

Record review of untitled and undated facility document that was a list of employees, showed Staff C, Care Associate, stated employment at the facility on 11/14/2024.

Record review of Staff C's "[facility name] Continuing Care Community, New Employee Required Documents", dated 11/14/2024, showed Staff C was to complete their food handlers card on 12/14/2024. The document was signed and dated by Staff C that showed they understood that it was their responsibility to complete the required documents for their employment.

Record review of Staff G's Washington State Food Worker Card, dated 03/29/2025, showed it had valid dates from 03/29/2025 through 03/29/2027. This was completed 120 days after the required time.

In an interview and observation on 03/31/2025 at 11:24 AM, Staff B, Registered Nurse/ Wellness Director, stated Staff E had sent a copy of their food worker card to their cellular phone. Staff B stated the date on Staff E's food worker card was 01/23/2025. Staff B then showed Staff E's food worker card on their cellular phone that showed the

date on the card was 03/29/2025. Staff B reviewed the date on Staff E's worker card and verified that the date was 03/29/2025. This was the date that the Department requested to review Staff E's food worker card. Staff B stated they were just telling staff a few weeks prior that they needed to complete their food worker card.

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 4/24/2025

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 5 sampled staff (Staff D, Staff C, Staff G) complete and received their fingerprint background check. This failure placed 78 of 78 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Washington Administrative Code (WAC) 388-78A-24681 "Background checks—Employment—Provisional hire—Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:
(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and (2) The results of the national fingerprint background check are pending."

Record review of the State of Washington Department of Social and Health Services letter 2022-015, dated 04/28/2022, showed beginning 05/01/2022, long-term care workers would again need to complete a fingerprint- based background check as required by law. All providers and staff who began working between 11/01/2019 and

date on the card was 03/29/2025. Staff B reviewed the date on Staff E's worker card and verified that the date was 03/29/2025. This was the date that the Department requested to review Staff E's food worker card. Staff B stated they were just telling staff a few weeks prior that they needed to complete their food worker card.

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 5 sampled staff (Staff D, Staff C, Staff G) complete and received their fingerprint background check. This failure placed 78 of 78 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included…

Washington Administrative Code (WAC) 388-78A-24681 "Background checks—Employment—Provisional hire—Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:
(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and (2) The results of the national fingerprint background check are pending."

Record review of the State of Washington Department of Social and Health Services letter 2022-015, dated 04/28/2022, showed beginning 05/01/2022, long-term care workers would again need to complete a fingerprint- based background check as required by law. All providers and staff who began working between 11/01/2019 and

04/30/2022 would have 120 days to obtain non-disqualifying fingerprint results from the Background Check Central Unit (BCCU). That meant that providers must have non-disqualifying results dated not later than 08/28/2022. New providers who start providing care on or after 05/01/2022 would have 120 days to get their results from BCCU. Setting should monitor for compliance with fingerprint completion per normal procedures. The Department requested that all new providers have a fingerprint appointment scheduled before providing care, per current WAC 388-113-0109 and emergency WAC 388-06-0525. This requirement has been in place in chapter 388-113 WAC.

Record review of, "New Employee Required Documents", undated, showed the state required the following items be completed by specific dates to be in compliance with regulations. If you do not complete these items in the assigned time allowance, you would be taken off the schedule. Under requirement section showed fingerprint appointment was to be completed at hire.

On 03/28/2025 at 12:23 PM, the Department requested Staff D, Nurse, Staff C, Care Associate, and Staff G's, Care Associate, background checks completed in the employees file for review.

Record review of untitled and undated facility document, that was a list of employees, showed Staff C started employment at the facility on 11/14/2024, Staff D started employment at the facility on 10/30/2024, and Staff G started employment at the facility on 03/29/2022.

Record review on 03/28/2025 of Staff D's employee file, showed there was no final fingerprint background check for review.

Record review on 03/28/2025 of Staff C's employee file, showed there was no final fingerprint background check for review.

Record review of Staff G's Washington state final fingerprint background check results, dated 08/15/2023, showed it was completed 352 days past the required time.

In an interview on 03/28/2025 at 3:32 PM, Staff A, Executive Director, acknowledged that Staff C and Staff D had not completed their final fingerprint background check.

In an interview on 04/01/2025 at 2:27 PM, Staff J, Business Office Manager, said that Staff S, Receptionist, completed facility staff background checks. Staff A said within an employee's first or second day of employment at the facility Staff S scheduled their final fingerprint background check. Staff J said the facility staff referenced the "New Employee Required Documents" form to know when fingerprint background checks were due.

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 4/24/25

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;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow and implement their policy and procedure for grievances for 4 of 4 reported grievances (Resident Council, Chef Talk, Town Hall, and Resident 6 [R6]). The facility failed to follow and implement their abuse and neglect policy for 2 of 6 staff (Staff CC and Staff Q). The facility failed to develop a policy for alert charting when a resident has a change in their baseline behavior for 3 of 9 residents (Resident 1 [R1], R6, and Resident 5 [R5]). These failures placed the residents at risk for unmet care needs, unresolved grievances, and lack of response for decline in resident conditions, and at risk of not being protected during allegations of abuse and neglect.

Findings included...

Revised Code of Washington (RCW) 70.129.060 Grievances. "A resident has the right to; (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Record review of the facility policy, "Grievances", dated "09/2011" showed it was the community's goal to meet the expectations of their residents and families. Formal meetings such as resident council, dining services committee, and town hall were made

Plan/Attestation Statement

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Administrator (or Representative) Date

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;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow and implement their policy and procedure for grievances for 4 of 4 reported grievances (Resident Council, Chef Talk, Town Hall, and Resident 6 [R6]). The facility failed to follow and implement their abuse and neglect policy for 2 of 6 staff (Staff CC and Staff Q). The facility failed to develop a policy for alert charting when a resident has a change in their baseline behavior for 3 of 9 residents (Resident 1 [R1], R6, and Resident 5 [R5]). These failures placed the residents at risk for unmet care needs, unresolved grievances, and lack of response for decline in resident conditions, and at risk of not being protected during allegations of abuse and neglect.

Findings included...

Revised Code of Washington (RCW) 70.129.060 Grievances. “A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.”

Record review of the facility policy, "Grievances", dated "09/2011" showed it was the community's goal to meet the expectations of their residents and families. Formal meetings such as resident council, dining services committee, and town hall were made

available to routinely provide communication and immediate answers to questions. If a concern arose the facility provided a format for complaint resolution. Complaints could be made verbally or in writing. Attempts to resolve the complaint with the person at the level the complaint arose. If the complaint could not be resolved refer the complaint to the department manager responsible for the area involved. If the complaint was still not resolved refer the concern to the executive director. If the complaint had still not been resolved refer it to the home office. Residents or families could contact the state long term care ombudsman or the appropriate state number for reporting abuse and neglect.

Record review of the Department of Social and Health Services book, “Assisted Living Guidebook”, dated February 2018, showed facilities were required to report 24 hours a day, seven days a week to the Departments CRU (Complaint Resolution Unit) hotline via phone or online for any reasonable cause to believe violations involving abuse or neglect.

Record review of the facility policy titled, "Abuse & Neglect", dated "09/2017", showed all facility staff were educated about abuse and neglect. If facility staff had reasonable cause to believe an incident was reportable, they must report to the Washington state complaint resolution unit as soon as the resident was protected from harm and they were to notify their immediate supervisor, manager on duty, or the executive director of the alleged incident.

Record review of an email dated 04/01/2025 at 8:54 AM, showed the Department requested the facilities alert charting policy. Staff B, Registered Nurse Wellness Director, provided the email in printed form and in handwritten notes next to alert charting policy showed “no specific policy”.

Grievances

Record review of, "Resident Council Meeting Minutes", dated 01/13/2025, showed Staff R, Life Enrichment Director, had been the facilitator and scribe for the meeting that six residents attended. The dining services comments and suggestion showed the residents expressed concern about the serving size being inconsistent, food served did not match what was on the menu, the Willow dining room staff did not ask the residents what they wanted and just served the residents. There were concerns expressed about the serving time in Dogwood had been delayed, snack trays at the nurses station were inconsistent, dining room tables were not cleaned, preference to have time to eat the salad before the main meal came out, tartar sauce, barbeque sauce, and Worcestershire sauce as an available condiment, training for staff on how to serve restaurant style, and more communication with the kitchen manager versus the facility staff apologizing. The management comments and follow up section had been blank. The front office/administration comments and suggestion section showed the residents expressed that the staff could greet new faces that entered the door. The management comments and follow up section had been blank. The housekeeping comments and suggestion section showed a concern about lost laundry and what was the process if an item had been lost for over a week. The management comments and follow up section had been blank.

Record review of, "Resident Council Meeting Minutes", dated 02/17/2025, showed Staff R had been the facilitator for the meeting that seven residents attended. The dining services comments and suggestion showed the assisted living residents inquired if the

nurses station received a snack tray, the preference for mashed potatoes and cauliflower were not served at the same time, and if the soup that was served could match the main course that was served. The management comments and follow up section had been blank.

Record review of, "Resident Council Meeting Minutes", dated 03/07/2025, showed Staff R had been the facilitator for the meeting that 10 residents attended. The dining services comments and suggestion section showed the assisted living residents inquired if the snack tray had only been for residents who required assistance, preference to try minced clams instead of whole, preference not to be served turkey stroganoff again, shutting the kitchen door at 8:00 AM in the Cedar dining room, and if the tables could be wiped down after every meal. The management comments and follow up section had been blank. The maintenance comments and suggestion section showed residents inquired if the dining room chairs could have pads put on the bottom of the legs. The management comments and follow up section had been blank. The wellness comments and suggestion section showed the wellness staff took a long time to get the Dogwood dining services started. The management comments and follow up section had been blank. The other comments and suggestion section showed that residents inquired if low volume music could play in the lobby and if the landscapers could address the dead bushes. The management comments and follow up section had been blank.

Record review of, "Chef Talk", dated 01/21/2025, showed hand written notes that said ran short of food, want hash brown patty's, put the menu out the day before, too much mixed veggies, clean out ice box in Willow, clean floors in Willow, get food out in time, [Resident Name] with six stars next to it, softer foods, help [Resident Name] first table, want to know the cooks, and like clear tables. There was no documentation to show how the resident concerns were addressed.

Record review of, "Chef Talk', dated 03/26/2025, showed hand written notes that said want tender meats, napkins too full at night, want gravy with turkey cranberry and mashed potatoes, too much meat at breakfast one day and none the other days, , dinner time they were served sides first, been getting food later, want smaller serving trays, want everything at once, no more ham sandwiches, potato salad chopped fine, spread mayo all over bread, and the vegetable plate to look nicer. There was no documentation to show how the resident concerns were addressed.

In an interview on 04/02/2025 at 10:10 AM, Staff A, Executive Director said the facility had town hall quarterly. Staff A said the facility could not provide any notes to review from the last town hall meeting. Staff A said the next town hall meeting had been scheduled for 04/15/2025. Staff A said they could not provide any documentation for February's 2025 monthly chef talk to review.

In an observation and interview on 03/31/2025 at 11:35 AM, the Department entered the Dogwood dining room, and eight residents had already been sat down waiting for lunch. At 11:37 AM, Staff FF, Dining Services Associate, started the process to confirm resident's drink orders. At 11:45 AM, Staff FF started to take the first table of three residents food orders. At 11:51 AM, two other residents sat down at the first table. Staff FF returned with soup to distribute to the three residents. Staff FF then took the two resident orders who just sat down at the first table. At 11:58 AM, Staff FF returned to distribute more food to residents at table one. More residents entered the dining room and continued to sit down at various tables inside of the room. At 12:01 PM, Staff FF had moved on to take the second tables food orders. At 12:04 PM, an unknown male facility

worker entered the dining room and took the order of one table of residents who had just sat down versus the unknown worker taking the order of the original eight residents who were in the dining room as of 11:35 AM. Staff CC, Medication Technician said the servers would take the residents food order and deliver their order before they moved on to take the next tables order. Staff CC said sometimes multiple servers took residents orders. Staff CC said the servers had to work in both dining rooms. Staff CC confirmed that the male worker took the residents who entered the room last, first. Staff CC said residents did express concern of long wait times to be served.

In an interview on 04/01/2025 at 3:16 PM, Staff R confirmed they attended resident council and typed up the meeting minutes. Staff R said after resident council was over, they emailed the resident concerns to the facility department heads and asked them to respond to the concerns addressed in the meeting. Staff R said if the management comments and follow up section had been blank it was because they did not receive a response back. Staff R said after January's resident council meeting, they had encouraged the residents to bring up concerns with food during the monthly chef talks. Staff R noted that was why there had been a decrease in dining service concerns in the month of February. Staff R said they did not take notes during the chef talk. Staff R said town hall meetings took place quarterly. Staff R said the first town hall meeting they would be apart of since they became the Life Enrichment Director was scheduled in April 2025. Staff R said if a resident had a grievance or concern that the facility staff would try and address the situation immediately. Staff R said if the concern could not be resolved then they would inform the department head to follow up. Staff R said concerns did not need to be written down.

In an interview on 04/02/2025 at 12:53 PM, Staff X, Dining Services Director, said they had monthly chef talk meetings where a facility staff member took notes for them. Staff X said they verbally followed up with the concerns expressed in chef talk. Staff X said the concern about long wait times in Dogwood dining was because the servers had to wait to serve residents until a care associate had been present. Staff X said if the care associate was behind it caused the service to be delayed because the servers would start in the Cedar dining room instead of the Dogwood dining room. Staff X said the facility servers would take orders and serve residents in one dining room before they moved onto the other dining room. Staff X said in the Cedar dining room the facility staff would rotate what table they served first. Staff X said they did not rotate what table had been served first in the Dogwood dining room. Staff X did confirm that long wait times had been an ongoing issue. Staff X said sometimes the kitchen staff had been short staffed due to staff call outs. Staff X said at times they had to take resident orders and serve residents. Staff X could not verbally reiterate how all resident concerns had been followed up on from January, February, and March chef talks. Staff X confirmed that after resident council Staff R sent out emails to the department head requesting follow up of concerns expressed. Staff X reiterated they addressed residents concerns verbally in chef talk.

R6

Record review of R6's, Move In Record, dated 03/06/2025, showed R6 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted] and [redacted].

In an interview on 04/01/2025 at 10:53 AM, Collateral Contact 3 (CC3), Power of Attorney for R6, stated the facility is frequently losing R6's laundry. CC3 stated it has been a concern for the last two years. CC3 stated they were always in communication with Staff A, Executive Director, but R6's clothing continued to come up missing.

In an interview on 04/01/2025 at 3:38 PM, Staff A said residents at the facility could opt to complete their own laundry or pay a service fee of $90.00 for the facility staff to complete it. Staff A and Staff B, Registered Nurse Wellness Director, said if the residents paid for the facility to complete their laundry, then it was washed individually. Staff A said they would need to consult with Staff GG, Environmental Services Director. Staff B said the facility addressed missing items by going and searching for it. Staff B said the facility had a lost and found. Staff B said if the facility could not locate a missing item, they informed the resident or residents representative to provide a receipt for the item and it would be reimbursed. Staff A and Staff B had knowledge of R6's residents representatives concern that the facility had lost R6's pants. Staff B said it had been claimed that the facility had lost approximately 30 pairs of R6's pants. At 3:48 PM, Staff GG said residents' laundry got picked up individually, goes into a community bin that got sorted, was washed with other resident laundry, and then re distributed to the residents. Staff GG had knowledge of the ongoing concern that R6 had missing clothing.

Abuse Neglect Reporting

In an interview on 03/31/2025 at 12:08 PM, Staff CC, Medication Technician said if they had concerns about a resident being abused or neglected, they would report it directly to their manager. Staff CC said the management team would report the incident externally. Staff CC said they could not recall who the management would need to report the abuse or neglect to.

In an interview on 04/01/2025 at 1:12 PM, Staff Q, Housekeeper, said if they had concerns about a resident being abuse or neglected, they would report it to Staff B, Registered Nurse, Wellness Director.

In an interview on 04/02/2025 at 1:23 PM, Staff B said the facility staff had been made aware they were mandated reporters and if they were concerned a resident was being abuse or neglected, they were supposed to make a report online or by telephone to the state hotline.

Alert Charting

R1

Record review of R1's Move In Record, dated 03/06/2025, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R1's customized service plan, dated 11/01/2024, showed R1 was able to make themselves understood and able to understand others. There was no documentation that R1 had any cognitive deficits or any behaviors.

Record review of R1's treatment administration record, dated 02/01/2025 through 02/28/2025, showed there were no behaviors listed for the licensed nurses to document or monitor.

Record review of R1's progress note, dated 02/06/2025 at 10:42 AM, Under the section, "reason for alert charting", showed anger on night shift. Under the section, "current symptoms present", showed R1 came out of their room angry and mad calling the caregiver stupid. R1 was very confused on the time that required R1 to be redirected and re-oriented to time. There was no other documentation or progress notes completed through 02/10/2025 about R1's mood and if any behaviors at night.

R6

Record review of R6's, Move In Record, dated 03/06/2025, showed R6 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R6's, customized service plan, dated 10/31/2024, located in the caregiver's binder of resident service plans, showed R6's primary mode of expression was speech with difficulties. Staff were to allow R6 time to find words or respond to yes or no questions. R6 experienced word salad (). Under the section titled, "cognitive/behavioral support/mental health", showed R6 had a history of resisting activities of daily living care services at night and staff were to redirect the resident. There was nothing in R6's service plan that showed R6 experienced episodes of unresponsiveness.

Record review of R6's, "encounter notes", dated 03/27/2025, showed it was a note from the hospice registered nurse (RN) visit with R6 on 03/27/2025 at 10:01 AM. R6 no longer talked and just mumbled occasionally. Staff reported that R6 experienced several syncope episodes (a temporary loss of consciousness or fainting) on 03/24/2025, 03/25/2025, and 03/26/2025 that resulted in R6 not eating lunch and required to be laid down in bed.

Record review of R6' progress note, dated 01/10/2025 at 1:44 PM, showed R6 was in the dining room for lunch, when R6 suddenly became less responsive and slouched. R6 appeared to be having a syncopal episode. R6 had a history of there every so often. R6 was required to be put back to bed.

Record review of R6's progress notes, dated 01/11/2025 through 01/17/2025, showed there was no documentation about R6's condition other than R6 had a shower.

Record review of R6' progress note, dated 02/07/2025 at 9:24 PM, showed R6 had an unresponsive episode. Hospice and R6's power of attorney was called and informed of the event.

Record review of R6's progress note, dated 02/08/2025 at 4:28 PM, Showed R6 had an episode that required R6 to be placed in bed. R6 was placed on alert charting for 72 hours to monitor for further episodes and notify hospice with each episode. There were no progress notes on R6's condition on 02/10/2025 and 02/11/2025 for review.

Record review of R6's progress note, dated 03/04/2025 at 5:09 PM, showed "syncope episode at 5PM, hospice notified".

Record review of R6's progress note, dated 03/05/2025 at 5:51 PM, showed "syncope episode, hospice notified and daughter".

Record review of R6's progress notes, dated 03/06/2025 through 03/11/2025, showed there was no further documentation about R6's condition from the recent syncope episodes for review.

Record review of R6's progress notes, dated 03/22/2025 through 03/27/2025, showed there was no further documentation about R6's condition from the recent syncope episodes that were documented by the hospice RN on 03/24/2025, 03/25/2025, and 03/26/2025 for review.

R5

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R5's, "Service Plan Report", dated 10/29/2024, the communication section showed R5 could make themselves understood, give R5 time to express themselves. The cognitive/behavioral support/mental health section showed R5 had episodes of hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not actually there) or delusions (a false belief that conflicted with reality despite evidence to the contrary). The document had been signed by Collateral Contact 2, R5's resident representative, Staff A, Staff B, and the Business Office Manager.

Record review of R5's, "Progress Notes", dated 02/23/2025, showed Staff N, Nurse, wrote R5 was extremely confused, R5 had a transient thought process (disruption in one's thoughts), and had been combative with staff. The facility faxed R5's medical provider for an order for a urine analysis and inquired about a new prescription for residents Seroquel (medication that treated mental health conditions).

Record review of R5's, "Progress Notes", dated 02/24/2025 - 03/04/2025, showed there were no follow up progress notes to review related to R5's confusion, combativeness with staff, urine analysis, and Seroquel medication to review that took place on 02/23/2025.

Record review of R5's, "Progress Notes", dated 03/16/2025, showed Staff N wrote care staff attempted to assist R5 to lay down and R5 slapped the care staff in the face.

Record review of R5's, "Progress Notes", dated 03/17/2025 - 03/19/2025, showed there were no follow up progress notes to review related to R5's combativeness with staff that took place on 03/16/2025.

Record review of R5's, "Progress Notes", dated 03/23/2025, showed Staff N wrote that they informed R's family member that R5 had a strange episode today. R5 sat on the side of their bed with the facility staff when R5 suddenly stopped talking, their eyes grew wide, and they slumped back onto their bed. The facility staff attempted to get R5

to respond for approximately 10 seconds and R5 had not been responsive. R5 then became responsive and R5 could not explain the incident.

Record review of R5's, "Progress Notes", dated 03/24/2025 - 03/28/2025, showed there were no follow up progress notes to review related to R5's unresponsive episode that took place on 03/23/2025.

In an interview on 04/01/2025 at 12:31 PM, Staff V, Care Associate, said last week they were present when R5 had an unresponsive episode. Staff V said they were in the middle of assisting R5 up and out of bed when R5 suddenly had a blank expression on their face. Staff V said they put a pillow behind R5's head and within a couple of seconds R5 returned to their normal self.

In an interview on 04/02/2025 at 10:36 AM, Staff P, Medication Technician, said they heard R5 had an unresponsive episode. Staff P said maybe R5 had zoned out. Staff P said if R5 zoned out it would be considered a new behavior for them and it would need to be alert charted on. Staff P said they would consider it a new behavior because R5 baseline was that they were talkative. Staff P said they had heard R5 had been combative. Staff P then said maybe not combative but more angry and feisty. Staff P said R5's demeanor had been new, and it would be considered a behavior.

In an interview on 04/02/2025 at 11:12 AM, Staff I, Licensed Practical Nurse, said they thought they had heard that R5 had an unresponsive episode but had not experienced it for themselves. Staff I said the facility staff could interpret an unresponsive episode differently between each staff member. Staff I said if a resident did have an unresponsive episode, then it would need to be alert charted on. Staff I said they did not have a specific facility reference they utilized of when to put residents on alert charting. Staff I said they knew when to put residents on alert from experience. Staff I said they had not experienced R5 become combative with facility staff. Staff I said residents acted different with morning shift workers compared to evening shift workers. Staff I said R5 had not had negative behaviors with day shift workers. Staff I said R5 had been very confused but R5's demeanor could be affected by the facility staff's approach.

This is a recurring deficiency previously cited on 05/02/2024.

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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/30/25.

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

Administrator (or Representative) Date 4/24/2025

to respond for approximately 10 seconds and R5 had not been responsive. R5 then became responsive and R5 could not explain the incident.

Record review of R5's, "Progress Notes", dated 03/24/2025 - 03/28/2025, showed there were no follow up progress notes to review related to R5's unresponsive episode that took place on 03/23/2025.

In an interview on 04/01/2025 at 12:31 PM, Staff V, Care Associate, said last week they were present when R5 had an unresponsive episode. Staff V said they were in the middle of assisting R5 up and out of bed when R5 suddenly had a blank expression on their face. Staff V said they put a pillow behind R5's head and within a couple of seconds R5 returned to their normal self.

In an interview on 04/02/2025 at 10:36 AM, Staff P, Medication Technician, said they heard R5 had an unresponsive episode. Staff P said maybe R5 had zoned out. Staff P said if R5 zoned out it would be considered a new behavior for them and it would need to be alert charted on. Staff P said they would consider it a new behavior because R5 baseline was that they were talkative. Staff P said they had heard R5 had been combative. Staff P then said maybe not combative but more angry and feisty. Staff P said R5's demeanor had been new, and it would be considered a behavior.

In an interview on 04/02/2025 at 11:12 AM, Staff I, Licensed Practical Nurse, said they thought they had heard that R5 had an unresponsive episode but had not experienced it for themselves. Staff I said the facility staff could interpret an unresponsive episode differently between each staff member. Staff I said if a resident did have an unresponsive episode, then it would need to be alert charted on. Staff I said they did not have a specific facility reference they utilized of when to put residents on alert charting. Staff I said they knew when to put residents on alert from experience. Staff I said they had not experienced R5 become combative with facility staff. Staff I said residents acted different with morning shift workers compared to evening shift workers. Staff I said R5 had not had negative behaviors with day shift workers. Staff I said R5 had been very confused but R5's demeanor could be affected by the facility staff's approach.

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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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

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

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

(ii) The resident's full assessments;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Customize Service Plan (facility's version of the negotiated service agreement [NSA]) the plan to provide the care and services necessary to support the residents preferences and care needs, the plan to provide assistance with activities of daily living, and appropriate behavioral interventions for 5 of 9 sampled residents (Resident 6 [R6], Resident 9 [R9], Resident 5 [R5], Resident 4 [R4], and Resident 1 [R1]). This failure placed all five residents at risk for unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's wellness policies and procedures titled, "Customized Service Plan", dated "10/2021", showed all residents living at the assisted living licensed rooms would have a customized service plan based upon their needs and preferences to ensure the resident's needs could be safely met within the community.

R6

Record review of R6's Move In Record, dated 03/06/2025, showed R6 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R6's untitled document, dated 11/06/2024, showed due to change in condition, hospice would not be discharging R6 from services. R6 continued to qualify for hospice services.

Record review of R6's, "encounter notes", dated 03/27/2025, showed it was a note from the hospice registered nurse (RN) visit with R6 on 03/27/2025 at 10:01 AM. The note showed R6 was transferred from bed to the wheelchair with use of the Hoyer life (mechanical lift device that picks a person up and moves them to another surface) and

two-person. The RN documented the R6 was no longer able to stand and pivot with assistance. R6 ate lunch with staff assistance. Per nurse at the facility, R6 required staff to assist them with eating. R6 was still able to feed self at times finger foods. R6 no longer talked and just mumbled occasionally. R6 remained incontinent of bowel and bladder. Staff reported that R6 experienced several syncope episodes (a temporary loss of consciousness or fainting) on 03/24/2025, 03/25/2025, and 03/26/2025 that resulted in R6 not eating lunch and required to be laid down in bed.

In an observation on 03/28/2025 at 12:32 PM, R6 was siting upright in their manual wheelchair at the dining room table in the assisted living assisted dining room. R6 was using a spoon that was upside down with some chocolate pudding on it that had spilled onto R6's shirt. R6 dropped the spoon onto the ground. Staff C grabbed a new fork sat down and assisted R6 with feeding R6 bites of pudding.

In an observation and interview on 03/31/2025 at 4:00 PM, Staff G, Care Associate, and Staff H, Care Associate, came into R6's room to assisted them with personal care and to get up for dinner time. R6 was lying in bed. Staff G and Staff H rolled R6 on either side to provide incontinent care. When R6 was rolled onto the right side, R6 had urinated without notifying Staff G or Staff H that they needed to urinate. R6 required Staff G to provide total incontinent care with no assistance from R6. Staff G and Staff H assisted together R6 to sit upright onto the side of the bed. R6 did not assist at all with sitting up. Staff G assisted R6 with pulling down the upper part of their dress down over their chest and arms while Staff H held R6 upright on the side of the bed. R6 did not assist with adjusting their upper body clothing. Staff G and Staff H put a gait belt around R6's upper waist area, they lifted R6 up with the gait belt together. Staff G and Staff H stood R6 up into the air and transferred R6 into the wheelchair. R6 did not stand on their feet during the transfer to assist Staff G and Staff H with the transfer. R6's legs were crossed during the entire transfer, when R6 was being rolled, and during incontinent care when they were in bed. Staff G stated R6's legs were contracted, crossed over each leg. Staff G stated R6 never uncrossed their legs. Staff G tilted the back of R6's wheelchair back so R6 was reclined back. Staff H pushed R6 in the wheelchair to the assisted living assisted dining room for dinner without R6's assistances or request for assistance.

In an observation and interview on 03/31/2025 at 12:05 PM, Staff II, Care Associate, stated finger foods were great to give to R6. At 12:08 PM, R6 was eating the top bun of their sloppy joe sandwich with their fingers. At 12:21 PM, Staff W, Care Associate, sat down next to R6 in the dining room and began to feed R6 the meat of their sloppy joe sandwich with a fork.

In an observation and interview on 03/31/2025 at 3:28 PM, Staff BB, Medication Technician, stated R6 took their medications crushed and mixed with pudding. Staff BB stated they had to spoon feed R6 their crushed medications. At 4:22 PM, Staff BB spoon fed R6 their medications. R6 was noted to spit out chunks of the medication despite Staff BB encouraging R6 to take a drink of water.

Record review of R6's, customized service plan, dated 10/31/2024, that was in the caregiver's binder of resident service plans, under the section titled, "ambulation/transfers", showed R6 required two-person assistance with transfers with use of gait belt with no use of mechanical device. There was nothing about the resident's legs being contracted (in ability to move or stuck in a position) crossed over each other above the knee's. There was nothing about R6 requiring a wheelchair for all mobility that required staff escort. There was no documentation about the back of the

wheelchair could be titled back for comfort. R6 was able to dress and undress their upper body with stand by assistance and cues from staff. There was no documentation that showed R6 required two person assist with rolling over in bed and bed mobility. R6 was on a general regular house diet with only needing staff to set up R6 for meals and cues to complete meals with assistance as needed to eat. There was no documentation that staff had to feed R6 at every meal and that R6 did better with finger foods. Under the section titled, "toileting", showed "hospice supplies not family". R6 had occasional episode of incontinence of bladder. There was no other documentation that showed R6 was on hospice services or that R6 was incontinent all the time of bladder. Under the section titled, "medication management", showed staff order, stored, and delivered medications per health care provider orders. There was no documentation that R6 required their medications crushed, mixed with pudding, and spoon fed their medications by the licensed nurse. There was no documentation on the service plan that showed R6 received outside care services.

R9

Record review of R9's, Move In Record, dated 03/06/2025, showed R9 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

In an observation and interview on 03/31/2025 at 2:05 PM, R9 was in their room watching television at a very high volume. R9 was sitting upright in a manual wheelchair and was able to self-propel themselves around the room independently with their lower legs. R9 stated they would rather use the wheelchair than the walker that was in their room. R9 had a urinal that was quarter full of dark yellow urine that sat on the ground to the right side of their bed. R9 stated they used the urinal when they were in bed. R9 wore glasses and had their upper and lower dentures on the bed when they ate popcorn. R9 stated they did not like to wear their dentures when they ate. Throughout the interview, R9 on multiple occasions stated, "I don't know why I am here other than my bummed leg" and that he had not seen a doctor since he has lived here.

Record review of R9's customized service plan, dated 02/11/2025, showed R9 was able to make themselves understood and understood others. There was no documentation that R9 had any memory deficits. R9 was independent with hearing and vision needs. There was no documentation that R9 was hard of hearing or used glasses. R9 was independent with all toileting tasks independently. There was no documentation that R9 used a beside urinal. R9 used ambulated long distances in the wheelchair. There was nothing documented that he was able to self-propel with lower legs in the wheelchair in their room. R9 ate regular/general house diet. There was nothing documented that resident preferred to eat without their upper and lower dentures.

R5

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R5's, "Service Plan Report", dated 10/29/2024, the communication section showed R5 could make themselves understood, give R5 time to express themselves. The cognitive/behavioral support/mental health section showed R5 had

episodes of hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not actually there) or delusions (a false belief that conflicted with reality despite evidence to the contrary). The ambulation/transfer section indicated R5 was a two-person assistance with transfers and a gait belt. The falls section showed place chair alarm on when R5 was in their wheelchair. The supportive devices section showed R5 used a half side rail on their bed.

The document had been signed by Collateral Contact 2 (CC2), R5's resident representative, Staff A, Executive Director, Staff B, Registered Nurse, Wellness Director, and the Business Office Manager.

Record review of R5's, WA Cascade Level of Care Assisted Living, dated 02/25/2025 showed resident could make themselves understood, give R5 time to express themselves.
The ambulation assistive device section showed R5 had a manual wheelchair.

Record review of R5's, "Progress Notes", dated 02/23/2025, showed Staff N, Nurse, wrote R5 was extremely confused, R5 had a transient thought process (disruption in one's thoughts), and had been combative with staff.

Record review of R5's, "Progress Notes", dated 03/16/2025, showed Staff N wrote care staff attempted to assist R5 to lay down and R5 slapped the care staff in the face.

In an observation on 03/28/2025 at 12:32 PM, in the assisted living assisted dining room, R5 sat in their tilt n space wheelchair (a specialized wheelchair that allowed the entire seat to tilt backward which helped improve posture and alleviate pressure).

In an interview on 04/01/2025 at 9:15 AM, CC2 confirmed R5 used a tilt and space wheelchair.

In an interview on 04/01/2025 at 12:00 PM, Staff Z, Care Associate, confirmed R5 used a tilt n space wheelchair.

In an interview on 04/01/2025 at 12:23 PM, Staff U, Medication Technician and Staff V, Care Associate confirmed R5 used a tilt n space wheelchair. Staff U said R5 Parkinson's caused their hands to have random movements which they thought frustrated R5. Staff U said if the facility staff knew R5 was frustrated they would verbally inform one another during rounds.

In an interview on 04/02/2025 at 10:36 AM, Staff P, Medication Technician said they had heard R5 had been combative. Staff P then said maybe not combative but more angry and feisty. Staff P said R5's demeanor had been new, and it would be considered a behavior. Staff P went into R5's service plan binder for caregivers to review that was at the nurse's station and confirmed that R5 having behaviors had not been documented in R5's service plan.

In an interview on 04/02/2025 at 11:12 AM, Staff I, Licensed Practical Nurse, said they had not experienced R5 become combative with facility staff. Staff I said residents acted different with morning shift workers compared to evening shift workers. Staff I said R5 had not had negative behaviors with day shift workers. Staff I said R5 had been very confused but R5's demeanor could be affected by the facility staff's approach.

episodes of hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not actually there) or delusions (a false belief that conflicted with reality despite evidence to the contrary). The ambulation/transfer section indicated R5 was a two-person assistance with transfers and a gait belt. The falls section showed place chair alarm on when R5 was in their wheelchair. The supportive devices section showed R5 used a half side rail on their bed.

The document had been signed by Collateral Contact 2 (CC2), R5's resident representative, Staff A, Executive Director, Staff B, Registered Nurse, Wellness Director, and the Business Office Manager.

Record review of R5's, WA Cascade Level of Care Assisted Living, dated 02/25/2025 showed resident could make themselves understood, give R5 time to express themselves.
The ambulation assistive device section showed R5 had a manual wheelchair.

Record review of R5's, "Progress Notes", dated 02/23/2025, showed Staff N, Nurse, wrote R5 was extremely confused, R5 had a transient thought process (disruption in one's thoughts), and had been combative with staff.

Record review of R5's, "Progress Notes", dated 03/16/2025, showed Staff N wrote care staff attempted to assist R5 to lay down and R5 slapped the care staff in the face.

In an observation on 03/28/2025 at 12:32 PM, in the assisted living assisted dining room, R5 sat in their tilt n space wheelchair (a specialized wheelchair that allowed the entire seat to tilt backward which helped improve posture and alleviate pressure).

In an interview on 04/01/2025 at 9:15 AM, CC2 confirmed R5 used a tilt and space wheelchair.

In an interview on 04/01/2025 at 12:00 PM, Staff Z, Care Associate, confirmed R5 used a tilt n space wheelchair.

In an interview on 04/01/2025 at 12:23 PM, Staff U, Medication Technician and Staff V, Care Associate confirmed R5 used a tilt n space wheelchair. Staff U said R5 Parkinson's caused their hands to have random movements which they thought frustrated R5. Staff U said if the facility staff knew R5 was frustrated they would verbally inform one another during rounds.

In an interview on 04/02/2025 at 10:36 AM, Staff P, Medication Technician said they had heard R5 had been combative. Staff P then said maybe not combative but more angry and feisty. Staff P said R5's demeanor had been new, and it would be considered a behavior. Staff P went into R5's service plan binder for caregivers to review that was at the nurse's station and confirmed that R5 having behaviors had not been documented in R5's service plan.

In an interview on 04/02/2025 at 11:12 AM, Staff I, Licensed Practical Nurse, said they had not experienced R5 become combative with facility staff. Staff I said residents acted different with morning shift workers compared to evening shift workers. Staff I said R5 had not had negative behaviors with day shift workers. Staff I said R5 had been very confused but R5's demeanor could be affected by the facility staff's approach.

In an interview on 04/02/2025 at 12:17 PM, Staff B said if a resident had behaviors, it should be documented in the service plan to review. Staff B said when a resident's service plan had been updated then they put the updated copy into the resident's binder and flagged it, so facility staff knew to review the information and sign off on it. Staff B said service plans were living documents and could change often. Staff B said they encouraged the facility staff to write in the service plan as needed.

Record review of R5's, "Service Plan Report", dated 10/29/2024, showed the service plan did not specify that R5 used a tilt n space wheelchair. The service plan did not indicate R5 had behaviors and interventions the facility staff should use when R5 had behaviors.

Record review of R5's, WA Cascade Level of Care Assisted Living, dated 02/25/2025 showed the assessment did not specify that R5 used a tilt n space wheelchair. The assessment did not indicate R5 had behaviors and interventions the facility staff should use when R5 had behaviors.

R4

Record review of R4's Move In Record, dated 03/06/2025, showed R4 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted]

Record review of R4's customized service plan, dated 10/31/2024, located in the caregiver's service plan binder, showed R4 was able to make themselves understood and understood others. R4 experienced episodes of agitation or anxiety that was triggered by being unable to answer questions. Staff were to redirect, distract, or validate by allowing R4 to ask questions. There was no documentation to show that staff were to tell R4 that Collateral Contact 1 (CC1), Spouse of R4, was coming to take them home as an intervention or not to say that to help prevent any increase in behaviors or triggers.

In an interview on 04/02/2025 at 11:10 AM, CC1 stated they talked to Staff A, Executive Director, about staff not telling R4 that CC1 was coming to the facility to take R4 home. CC1 stated that staff have reported that R4 had an increase in behaviors when CC1 comes to visit and does not take R4 home. CC1 stated the helping staff members (agency staff) would tell R4 that CC1 was coming to take R4 home the most.

R1

Record review of R1's Move In Record, dated 03/06/2025, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted]

Record review of R1's customized service plan, dated 11/01/2024, showed R1 was able to make themselves understood and able to understand others. There was no documentation the R1 had any cognitive deficits or any behaviors.

Record review of R1's progress note, dated 01/09/2025 at 11:27 AM, showed R1 refused their shower after they were reapproached multiple times.

Record review of R1's progress note, dated 01/18/2025 at 8:56 PM, showed R1 was heard yelling from their room. R1 was standing over roommate, shaking the roommate and yelling at them. Staff were unable to get R1 say what they were doing. R1 was unable to tell the nurse what had happened.

Record review of R1's progress note, dated 02/06/2025 at 10:42 AM, showed R1 came out of their room angry and mad calling the caregiver stupid. R1 was very confused on the time that required R1 to be redirected and re-oriented to time.

Record review of R1's progress note, dated 02/20/2025 at 9:40 PM, showed R1 refused their shower that evening.

Record review of R1's progress note, dated 03/24/2025 at 12:21 PM, showed R1 refused their shower after multiple attempts from staff.

In an interview on 04/01/2025 at 2:23 PM, Staff O, Care Associate, stated that R1 can have behaviors when they were hungry. Staff O stated R1 was not able to say that they are hungry and often would get frustrated and lash out. Staff O stated when there were other residents that were experiencing behaviors or there was a lot of stimulation around R1, then R1 would become frustrated, yell, and lash out.

In an interview on 04/02/2025 at 12:17 PM, Staff B, Registered Nurse/Wellness Director, stated any staff member could write on the resident's service plan of updates as in resident's preference to eat with finger foods. Staff B stated when the residents service plan was ready to be reviewed for their routine update, the updates that were handwritten on the service plan if it still were pertinent to the resident would be incorporated to the permanent customized service plan.

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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 7/20/2025.

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

Tracy Hunter — Administrator (or Representative)

4/24/2025 — Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

Record review of R1's progress note, dated 01/09/2025 at 11:27 AM, showed R1 refused their shower after they were reapproached multiple times.

Record review of R1's progress note, dated 01/18/2025 at 8:56 PM, showed R1 was heard yelling from their room. R1 was standing over roommate, shaking the roommate and yelling at them. Staff were unable to get R1 say what they were doing. R1 was unable to tell the nurse what had happened.

Record review of R1's progress note, dated 02/06/2025 at 10:42 AM, showed R1 came out of their room angry and mad calling the caregiver stupid. R1 was very confused on the time that required R1 to be redirected and re-oriented to time.

Record review of R1's progress note, dated 02/20/2025 at 9:40 PM, showed R1 refused their shower that evening.

Record review of R1's progress note, dated 03/24/2025 at 12:21 PM, showed R1 refused their shower after multiple attempts from staff.

In an interview on 04/01/2025 at 2:23 PM, Staff O, Care Associate, stated that R1 can have behaviors when they were hungry. Staff O stated R1 was not able to say that they are hungry and often would get frustrated and lash out. Staff O stated when there were other residents that were experiencing behaviors or there was a lot of stimulation around R1, then R1 would become frustrated, yell, and lash out.

In an interview on 04/02/2025 at 12:17 PM, Staff B, Registered Nurse/Wellness Director, stated any staff member could write on the resident's service plan of updates as in resident's preference to eat with finger foods. Staff B stated when the residents service plan was ready to be reviewed for their routine update, the updates that were handwritten on the service plan if it still were pertinent to the resident would be incorporated to the permanent customized service plan.

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, Alpine Way Retirement Apartments 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 interview and record review the facility failed to ensure 1 of 3 sampled pets (Resident 10 [R10]'s pet) had regular examinations and were certified by a veterinarian to be free of diseases transmittable to humans. This failure placed 78 of 78 residents, staff, and visitors at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility policy, "Pets", dated "09/2011", showed prior to a resident bringing a pet into the community a statement from the veterinarian attesting to the pets freedom from any disease that could be communicable to humans or other pets, and all immunizations were required for the breed and must be current. Vaccinations needed included rabies (a disease that affected the central nervous system that is transmitted through saliva) for cats and dogs. Residents were responsible to maintain the current health care records which included immunizations for the pet. All community pets would have a file with designated records maintained in the executive director's office.

Record review of R10's, "Pet Record", undated, showed R10's cat had their last rabies vaccination on 01/07/2024 and it was due 01/06/2025.

Record review of R10's, "Visit Summary", dated 01/07/2024, showed R10's cat had been seen by the veterinarian on 01/07/2024 and their next wellness examination was due 01/06/2025. R10's cat rabies vaccination was given on 01/07/2024 and their next rabies vaccination was due 01/06/2025.

In an interview on 03/28/2025 at 3:02 PM, Staff A, Executive Director, said R10's updated pet records should be located in the file that had been provided. Staff A said they would have Staff R, Life Enrichment Director, call R10's resident representative to inquire if they could provide updated pet records for R10's cat.

In an interview on 03/28/2025 at 3:32 PM, Staff A said Staff R contacted R10's resident representative and they could not provide updated pet records for R10's cat to review. Staff A said Staff S, Receptionist, was the person in charge to ensure pet records were up to date.

In an interview on 04/01/2025 at 2:27 PM, Staff J, Business Office Manager, said they had been unsure who was responsible for the upkeep of pet records at the facility. Staff J left the interview to inquire with a colleague who had been responsible. Staff J returned and said it was themselves, Staff S, and Staff T, Concierge, who had been responsible for the upkeep of facility pet records.

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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/30/2025.

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

Administrator (or Representative) Date 4/34/25

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 3 of 3 sampled resident care areas (Resident 5 [R5] room, Resident 7[R7] room, and assisted dinning room). The failure to secure medications placed 52 of 52 assisted living residents at risk of access to and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility policy, "Medication Management", dated "11/2023", showed the community consulted with the health care provider, the resident, and the residents responsible party to determine the resident's ability to self administer their own medications or the need for medication management services.

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 03/28/2025, showed four of 52 assisted living residents were labeled to have dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making).

R5

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, Alpine Way Retirement Apartments 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-2260 Storing, securing, and accounting for medications.

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 3 of 3 sampled resident care areas (Resident 5 [R5] room, Resident 7[R7] room, and assisted dinning room). The failure to secure medications placed 52 of 52 assisted living residents at risk of access to and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility policy, “Medication Management”, dated “11/2023”, showed the community consulted with the health care provider, the resident, and the residents responsible party to determine the resident's ability to self administer their own medications or the need for medication management services.

Record review of the facility’s “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, dated 03/28/2025, showed four of 52 assisted living residents were labeled to have dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/Alzheimer’s (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making).

R5

Record review of R5's, "Move in Record", dated 03/06/2025, showed R5 moved into the facility on [redacted]/2021. R5 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R5's, "service Plan Report", dated 10/29/2024, showed under the medication management section that the facility staff ordered, stored, and delivered R5 all of their medications. The document had been signed by Collateral Contact 2, R5's resident representative, Staff A, Executive Director, Staff B, Registered Nurse, Wellness Director, and the Business Office Manager.

In an observation on 04/01/2025 at 1:05 PM, R5's bedroom door had been opened. Inside of R5's bathroom on the counter next to the sink showed a container of 22 grams of 2% mupirocin ointment (a medication that treats bacterial skin infections), in a box there was 22 grams of mupirocin ointment, and a container of 0.025% capsaicin cream (a medication that relieves pain).

In an observation and interview on 04/04/2025 at 10:45 AM, R5's bedroom door had been opened. Inside of R5's bathroom on the counter next to the sink showed a container of 0.025% capsaicin cream and in a box, there was 22 grams of mupirocin ointment. Staff P, Medication Technician, had been notified of the medication inside of R5's bathroom. Staff P confirmed the facility staff helped administer the medications inside of the bathroom to R5. Staff P said they would follow up to see if R5 had an order to keep the medication inside of their bathroom. Staff P had been observed to take the two medications out of R5's room. At 10:53 AM, Staff P said they gave R5's medications to Staff I, Licensed Practical Nurse.

In an interview on 04/04/2025 at 10:58 AM, Staff I confirmed the facility staff applied the ointments in R5's bathroom to R5. Staff I said they checked in with Staff B, who informed them that when a resident had been physically unable to take their medications and could not reach their medications then it was okay to store the medications inside of the resident's bathroom.

R7

Record review of R7's, "Move in Record", dated 03/06/2025, showed R7 moved into the facility on [redacted]/2022. R7 had multiple medical diagnosis which included [redacted] and [redacted].

Record review of R7's, "Service Plan Report", dated on 03/05/2025, showed under the medication management section that the facility staff ordered, stored, and delivered R7 all of their medications. The document had been signed by R7, R7's resident representative, Staff A, Staff B, and Staff J, Business Office Manager.

In an interview and observation on 03/31/2025 at 3:40 PM, R7 said the facility staff provided them their medications twice daily. Inside of R7's bathroom on the counter next to the sink showed a container of 24 soft gels of equates cold and flu medication (medication that relived common symptoms such as cough and throat irritation), a container of 48 tablets of equate cold relief aspirin (medication that would reduce fever, relieve pain, and reduce swelling), a container of fourteen extended release Mucinex

(medication that relieved coughs by loosening mucus in airways), and 12 fluid ounces of Nyquil cold and flu acetaminophen (a combination medication used to treat symptoms such as sore throat, fever, cough, and runny nose).

In an interview on 03/31/2025 at 3:50 PM, Staff K, Medication Technician, confirmed R7 had been on medication services to where the facility staff provided R7 their medications. Staff K said to their knowledge R7 should not have medications inside of their room.

Willow Dining Room

In an observation and interview on 03/28/2025 at 10:08 AM, the Willow dining room kitchenet cabinet had been unlocked. Inside of the cabinet had been a bottle that contained 24 capsules of Tylenol (medication that treated aches, pains, and could reduce fever). Staff B said the Tylenol was a facility staff members' and it was not supposed to be in the unlocked cabinet.

In an interview on 04/04/2025 at 12:17 PM, Staff B said residents who were approved for self medication administration were the only residents who could have medications inside of their room. Staff B said sometimes residents' medical providers would write them an order to have certain medications inside of their room. Staff B confirmed R5 was not supposed to have medication such as capsaicin cream inside of their room.

In an interview on 04/04/2025 at 1:23 PM, Staff A confirmed R7 had been on medication services where the facility ordered, stored, and provided R7 their medications. Staff B said that R7 went shopping independently and at times brought back medications that they would find and confiscate. Staff A confirmed the facility staff informed them that R5 had medications inside of their room. Staff B confirmed that a facility staff member left their personal bottle of Tylenol inside of the Willow dining 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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/20/2025

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

Trudy Hunter — Administrator (or Representative)

4/24/2025 — 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.

(medication that relieved coughs by loosening mucus in airways), and 12 fluid ounces of Nyquil cold and flu acetaminophen (a combination medication used to treat symptoms such as sore throat, fever, cough, and runny nose).

In an interview on 03/31/2025 at 3:50 PM, Staff K, Medication Technician, confirmed R7 had been on medication services to where the facility staff provided R7 their medications. Staff K said to their knowledge R7 should not have medications inside of their room.

Willow Dining Room

In an observation and interview on 03/28/2025 at 10:08 AM, the Willow dining room kitchenet cabinet had been unlocked. Inside of the cabinet had been a bottle that contained 24 capsules of Tylenol (medication that treated aches, pains, and could reduce fever). Staff B said the Tylenol was a facility staff members' and it was not supposed to be in the unlocked cabinet.

In an interview on 04/04/2025 at 12:17 PM, Staff B said residents who were approved for self medication administration were the only residents who could have medications inside of their room. Staff B said sometimes residents' medical providers would write them an order to have certain medications inside of their room. Staff B confirmed R5 was not supposed to have medication such as capsaicin cream inside of their room.

In an interview on 04/04/2025 at 1:23 PM, Staff A confirmed R7 had been on medication services where the facility ordered, stored, and provided R7 their medications. Staff B said that R7 went shopping independently and at times brought back medications that they would find and confiscate. Staff A confirmed the facility staff informed them that R5 had medications inside of their room. Staff B confirmed that a facility staff member left their personal bottle of Tylenol inside of the Willow dining 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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement proper infection control hand washing measures when job tasks were changed for 6 of 6 observed staff (Staff C, Staff G, Staff U, Staff CC, Staff Z, and Staff P) during resident care tasks. This failure placed all 78 of 78 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Record review of Centers for Disease Control and Prevention (CDC) fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to prevent the spread of germs and keep employees healthy. Hand hygiene was one of the best ways to prevent employees from getting sick and spreading germs to others in the workplace. Good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It can also mean using alcohol-based hand sanitizer with at least 60% alcohol if soap and water were not readily available. Employees were to wash their hands use soap and water instead of hand sanitizer when their hands were visibly dirty. Under the section titled, "tips for protecting employee health", showed provide soap, water, and way to dry hands (for example paper towels or a hand dryer) so employees can wash and dry hands properly. An alcohol-based hand sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Record review of the Washington State Department of Health's (DOH) document DOH 505-144 titled, "hand hygiene policy and procedure", dated "May 2018", showed effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team would comply with current CDC hand hygiene guidelines. Under the section titled, "indications for handwashing and hand rubbing", showed handwashing was to be conducted when hands were visibly dirty or contaminated with proteinaceous material or were visibly soiled with blood or other body fluids, wash hands with either non-antimicrobial soap and water or an antimicrobial soap and water. Handwashing may also be used routinely decontaminating hands (reduce bacterial count on hands by performing hand hygiene) in the clinical situations that included after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, ever if hands were not visibly soiled. Indications for use of hand rubbing included if hands were not visibly soiled. When gloves were used and removed the healthcare personnel were to decontaminate hands after removing gloves.

Record review of the facility's wellness policies and procedures titled, "infection control", dated "11/2023", showed the facility would follow applicable regulatory guidelines for preventing the spread of infection in the community. All associates would wash their hands following established handwashing guidelines prior to placing gloves on. Alcohol gel may be used rather than handwashing if hands were not visibly soiled and per manufacturers guidelines. Gloves would be changed after contact with each

resident. Hands must be washed thoroughly after removing gloves. Hand would be washed immediately after gloves were removed. All associates were trained on bloodborne pathogens, exposure control, and infection control policies at least annually. Under the section titled, “handwashing”, showed associates would wash their hands before obtaining clean linens, before putting on gloves, before giving personal care to residents, before preparing and/or serving food and beverages, after contact with dirty linens, after direct resident contact, after removing gloves, after eating or drinking. Gloves were not a substitute for good handwashing.

In an observation on 03/28/2025 at 12:32 PM, in the assisted living assisted dining room, Staff C, Care Associate, was observed to pick up soiled, eaten off lunch plates from the dining tables. Staff C was scraping the remanence of food on the plates into the trash and placed the soiled dishes in a bin. Staff C picked up a spoon that Resident 6 [R6] had dropped on the ground and put it in the bin of dirty dishes. Staff C grabbed a clean fork sat down beside R6 and began feeding R6 their chocolate pudding. Staff C was not observed to perform hand hygiene after touching soiled dishes and before feeding R6.

In an interview on 03/28/2025 at 12:03 PM, Staff X, Dining services Director, said the facility staff members were supposed to perform hand hygiene before they put on gloves, but it did not always happen. Staff X said the facility staff were supposed to change their gloves in between tasks.

In an observation on 03/31/2025 at 11:51 AM, Staff U, Medication Technician, entered into the assisted living assisted dining room. Staff U walked to a drawer that was beside the hot table, opened the drawer, and pulled out some gloves. Staff U put the gloves on both hands. Staff U was not observed to perform hand hygiene upon entering the assisted dining room or prior to putting the gloves on. Staff U walked over to the hot table and removed the foil tops from the ready to eat food. Staff U then walked over to a table of residents rested their gloved hands onto their pant legs when they bent over to be eye level, when they asked the resident what they wanted for lunch. Staff U then returned to the hot table and began dishing ready to eat food. Staff U did not change their gloves after touching their pant legs while talking to the residents. At 11:52 AM, Staff V, Care Associate, entered the assisted living assisted dining room. Staff V opened the drawer and grabbed disposable gloves and put them on. Staff V was not observed to perform hand hygiene upon entering the dining room or prior to putting the gloves on. Staff V began pouring drinks to the residents that sat at the table. Staff At 11:57 AM, Staff V removed their gloves, threw them away, grabbed paper menus and placed them on resident food trays. At 12:00 PM, Staff V exited the dining room. Staff V was not observed to perform hand hygiene after removing their gloves. At 12:03 PM, Staff U bent over and rested their gloved hand on their pant legs while asking Resident 5 (R5), what they wanted to eat. Staff U then removed their gloves, assisted R5’s back of the wheelchair upright, then threw their soiled gloves away. Staff U walked over to the drawer by the hot table, opened the drawer, pulled out a new pair of gloves, and put them on. Staff U was not observed to perform hand hygiene after removing gloves, after touching R5’s wheelchair, or before putting the new gloves on. Staff U began to dish ready to eat food onto the plates. At 12:06 PM, Staff U walked over to Resident 13‘s (R13) table, bent over with her gloved hands resting on their thigh area of their pant legs. Staff U took R13’s order. Staff U returned to the hot table and dished ready to eat food onto a plate and served it to R13. At 12:14 PM, R5 spilled their tall cup into their plate. Staff U removed their gloves, grabbed R5’s cup, and took it over to the sink and rinsed it off with water only. Staff U brought the cup back to R5 after it was rinsed and

then patted R5 on the back. Staff U returned to the drawer by the hot tabled, opened the drawer, removed a pair of gloves, and put them on. Staff U was not observed to perform hand hygiene after removing their gloves, after touching and rinsing R5's cup, after touching R5's back and clothes, and before putting on a new pair of gloves. Staff U returned to the hot table and dished up a scoop of broccoli and cheese casserole onto the plate. At 12:23 PM, Staff W, Care Associate, entered the assisted living assisted dining room, pulled up their sleeves on their arms, walked over to the drawer by the hot table, pulled out a pair of gloves, put them on. Staff W was not observed to perform hand hygiene upon entering the dining room, after pushing up their coat sleeve, or before they put the gloves on. Staff W sat down in the chair beside R6 and began to feed them. At 12:23 PM, Staff U removed their gloves, put new gloves on, and then sat down beside R5 and assisted R5 with eating and cutting up their food on their plate. As of 12:25 PM, Staff U was not observed to perform any hand hygiene since first observed entering the assisted living assisted dining room at 11:51 AM.

In an observation on 03/31/2025 at 4:00 PM, Staff G, Care Associate, was in R6's room assisting R6 with getting ready to get up out of bed for dinner. Staff G put on disposable gloves and provided R4 with peri care. Staff G and Staff H, Care Associate, assisted R6 with rolling onto their side. Staff G cleaned R6's buttocks area of bowel movement. Staff G removed their soiled gloves and threw them away. Staff G then put on a new pair of gloves. There was no observed hand hygiene perform prior to the new clean gloves being put on. When Staff G and Staff H rolled R6 onto their other side, R6 had urinated on them self. Staff G wiped the urinated area on R6's upper right thigh with wipes. Staff G put on a new depends on R6. Staff G did not change their gloves after wiping R6's leg or urine and securing the clean, new depends on R6. Staff G removed their gloves and threw them away. Staff G and Staff H transferred R6 into their wheelchair. Staff G then used the remote on the bed and lowered R6's bed down to lower level. At 4:13 PM, Staff G put on a new pair of gloves and removed the urine soiled bed linens from R6's bed. Staff G put them in a bag. Staff G was not observed to performed hand hygiene after removing of gloves and prior to putting new gloves on.

Dogwood Dining Room

In an observation and interview on 03/31/2025 at 11:43 AM, Staff CC, Medication Technician, said they were the facility staff member who had been assigned to the Dogwood dining room for lunch. Without performing hand hygiene Staff CC had been observed to help multiple residents inside of the room put on shirt protectors over their clothing. Staff CC had been observed to touch the resident's shoulders and move their hair out of the way to secure the shirt protector. Without performing hand hygiene Staff CC had been observed to get more shirt protectors out of the cabinet. Staff CC said they took roll of which residents were inside of the dining room. Staff CC had been observed to pick up a pen up and used it to write on a piece of paper. At 11:45 AM, Staff CC coughed, and they had been observed to bring their hand to their mouth. At 11:51 AM without performing hand hygiene Staff CC helped another resident put on a shirt protector. Staff CC had been observed to cough more. At 12:04 PM, an unknown facility worker asked Staff CC to get a shirt protector for a resident. Staff CC momentarily left the room. Staff CC returned and without performing hand hygiene they placed a shirt protector on a resident.

Willow Dining Room

In an observation and interview on 04/01/2025 at 12:00 PM, R5 had been observed

inside of the Willow dining room for lunch. At 12:05 PM, Staff Z, Care Associate, said R5 had been mostly independent with eating, but they were going to help assist them after they prepared a tray for another resident. At 12:11 PM, R5 dropped their pudding cup on the floor. Staff Z had been observed to pick the pudding cup off of the floor and told R5 they would get them another dessert. Staff Z had not been observed to perform hand hygiene after they picked up the pudding cup. At 12:12 PM, Staff Z asked R5 if they were finished with their main meal and cleared their plate. Staff Z had not been observed to perform hand hygiene after they cleared R5's plate. At 12:14 PM, it appeared as if R5 had tried to get a bite of pudding from the cup. R5's spoon missed the cup and R5 motioned the spoon forward multiple times on the napkin that had been placed on their lap. Without performing hand hygiene Staff Z approached R5 and said your dessert is up here while they touched R5's shoulder. Staff Z then moved R5's wheelchair they sat in closer to the table. Staff Z said they would help R5 eat their pudding. Without performing hand hygiene Staff Z physically fed R5 their pudding until they finished eating at 12:17 PM.

R5's Room

In an observation on 04/02/2025 at 10:36 AM, Staff P, Medication Technician, provided R5 a container of vanilla ice cream. Staff P said they needed to get R5 a spoon and left R5's room. At 10:40 AM, Staff P returned and was not observed to perform hand hygiene before they provided R5 the spoon. Staff P opened R5's kitchenet cabinet drawer. Staff P placed a towel on R5's lap and a shirt protector on over their shirt. At 10:43 AM, without performing hand hygiene Staff P helped physically feed R5 their ice cream.

In an interview on 04/01/2025 at 1:52 PM, Staff V stated they were to wash their hands before and after all resident care needs. Staff V stated they could wash their hand with either soap and water or with hand sanitizer. Staff V stated they did not carry hand sanitizer, but it was available all throughout the facility.

In an interview on 04/01/2025 at 2:23 PM, Staff Y, Nurse, stated all staff were expected to wash their hands before and after they used gloves. Staff were to carry hand sanitizer on them during their shift. Staff were to only use hand sanitizer three times before they needed to wash their hands with soap and water.

In an interview on 04/01/2025 at 10:43 AM, Staff L, Care Associate, stated staff were to wash their hands before and after any care that was provided, before and after any glove use, and after any contact with a resident. Staff L stated they did not carry hand sanitizer on them, but that hand sanitizer was available all throughout the facility.

In an interview on 04/02/2025 at 12:17 PM, Staff B, Registered Nurse Wellness Director, stated staff were expected to wash their hands between each resident's care and before and after gloves use. Staff B stated the expectation for staff to wash their hands was the same for resident care services as it was for dining room services. Staff B stated staff were ok to use hand sanitizer as a method of hand hygiene but would need to use soap and water after three times using hand sanitizer.

This is a recurring deficiency previously cited on 11/02/2023.

Statement of Deficiencies	License #: 2141	Compliance Determination # 57103
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 52 of 52	Licensee: Cascade Living Group - Shelton, LLC	04/16/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 5/20/25.

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

Tracey Hunter
Administrator (or Representative)

Date 4/24/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

04/24/2025

Cascade Living Group - Shelton, LLC
Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

RE: Alpine Way Retirement Apartments # 2141

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/16/2025 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 Return the Plan/Attestation Statement and report with signatures to:

Cory Cisneros, Field Manager
Residential Care Services
Region 3, Unit E
Preferred methods:

eFax: (360) 992-7969
Email: rcsregion3email@dshs.wa.gov
Optional method:
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• 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-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

The facility failed to ensure 1 of 2 staff members reviewed (Staff F) had a background check completed two years from the initial background check was completed. Staff F's background check was completed two months past the two year requirement. The facility identified the break and has since developed a system to ensure staff get a new background check completed within two years from the initial background check was conducted.

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:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Enclosure