



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

Caring Places Management, LLC
San Juan Villa
112 Castellano Way
Port Townsend, WA 98368

RE: San Juan Villa License # 2143

Dear Administrator:

This letter addresses Compliance Determination(s) 57066 (Completion Date 03/27/2025) and 53546 (Completion Date 01/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/27/2025 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-2230-1-c-ii

The Department staff who did the on-site verification:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

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



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

Statement of Deficiencies	License #: 2143	Compliance Determination # 53546
Plan of Correction	San Juan Villa	Completion Date
Page 1 of 4	Licensee: Caring Places Management, LLC	01/24/2025

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

The department completed data collection for an unannounced on-site follow-up on 01/23/2025 of:
San Juan Villa
112 Castellano Way
Port Townsend, WA 98368

This document references the following SOD dated: 01/24/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 32 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

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

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

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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.

<i>Cory Cisneros</i>	02/04/2025
Residential Care Services	Date

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

<i>CSayle</i>	2-11-2025
Administrator (or Representative)	Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to notify the physician when 1 of 4 sampled residents (Resident 1 [R1]) refused their medications. This failure placed the resident at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 11/08/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2230] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff

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A, Administrator, signed the document on 12/03/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 12/22/2024."

Record review of the facility's, plan of correction, undated, showed for deficiency WAC 388-78A-2230 medication refusals the action from the facility would be to retrain all medication aides to fax the resident's physician every time a medication was refused.

Record review of R1's, "Med [medication] Aide Meeting Agenda", dated 11/18/2024, showed if a resident refused a medication, then the facility staff were to fax the physician every time the resident refused. Seven facility members signed the sign in sheet on 11/18/2024.

Record review of the facility untitled and undated policy, showed when to notify the doctor and they could be faxed 24 hours a day. The doctor should be notified when there was a refusal of medication.

Record review of the facility's, "Missed/Refused Medications" document, undated, showed a prefilled fax sheet that showed a section for the date, provider name, patient name, patient date of birth, refused/missed medications, reason, medication aide's name, physician reply, and physician signature.

Record review of R1's, "Service Agreement", dated 12/31/2024, showed R1 needed full medication administration. The facility Medication Aides were to administer R1's medication and treatment per R1's physician orders. R1 was to wear their oxygen at all times. R1 would take their oxygen cannula (a thin flexible tube that delivered oxygen to a resident through their nose) off or refuse to wear it, especially when R1 was agitated.

Record review of R1's, "Medication Administration Record", dated 01/01/2025 – 01/23/2025, showed R1 had an order to wear their oxygen at two liters. R1 used their concentrator (a medical device that separated nitrogen from the air to produce oxygen) when in their room and a portable (lightweight device that provided oxygen) when they were out of their room. The medication pass notes section showed on 01/11/2025 R1 refused to wear their oxygen and got aggressive during their care at night. On 01/18/2025 R1 refused to wear their oxygen.

In an interview on 01/23/2025 at 12:58 PM, Staff A, Executive Director, said if a resident refused their medication their physician should be notified after every occurrence.

In an interview and observation on 01/23/2025 at 2:36 PM, Staff B, Medication Aide, said if a resident refused their medication, then the facility staff were to notify the residents physician every time. Staff B said the facility staff notified resident physicians by fax

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and provided the Department a copy of the prefilled out sheet to review.

Record review of an email sent to the Department on 01/23/2025 at 2:17 PM, showed Staff A said the facility could not provide documentation to show R1's physician had been notified when R1 refused their medication on 01/11/2025 and 01/18/2025.

This is an uncorrected deficiency previously cited on 11/08/2024.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) March 10, 2025

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

OSullivan
Administrator (or Representative)

2-11-2025
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

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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 10/29/2024 and 10/30/2024 of:

San Juan Villa
112 Castellano Way
Port Townsend, WA 98368

The following sample was selected for review during the unannounced on-site visit: 7 of 32 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licenser
Emily Boniface, Community Program Nurse Licenser
Celeste Vashey, ALF LTC Licenser

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

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

12/02/2024

Date

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

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

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C Soule
Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105° F and 120° F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure water temperature was maintained between 105 degrees and 120 degrees Fahrenheit (F) in 6 of 6 resident accessible sinks and 4 of 4 sampled sinks inside resident rooms (Resident 4 [R4], Resident 9 [R9], Resident 7 [R7], and Resident 1 [R1]). This failure placed 32 of 32 residents and 30 staff at risk for potential skin burns.

Findings included...

Record review of the facility provided document titled, "water temperature log for San Juan Villas", undated, showed "hot water in all sinks and fixtures used must be between 105-120 F at all times."

Record review of 'temperature log' documentation, dated 10/08/2024, showed Staff K's initials as the person who last checked the water temperature. The document showed 12 different areas checked, 5 of those areas were resident rooms, however, the room number was not specified.

In an observation on 10/29/2024 at 10:58 AM inside the mechanical room closet labeled "Door 6," there was an undated form on the wall named "water temperature log for San Juan Villa" form. On the form was the month, location, name with dates and times to track temperatures throughout the building. The form was empty, and listed on the bottom was a legend that detailed proper water temperatures for different rooms throughout the facility; the hand washing sinks parameters were listed as 105degrees F to 120 degrees F.

In an observation on 10/29/2024 at 10:42 AM, in the unlocked public resident accessible restroom on the east side of the facility the hot water temperature was 123.9 degrees F.

In an observation on 10/29/2024 at 11:00 AM, in the unlocked resident accessible restroom across from the person protective equipment and housekeeping closets, the hot water temperature was 126 degrees F. The hot water had steam rising while it ran and was hot to touch.

In an observation on 10/29/2024 at 11:14 AM, in the resident dining room at the accessible sink, the hot water temperature was 121.9 degrees F.

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In observation on 10/29/2024 at 11:17 AM, inside R4's bathroom sink, the hot water was 125.6 degrees F.

In an observation on 10/29/2024 at 11:18 AM, the unlocked bathroom in the dining room located next to the kitchen area showed a water temperature of 123.7 degrees F.

In an observation on 10/29/2024 at 11:18 AM, inside R9's room, the sink hot water temperature measured 121.7 degrees F.

In an observation on 10/29/2024 at 11:19 AM, the unlocked bathroom in the dining room located next to the exit showed a water temperature of 124.2 degrees F.

In an observation on 10/29/2024 at 11:24 AM, inside R7's bathroom, the sink's hot water temperature was 122.2 degrees F.

In an observation and interview on 10/29/2024 at 11:27 AM, inside R1's bathroom, the sink's hot water temperature was 121.1 degrees F. R1 stated their hot water was "very hot" and raised their eyes wide open when they said that.

In an observation on 10/29/2024 at 12:32 PM, inside the unlocked resident accessible bathroom across from the linen and mechanical storage closets the sink's hot water temperature was 124.7 degrees F.

In an interview on 10/29/2024 at 11:40 AM, Staff K, Housekeeping Manager said the water temperatures are supposed to stay between 105 degrees F and 120 degrees F and that both Staff K and Staff I, Maintenance Supervisor, checked the water temperatures every two weeks.

In an interview on 10/29/2024 at 11:55 AM, Staff K said they did not remember which resident rooms were tested on the last testing date of 10/08/2024.

In an interview on 10/29/2024 at 1:45 PM, Staff A, Administrator, said they did not know the hot water temperature regulation parameters.

In an interview on 10/29/2024 at 1:52 PM, Staff K said they could not test the water temperature because the only facility thermometer was left in the maintenance truck, and that truck was not at the facility. Licensors offered to test the temperatures with Staff A and Staff K.

In an interview and observation on 10/29/2024, Staff A and Staff K accompanied licensors for water temperature re-checking in 3 of the 9 locations. At 1:49PM, the sink in R7's bathroom measured 123.8 degrees F. At 1:53 PM, the water temperature in R4's bathroom measured 123.9, and at 1:55 PM, the publicly accessible bathroom in the west hallway measured 123.6. All three measurements were also observed by Staff A and Staff K and both staff acknowledged these temperatures were too high.

In an interview on 10/29/2024 at 3:20 PM, Staff A said all water temperatures were still measured five degrees higher than intended and Staff S, Maintenance, had worked on the temperature adjustment.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/22/2024.

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

CSoule
Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;
- (3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and
- (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 for 6 of 6 locations (exterior of the facility, dining room, common hallway, Resident 1 [R1]'s bathroom, Resident 2 [R2]'s room and bathroom, and Resident 3 [R3]'s bathroom. This failure placed 32 of 32 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility provided document, titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", dated 10/13/2024, showed 32 of 32 residents had "Dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/ (condition causing memory loss and reduced functional abilities)

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/Cognitive Impairment (condition affecting thinking, memory, and decision-making). "

Record review of the facility's policy, titled, "Safety Inspections", dated 02/17/2016, showed the administrator and/or designated staff member would regularly inspect and walk through the facility looking for any hazards or potential hazards.

Record review of the facility's policy, titled, "cleaning resident rooms and furnishings", undated, showed all equipment and supplies would be stored in the commercial laundry room. The door would be locked when the housekeeper was not on duty. Supplies would be locked in separate cabinet and room with the commercial laundry room.

Record review of the Envirox H2Orange2 concentrate 117 sanitizer/virucide cleaner document titled, "safety data sheet", dated 04/05/2023, showed the cleaner had chemicals that included hydrogen peroxide (a chemical that is an antiseptic).

Record review of the Zep concentrated multi-purpose cleaner safety data sheet, dated 10/01/2023, showed the chemical had ethanol (a renewable, flammable, colorless chemical compound fuel) and alcohols.

Record review of the Armor all car wash-bottle safety data sheet, dated 09/15/2021, showed the chemical could cause serious eye damage and eye irritation. There were multiple ingredients in the chemical that included alkylbenzene sulfonic acid (a corrosive liquid) and methylchloroisothiazolinone (a preservative that is found in liquid cosmetics and personal care products.)

Record review of R1's face sheet, dated 10/22/2024, showed R1 moved into the facility on [REDACTED] /2023, with multiple medical diagnoses that included [REDACTED].

Record review of R2's, "Resident Info Sheet", undated, showed they had a diagnosis of [REDACTED].

Record review of R3's, "Resident Info Sheet", undated, showed they had a diagnosis of [REDACTED].

Exterior of the facility

In an observation and interview on 10/29/2024 at 10:31 AM, Staff A, Administrator, stated the outside fixtures located in back fenced in courtyard would be locked and inaccessible to residents. The shed in the grass had been unlocked. Inside of the shed there were clear plastic compartments that had sanitizer wipes, Lysol wipes, and hand sanitizer.

In an observation on 10/29/2024 at 11:41 AM, outside in the enclosed resident accessible back yard was an unlocked metal shed. Inside the metal shed were three full

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two-quart bottles of Armor All car wash solution. The car wash bottle showed "warning cancer and reproductive harm, avoid contact with eyes, skin and clothing. Wash hands after use. Do not swallow." There were multiple spray cans of Lysol disinfectant spray and opened plastic containers of Lysol disinfectant wipes.

Dining Room

In an observation on 10/29/2024 at 11:16 AM, inside the resident dining room in the upper unlocked cabinets above the resident accessible sink was a spray can of "Febreze". The can's label showed "caution keep out of reach of children and pets". The Febreze ingredients included alcohol denat (an alcohol product that adulterated with toxic that activates ingredients to penetrate deeper into the skin), hydrogenated castor oil (a hard white wax-like substance that comes from castor beans and could cause health risks if ingested), hydroxypropyl cyclodextrin (a plant-derived or synthetic carbohydrate that is used in skin care moisturizers, hair care products, and deodorant).

Common Hallway

In an observation on 10/29/2024 at 12:37 PM, just outside of the resident dining room across from the window of the kitchen were cabinets. Inside the upper right unlocked cabinet was a spray can of Febreze air mist.

R1

In an observation on 10/29/2024 at 11:27 AM, inside R1's bathroom sitting on top of the counter was a clear spray bottle that had "zep multi-purpose cleaner" (a chemical cleaning agent) written with black marker on the side. There was green lettering that was imprinted on the bottle that showed "H2Orange2 concentrate 117 sanitizer/virucide cleaner" (a chemical cleaner). Inside the unlocked double cabinet doors there was a bottle of nail polish, multiple bottles of various hair shampoos, a bottle of volumizing keratin condition that had ingredients that included alcohol, cetyl alcohol (waxy, white solid used in cosmetics, pharmaceuticals, and detergents), and keratin (a protein that helps build a person's hair stronger and smoother).

R2's room and bathroom and R3's bathroom

In an observation on 10/30/2024 at 10:29 AM, R2's side of the room which was closest to the exit door had a container of four ounces of premium hand sanitizer located on their nightstand next to their bed. At 10:30 AM, inside of R2 and R3's bathroom both sides of their cabinet that hung on the wall had been unlocked. The left side of the unlocked cabinet had been labeled as R2's belongings which had 18 fluid ounces of V05 strawberries and cream shampoo, 20 ounces of olive oil body wash, and 20 ounces of coconut shea butter bodywash. The right side of the unlocked cabinet had been labeled as R3's belongings which had 18 fluid ounces of passionate smooth conditioner, a container of argan oil shampoo, 24 fluid ounces of silkience bodywash, one purple container with an unidentified label, and one black container with an unidentified label. On top of the cabinet showed a bottle of Kirkland brand shampoo, Kirkland brand conditioner, and a container of Listerine mouth wash.

In an interview on 10/29/2024 at 12:40 PM, Staff K, Housekeeping Manager, stated all chemicals were to be locked up in a cabinet. Staff K stated sometime the caregivers

liked to leave the Lysol sprays and wipes out unlocked.

In an interview on 10/30/2024 at 10:55 AM, Staff B, Lead Medication Aide, said the facility had been a memory care unit. Staff B said the facility staff could never be sure if the resident's put items into their mouths and ingested something. Staff B said the facility policy was that there were not supposed to be any unsecured chemicals accessible to the residents. Staff B said items such as shampoo, Listerine mouth wash, and perfume should be locked in the resident's cabinets in their rooms. Staff B said the facility staff had keys to access the cabinets as needed.

In an interview on 10/30/2024 at 2:24 PM, Staff P, Caregiver, stated that all chemicals and disinfectant sprays were to be locked up in the facility. Staff P stated all resident shampoos and personal hygiene chemicals were to be locked up in the lockable cabinet in the resident's bathrooms.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/22/2024.

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

CSoull
Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and
- (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 areas (Interior facility and Exterior

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facility). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 32 of 32 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's policy, titled, "potential safety hazard reporting", dated 02/17/2016, showed staff would be expected to report any hazards or potential hazards to their supervisors or appropriate staff members. Common hazards may include cigarette butts or water containing tobacco residue, rough splintery furniture or equipment. Should a staff member become aware of safety hazards they were to report them immediately to a manager. If the staff member was able to correct the situation to minimize the likelihood that someone would get hurt, they were to do that.

Record review of the facility provided document titled, "Disclosure of Services Required by RCW 18.20.300", dated "03/2017", showed the assisted living facility must maintain resident living quarters and other areas residents may use in a safe, clean, and comfortable condition.

Interior Facility

In an interview on 10/29/2024 at 10:16 AM, Staff J, Office Manager, recommended that the Department staff did not utilize the public accessible bathrooms in the facility. Staff J recommended that the Department staff used the locked staff bathroom as it was the safest.

In an observation and interview on 10/29/2024 at 11:07 AM, Staff K, Housekeeping Manager, had a carpet cleaner in the common hallway. Staff K said they cleaned the carpets every other week. Staff K said they typically cleaned one side of the facility and then a couple days later would clean the other side of the facility. Staff K said they attempted to carpet clean the resident rooms every three weeks, unless it was needed sooner. Staff K said if they noticed a urine odor or that a resident urinated on the floor then they would carpet clean the ground immediately.

In an observation on 10/29/2024 at 11:15 AM, inside the resident dining room in the lower right cabinets by the public sink, the handle was pulled on when the Licensor's finger was pinched from a cabinet handle that was broke. When the cabinet handle was pulled on the plastic part separated and exposed the pointed part of the screw.

In an observation on 10/29/2024 at 11:30 AM, the baby doll station by room W2 showed the changing table had a soiled circular spot that had white chunks of an unknown substance on top of the soiled area.

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In an observation on 10/29/2024 at 11:19 AM showed in the resident dining room closest to the resident accessible bathroom across from the entry door to the facility lobby there were cabinets under a countertop. The cabinet to the right was noted to not be attached to the side of the cabinet frame. The child proof lock that was secured around the two cabinet doors was holding the cabinet door up. At 11:20 AM, inside the resident accessible public bathroom there was a soiled white brief disposed in the trash can. There was a strong pungent odor that resembled urine present.

In an observation on 10/29/2024 at 11:24 AM, inside R7's bathroom inside the trash was a disposed brief and blue disposable gloves. There was a strong pungent smell that resembled urine within the bathroom area.

In an observation on 10/29/2024 at 1:17 PM, inside R7's room behind the head of R7's bed on the wall there were large scrapes and various sized holes in the wall. The scrapes and holes started halfway down the wall and continued down to the top of the trim on the wall.

In an observation on 10/30/2024 at 9:58 AM, inside R1's room, there was a strong odorous smell that resembled urine.

In an observation on 10/30/2024 at 11:27 AM, inside R1's bathroom, there was an odorous smell that resembled urine that permeated the surgical mask that the licensior had worn.

In an interview on 10/30/2024 at 11:38 AM, Collateral Contact 1, R7's Daughter, when they visited with R7 in their room there was a smell of urine present.

In an observation on 10/30/2024 at 2:15 PM, the baby doll area station by room W2 showed the changing table still had the soiled circular spot that had white chunks of an unknown substance on top of the soiled area.

Exterior Facility

In an observation on 10/29/2024 at 10:32 AM, behind the building in the back fenced in courtyard the beige siding from the top to the bottom had been covered in an unknown green substance. At 10:32 AM the side of the building had white trim that had broken off and rested in the grass. There had been a box with an open empty soda can and a blue disposable cup inside that was by the fence and side door to the facility.

In an observation and interview on 10/29/2024 at 10:33 AM, the window next to the kitchen that overlooked the parking lot and covered awning showed a green box, a black rolling cart, four black rugs that were hung over a railing, a broom, and a mop were all in view of the resident accessible window. Staff A, Administrator said that the kitchen staff had access to the area through the door in the kitchen.

In an observation on 10/30/2024 at 2:47 PM, the kitchens back door that overlooked the parking lot had a grill with white wooden boards and netting stacked on top of it. There was a silver cylinder mechanism with wires that had water disposal typed on it. There were three grey bins and one yellow bin. There was a black rolling cart. Behind the cart were two bristled brooms and one blue mop. There were four black rugs that were hung over a railing. All items had been in the view of the resident accessible window. Unseen items that were located on the other side of the fenced awning showed a snow shovel, a blue bucket, an uncoiled hose, and brush. Behind a tree in the front of the building there had been a wheelbarrow that faced downwards and there was an empty egg carton. In an observation and interview on 10/29/2024 at 10:56 AM, outside in the enclosed resident courtyard on the ground behind a chair were two smoked cigarette butts, gray and black dust that resembled ash on the ground. Staff A acknowledged the cigarette butts.

In an interview on 10/30/2024 at 2:23 PM, Staff I, Maintenance Supervisor, said the maintenance department pressure washed the building on a yearly basis. Staff I said the maintenance department had not yet completed their yearly pressure washing of the building and the last time they completed the task had been September 2023.

In an interview on 10/30/2024 at 10:40 AM, Staff K said they were unsure when the outside of the facility had been pressure washed last. Staff K said they did not have a reference to utilize of when they were supposed to clean what.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/12/2024.

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


Administrator (or Representative)

12/3/2024
Date

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

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

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records for 2 of 2 facility devices (medication cart trash and medication cart computer). These failures placed 32 of 32 residents at risk for exposure of confidential records.

Findings included...

Record review of the facility's policy, titled, "HIPPA [Health Insurance Portability and Accountability Act] Privacy", undated, showed protected health information (PHI) was information that was created or received by the facility and its employees that relates to the past, present, or future physical or mental health or condition of a resident, and that identified the resident or for which there was a reasonable basis to believe the information could be used to identify the resident. The facility policy was to comply fully with HIPPA's requirements. All employees would receive training necessary and appropriate to permit them to carry out their job functions. All employees must comply with this privacy policy.

In an observation and interview on 10/30/2024 at 10:10 AM, in the medication room with the door open, in the medication cart trash can that did not have a lid, were multiple plastic white packages that were in the trash. On some of the white plastic packages showed it was a prescription label that had R8's first and last name and R8's medications, vitamin B12 (supplement to help keep a person's body's blood and nerve cells healthy), vitamin D (a supplement to helps regulate amount of calcium and phosphate in the body that keeps bones, teeth, and muscles healthy), and omeprazole (a prescribed medication that helps reduce the amount of acid in the stomach). A few other white plastic packages showed they had R9's first and last name and their medication names. Staff M, Medication Aide, stated they were trained to throw the resident prescription white plastic packages in the trash that was then taken out to the dumpster and then taken off by the waste management company. Staff M stated it would take a long time to scribble out the resident's name and personal information on all the white plastic packages. Staff M stated all residents PHI would be placed in the shred box to be destroyed.

In an observation on 10/30/2024 at 12:14 PM in the hallway across from the kitchen's door, the medication cart was stored and unattended with the computer screen on and open. The computer screen displayed 24 resident's names and pictures on the screen. Some of the resident pictures and names that were displayed included Resident 10, Resident 11, and Resident 5. At 12:16 PM, Staff M came out of the kitchen's door from being inside the kitchen and attended the medication cart.

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In an observation on 10/30/2024 at 12:17 PM, Staff M left the medication cart. On top of the medication cart, the computer was left open and on. The computer screen displayed R12's first and last name and picture. Staff M returned to the medication cart at 12:20 PM.

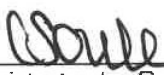
In an interview on 10/30/2024 at 12:32 PM, Staff M stated before they were to leave the medication cart and medication cart computer, they were to click on the black sunglasses on the electronic system to hide all personal resident information. Staff M stated they could also close the electronic system or close the top of the computer shut. Staff M stated they had a difficult time remembering to secure the medication cart's electronic record system.

In an interview on 10/30/2024 at 1:31 PM, Staff B, Lead Medication Aide, stated to secure residents' personal information on the medication cart computer, the medication aides were to click on the black sunglasses that would hide the information. Staff B stated the medication aide could close the computer's screen shut or exit out of the electronic system to hide the resident's personal information any time the medication aide left the medication cart or computer unattended. Staff B stated all of the resident's pharmacy white plastic packages with their first and last names, and the names of their medications were disposed in the normal trash on the medication cart. Staff B stated the trash on the medication cart was disposed in the big dumpster outside that was then taken to the public waste management. Staff B stated all PHI information was to be kept secured and if needed to be disposed placed in a special shredding box.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/22/2024.

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


Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

- (1) An initial skin test within three days of employment, and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to ensure that 5 of 5 sampled Staff (Staff A, Staff B, Staff C, Staff D, and Staff L) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within the required time frames. This failure placed 32 of 32 residents and staff at risk for exposure to TB.

Findings included...

Record review of the Centers of Disease Control document titled, "Testing for Tuberculosis: skin test", dated 04/22/2024, showed a TB skin test required two visits with a healthcare provider. If a person received a TB skin test, they would have two visits with the healthcare provider. During the first visit, the healthcare provider would inject a small amount of TB solution just under the skin on the lower part of the inner arm. On the second visit after two or three days, the person would return to the healthcare provider and have the skin test that was injected on the inner arm observed and determine if it was a positive or negative test result. Under the section titled, "two-step TB skin test", showed if someone was a healthcare worker they would have a two-step TB skin test. The two-step TB skin test could lower the chance that boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the first-step TB skin test was classified as negative, a second-step TB skin test would be given one to three weeks after the first test was read.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Staff A

Record review of the facility's document Employee HR [human resources] List, undated, showed Staff A, Administrator, was hired at the facility on 01/17/2022.

Record review of an email sent to the Department on 10/31/2024 at 11:34 AM, showed Staff A's first day of employment at the facility was on 02/01/2022.

Record review of Staff A's TB test by Mantoux method, undated, showed Staff A received their second step TB test on 07/29/2022. Staff A's second step TB test was read on 07/30/2024. Staff A's second skin TB test was read within 24 hours after the skin test was administered.

Staff B

Record review of the facility's document Employee HR List, undated, showed Staff B, Lead Medication Aide, was hired at the facility on 11/08/2023.

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Record review of an email sent to the Department on 10/31/2024 at 11:34 AM, showed Staff B's first day of employment at the facility was on 11/13/2023.

Record review of Staff B's TB test by Mantoux method, undated, showed Staff B received their step one TB skin test on 03/08/2024. Staff B's first step skin test was read on 03/09/2024. Staff B received their second step skin test on 03/22/2024. Staff B's second step TB skin test was read on 03/23/2024. Both of Staff B's TB skin tests were read within 24 hours after been give the skin test. Staff B's first step skin test was completed 113 days past the required time.

Staff C

Record review of the facility's document Employee HR List, undated, showed Staff C, Caregiver, was hired at the facility on 08/26/2024.

Record review of an email sent to the Department on 10/31/2024 at 11:34 AM, stated Staff C, Caregiver, first day of employment at the facility was on 08/27/2024.

Record review of Staff C's TB test by Mantoux method, undated, showed Staff C's step one TB skin test was administered on 09/14/2024. Staff C's step one TB skin test was administered 16 days after the required time.

Staff D

Record review of the facility's document Employee HR List, undated, showed Staff D, Caregiver, was hired at the facility on 07/02/2024.

Record review of an email sent to the Department on 10/31/2024 at 11:34 AM, stated Staff D's first day of employment at the facility was on 07/08/2024.

Record review of Staff D's TB test by Mantoux method, undated, showed Staff D's step one skin test was administered on 07/20/2024. Staff D's step one TB skin test was administered nine days after the required time.

Staff L

Record review of the facility's document Employee HR List, undated, showed Staff L, Life Enrichment Assistant, was hired at the facility on 07/20/2023.

Record review of an email sent to the Department on 11/08/2024 at 2:03 PM, stated Staff L's first day of employment at the facility was on 07/20/2023.

Record review of Staff L's TB test by Mantoux method, undated, showed Staff L's step one skin test was administered on 07/25/2023. Staff L's step one TB skin test was read on 07/26/2023 that was only 24 hours from the administration.

In an interview on 10/30/2024 at 11:45 AM, Staff A, Administrator, stated staff were required to receive the first step of their TB test series within the first three days of employment. Staff A said they were not sure if all staff had received their TB test within the first three days of employment.

In an interview on 10/30/2024 at 5:15 PM Staff A acknowledged some staff working at

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the facility did not receive their TB test within three days of hire.

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) <u>12/22/2024</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Boule</u> Administrator (or Representative)	<u>12/3/2024</u> Date

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

- (1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;
- (2) Be provided both orally and in writing in a language that the resident understands;
- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;
- (6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 4 of 7 sampled Residents (Resident 2 [R2], Resident 4 [R4], Resident 6 [R6], Resident 7[R7]). This failure placed these residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included...

R2

Record review of R2's "Resident Info Sheet", undated, showed R2 moved into the

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facility on [REDACTED]/2022.

Record review of an email sent to the Department on 11/06/2024 at 11:01 AM, showed Staff A, Administrator, stated that R2 did not have a Medicaid agreement to review.

R4

Record review of R4's "Resident Info Sheet," undated, showed that R4 moved into the facility on [REDACTED]/2024.

Record review of an email sent to the Department on 11/07/2024 at 2:03 PM, showed Staff A, Administrator, stated that R4 did not have a Medicaid agreement to review.

R6

Record review of R6's "Resident Info Sheet", undated, showed R6 moved into the facility on [REDACTED]/2024.

Record review of R6's Medicaid Agreement Acknowledgement, dated [REDACTED]/2024, showed it was not signed by the resident or the resident's representative.

R7

Record review of R7's "Resident Info Sheet", undated, showed R7 moved into the facility on [REDACTED]/2023.

Record review of R7's Medicaid Agreement Acknowledgement, undated, showed it was not signed by the resident or the resident's representative. There was a line that had been drawn diagonally through the document.

In an interview on 10/30/2024 at 4:39 PM, Staff A acknowledged that R6's Medicaid agreement was not signed by the resident or the resident's representative. Staff A acknowledged that R7's Medicaid agreement had a line through it. Staff H, Regional Director Operations, said historically they thought if the resident had already been on Medicaid services they did not need to have the resident or resident's representative sign the Medicaid agreement.

In an interview on 11/08/2024 at 3:45 PM, Staff A said the facility administrator was responsible for ensuring that each prospective resident receives and signed a Medicaid agreement.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 11/12/2024.

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


Administrator (or Representative)

11/13/2024
Date

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

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff completed proper hand hygiene, had appropriate storage, and cleaning procedures for 1 of 1 kitchen reviewed. These failures placed 32 of 32 residents at risk for exposure to food-borne illnesses.

Findings included...

Washington Administrative Code (WAC) 246-215-02310 "Hands and arms—When to wash (FDA Food Code 2-301.14). FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) After handling soiled EQUIPMENT or UTENSILS; (6) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (7) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (8) Before donning gloves for working with READY-TO-EAT FOOD unless a glove change is not the result of contamination; and (9) After engaging in other activities that contaminate the hands or gloves."

WAC 246-215-03300 "Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."

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WAC 246-215-04605

"Objective—Equipment food-contact surfaces and utensils (FDA Food Code 4-602.11). (1) EQUIPMENT, FOOD-CONTACT SURFACES, and UTENSILS must be cleaned: (5) Except when dry cleaning methods are used as specified under WAC 246-215-04620, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be cleaned: (a) At any time when contamination might have occurred; (d) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (i) At a frequency specified by the manufacturer; or (ii) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold."

WAC 246-215-03351

"Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

- (a) In a clean, dry location;
- (b) Where it is not exposed to splash, dust, or other contamination;

Record review of the facility's policy titled, "Infection Control", dated 02/17/2016, showed hand washing was the most single important measure for preventing the spread of infection and disease. All staff were responsible to carry out the hand washing policy. Hands should be washed before and after touching the resident. Hands should be washed after glove removal. Hands should be washed before handling food, or whenever a staff changed from doing a dirty task to a clean task. Dietary employees must wash hands at the sink upon reentry of the kitchen. The use of gloves does not replace handwashing.

Record review of the facility provided document titled, "Kitchen Sanitation Task Sheet", undated, showed daily tasks included to wash, rinse, sanitize, and air dry the front of all cabinets at 10:00 AM, 2:00 PM, and 6:00 PM. Weekly tasks included to clean all cabinets.

Hand Hygiene

In an observation on 10/30/2024 at 12:18 PM, Staff R, Housekeeper, was observed inside the kitchen in front of the serving line. Staff R wore black disposable gloves on both of their hands. Staff R grabbed her surgical mask and pulled it up over their nose with her gloved hand. Staff R grabbed four plates from the assembly line with ready to eat food and placed them on a gray rolling cart. Staff R pushed the gray rolling cart out the kitchen door. When Staff R approached a table with four residents, Staff R pulled their surgical face mask down with their black gloved hand and began to pass the ready to eat plates to the residents that sat at the dining tables. Staff R picked up some used drinking cups from resident table and placed it on the gray rolling cart with their gloved hand. Staff R approached the door to the kitchen and put in the code on the door to unlock with their gloved hand. Staff R entered the kitchen and removed the soiled cups from the rolling gray cart and placed them in the dish pit area. Staff R grabbed four ready to eat plates of food with the same black gloved hands and placed them on the gray rolling carts. Staff R opened the kitchen door and went out to the dining room area pushing the rolling gray cart. At 12:22 PM, Staff R grabbed the back of a resident dining

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chair with their same black gloved hands when they talked with a resident. Staff R returned to the kitchen's door and put in the code to unlock the door with their black gloved hand. Staff R entered the kitchen and stood in front of the assembly line when they pulled their surgical mask down with their gloved hand and leaned on the rolling gray cart with their forearms. At 12:24 PM Staff R lifted their surgical face mask up over their nose and grabbed ready to eat plates of food they placed on the rolling gray cart. At 12:26 PM Staff R exited the kitchen and was observed to touch her hat on her head with her gloved hands. Staff R delivered the ready to eat plates to the residents and then returned to the kitchen door when they put the code in with their gloved hands. Staff R approached to the assembly line where they were observed to lower their surgical face mask down under their chin and scratched their ear with their gloved hand. As of 12:28 PM, Staff R continued to wear the same black disposable gloves as first observed at 12:18 PM. Staff R was not observed to wash their hands with soap and water or use hand sanitizer.

In an interview on 10/30/2024 at 1:10 PM, Staff G, Dietary Manager, said facility staff were to perform hand hygiene when they entered the kitchen. Staff G said staff wore gloves when they served food and touched plates. Staff G said if gloves were used, they would need to change them when they changed tasks. Staff G said if facility staff needed to take off their gloves and put on new ones then they would need to perform hand hygiene.

Food Storage

In an observation and interview on 10/29/2024 at 3:35 PM, under the kitchen sink inside of the cabinet located across from the food line showed there was a green grated bucket that contained multiple containers of individually packaged grape jelly on the cabinets floor. There had been a container of 29.5 ounces of Folgers house blend coffee in a red container with a black lid. The coffee was on top of a box on the cabinet floor labeled breakfast essentials rich chocolate milk. Located above the coffee and to the side of the jelly was the white tubing that allowed water to drain out of the sink. At the top of the tubing's seal had a brown wet substance that had accumulated. The brown wet substance residue had dripped to the bottom of the tubing. At 3:41 PM, Staff G observed the food items that were underneath the kitchen sink and said that the facility staff did not normally store food under the sink.

In an observation on 10/30/2024 at 1:07 PM, under the kitchen sink inside of the cabinet still had the food observed on 10/29/2024 at 3:35 PM.

Cleanliness

In an observation and interview on 10/29/2024 at 3:42 PM, the ice machine inside of the kitchen showed when it was opened the left side of the silver siding had black speckled substances along the side of the wall. The black speckled substances were in a curve that aligned with the how the ice machine's black lid opened and closed. On the right side of the wall there was a white substance that formed on the wall. At 4:08 PM, Staff G said the ice machine had been cleaned every few months. Staff G said the ice machine broke a few months ago and that was the last time facility staff cleaned the machine. Staff G used a brown napkin to wipe the black speckled substance along the wall and there was a brown and black residue that came off onto the napkin. Staff G acknowledged the napkin had been soiled. Staff G said they had no idea what the black and brown substance was.

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In an observation on 10/29/2024 at 3:44 PM, the vent on the ceiling in front of the kitchen cabinets located across from the food line showed that there were five white squares that gradually decreased in size. In between each of the squares there was a fuzzy substance that moved as the air exited the vent. Each of the five white squares had brown markings that covered the once white fixture. The white wall that surrounded the vent had been discolored and it had brown splotches that accumulated around the square edges. At 3:47 PM, the grated vent outside of the entrance door showed it had once been white. The vent had been discolored to a brown color. There was a fuzzy substance on each of the grates that moved as the air exited the vent. At 4:10 PM, Staff G said they were unsure how often the kitchen vents were supposed to be cleaned. Staff G said they had followed up with the maintenance staff to clean the vents. Staff G confirmed the vent by the kitchen cabinets located across from the food line had accumulated debris that moved as the air exited the vent. Staff G said they had concerns about the vent located in front of the walk-in refrigerator and next to the kitchen hand washing sink. Observation showed that the vent above the hand washing sink had five white squares that had been covered in a brown color and had a fuzzy substance that moved as the air exited the vent.

In an observation on 10/29/2024 at 3:46 PM, the kitchen counter located across from the food line showed six of six yellow cabinets reviewed had brown splatters from the top to the bottom of cabinets.

In an observation and interview on 10/29/2024 at 3:51 PM, inside of the walk-in refrigerator showed the fire suppression system on the ceiling had a white bucket directly under it. Inside of the white bucket had been water droplets that started to accumulate. The right side of the refrigerator had a square unit that protruded out of the wall with a pipe that was above the food shelving unit. Around the pipe had an absorbent material that surrounded it. Under the pipe had a rectangular tray of water that sat on the shelving unit with water that had accumulated. At 3:55 PM, Staff G said that the fire expression system had been broken for approximately less than a month. Staff G said they had inquired with maintenance staff about the issue. To Staff G's understanding there had been a leak in the hose that caused the dripping water. Staff G said the item to the right of refrigerator was the cooler and nothing was wrong with the cooler. Staff G said the cooler leaked due to condensation and they put a pan underneath it to ensure water did not leak onto the food that had been stored underneath it.

In an interview on 10/29/2024 at 4:10 PM, Staff G said they recently had a company meeting where they met with corporate to discuss kitchen cleaning expectations. Staff G said the kitchen staff had been working on developing a cleaning schedule that worked for their kitchen. Staff G said the cleaning expectations had been through trial and error.

In an observation and interview on 10/30/2024 at 1:07 PM, Staff G observed the six yellow cabinets and confirmed there had been dirt on them. Staff G said could not provide a date of when the cabinets had last been cleaned. Staff G could not confirm when the cabinets were scheduled to be cleaned. Staff G said they had met with Staff H, Regional Director Operations, who provided them the kitchen sanitation task sheet to use. Staff G said they had printed the resource to use today 10/30/2024.

In an interview on 10/30/2024 at 2:23 PM, Staff I, Maintenance Supervisor, said they

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could not provide a date of when the vents in the facility had been cleaned. Staff I said they had not checked the facility vents in at least a year. Staff I said they tried to complete an annual check on the vents. Staff I said the kitchen staff would be responsible to clean the kitchen vents. Staff I then said if the Department asked Staff A, Administrator, who had been responsible to clean the vents Staff A would inform the Department it would be the maintenance department. Staff I had been notified that fuzz had accumulated on the vents and it blew in the wind as air exited the vents. Staff I said the maintenance department tried to clean the vents before they got that bad. Staff I said they tried to get the facility staff to work as a team because the maintenance department could not pay attention to every detail. Staff I said they did not have a guideline of basic maintenance regulatory guidelines that included when they should clean certain areas in the facility. Staff I said the kitchen staff would be responsible for cleaning the ice machine. Staff I said the fire suppression system in the fridge had a leak that caused ice to form. Staff I said they got the leak fixed. Staff I said the bucket in the fridge was because condensation formed and then would leak onto the ground. Staff I said they did not think it would be normal for a working kitchen to need a bucket in the fridge to catch water.

In an interview on 10/30/2024 at 4:39 PM, Staff A said the maintenance department had been responsible to clean the kitchen vents since it required the use of a ladder. Staff A and Staff H acknowledged the concern about the kitchen vents and how there had not been a cleaning schedule established. Staff H confirmed they gave staff G the kitchen sanitation task list to utilize. Staff A and Staff H had been requested to submit documentation to the Department to review about what the facility had done to fix the fire suppression system inside of the walk-in refrigerator in the kitchen.

As of 11/08/2024 the Department had not received documentation to support what the facility had done to fix the fire suppression system inside of the walk-in refrigerator in the kitchen.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/12/2024.

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

OSoule
Administrator (or Representative)

11/3/2024
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

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nursing for each resident; and

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(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:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to have Registered Nurse (RN) Delegation services and documentation in place for 1 of 7 sampled residents (Resident 1). This failure placed Resident 1 at risk for receiving care and services by untrained staff.

Findings included...

Washington Administrative Code (WAC) 246-840-930 Criteria for delegation. "(1) In community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE...

(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition...

(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing

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assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks, and may be more frequent. (13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient."

Record review of the Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", undated, showed medication administration was a way an individual received their medication from an authorized person. The task must be delegated if it was for the long-term care worker to complete. If a resident was not functionally able and or not cognitively aware they received medications, the long-term care worker with authorization would administer the delegated task to the resident. Administration required must be documented in the RN's assessment.

Record review of R1's face sheet, dated 10/22/2024, showed R1 moved into the facility on [REDACTED] /2023, with multiple medical diagnoses that included [REDACTED]

Record review of R1's Service Agreement (facility's version of the negotiated service agreement and assessment in one document), dated 10/11/2024, showed R1 had poor short and long-term memory. R1 was alert and disoriented. R1 could not follow simple instructions. R1 was unaware what day, season, or year it was. R1 was able to place medication in their mouth and swallow them whole. R1 required staff assistance with their medications. R1 was unaware of what medications they were on or why. Registered Nurse delegation was not checked as a service that R1 required.

Record review of R1's Medication Administration Record, dated 10/01/2024 through 10/31/2024, showed R1 had the following medication prescribed and administered by the facility that included, aspirin (a medication that can help reduce pain or inflammation and helps reduce the risk of your blood from clumping together into clots) taken daily, clobetasol propionate cream (a prescribed cream that helps reduce swelling, inflammation, redness and itching on the skin rash) that was applied to R1's upper back and neck, clobetasol propionate solution (a prescribed liquid that helps reduce swelling, inflammation, redness and itching on the head) applied to R1's scalp two times a day for a rash, clotrimazole- betamethasone cream (a medicated cream that helps reduces redness, inflammation, itching, and heal certain skin rashes) applied to R1 buttocks area two times a day, fiber laxative (a medication that is taken to help bult the stool and empty) five capsules two times a day, hydrocortisone cream (a medicated cream to help reduce swelling, redness, itching on the skin) applied to skin two times a day, loratadine (medication to help reduce symptoms of allergies that

include runny nose, itchy eyes, sneezing) given orally once a day, melatonin (a medication to help aid in sleeping) two tablets given once a day at bedtime, quetiapine fumarate (a prescribed medication to help treat mental health conditions and stabilize mood) given one tablet two times a day, and trazadone (a prescribed medication to help a person sleep at night) once a day at bedtime.

In an interview on 10/29/2024 at 3:51 PM, R1 stated "no I don't take medications", when they were asked if they took medications.

In an interview on 10/29/2024 at 4:03 PM, Staff M, Medication Aide, stated R1 required the medication aides to put one pill on a spoon at a time and administer it to R1. Staff M stated R1 had a difficult time swallowing all of their medications at once and if R1 was handed their medications they would put all of them in their mouth at once.

Record review on 10/29/2024 at 4:13 PM, of the facility's RN delegation binder showed there was a list of residents that were delegated. Review of the list showed R1 was not listed. Review of the document in the binder showed there were no RN delegation documents for R1 for review.

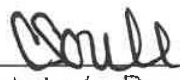
In an interview on 10/30/2024 at 1:31 PM, Staff B, Lead Medication Aide, stated the RN delegation binder was updated with all the residents that required RN delegated task and services.

In an interview on 11/07/2024 at 1:13 PM, Staff N, Director of Nursing Services, stated R1 was not delegated for their oral medications. Staff N stated all the documents in the RN delegation binder that was available for the Department to review were the only residents that had delegated nursing tasks.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/22/2024.

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


Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to notify residents when food substitutions were made for 1 of 1 kitchen reviewed. This failure placed all 32 of 32 residents at risk of diminished quality of life.

Findings included...

Record review of the facility provided document titled, "Weekly Menu", dated 10/27/2024 – 11/02/2024, showed on 10/29/2024 the lunch that was scheduled to be served was spiced apple pork chops, homestyle stuffing, baked squash, baked roll, and a soft snickerdoodle. On 10/30/2024 the lunch that was scheduled to be served was Salisbury steak, sour cream potatoes, country trio medley, baked roll, and fruit cobbler.

Record review of the facility provided document by Staff G, Dietary Manager, titled, "Weekly Menu", dated 10/27/2024 – 11/02/2024, showed there were no alterations or substitutions to the menu on 10/29/2024. On 10/30/2024 there had been one alteration marked on the dinner menu instead of the residents being served fish sticks and fries they had been served a chicken sandwich. In an interview on 10/30/2024 at 1:33 PM, Staff G, Dietary Manager, said if there had been a change to the menu, they wrote it on the daily menu outside of the kitchen on the bulletin board, so residents had knowledge of what the change was.

In an observation on 10/29/2024 at 12:35 PM, in the resident dining room, multiple residents were sitting at the dining tables eating and being served a bowl that had brown liquid, chunks of brown substance that resembled meat, white chunks that resembled potatoes, and orange chunks that resembled carrots. The residents had a smaller bowl that had peach colored wedge pieces that resembled peaches that were covered with brown oat crumble. Resident 5 stated the beef stew was good.

In an interview on 10/29/2024 at 2:00 PM, Resident 13 stated the facility food that was served was very bad and tasted terrible.

In an interview on 10/30/2024 at 12:01 PM, Staff R, Housekeeper, stated they believed chicken salad was being served for lunch. Resident 5 stated that was "boring at least add cheese". Resident 5 stated they never know what they will be eating for meals until it was served.

In an observation on 10/30/2024 at 12:03 PM, on the wall outside of the kitchen's door in the resident hallway, the "Weekly Menu", dated 10/27/2024 through 11/02/2024 was

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posted. The document showed on 10/29/2024 for lunch the residents were to be served spiced apple pork chops, homestyle stuffing, baked squash, baked roll, and a soft snickerdoodle without any of the items being crossed off or changed. On 10/30/2024 for lunch the residents were to be served Salisbury steak, sour cream potatoes, country trio medley, baked roll, and fruit cobbler w/out any edits or alterations made to the menu.

In an observation on 10/30/2024 at 12:17 PM, in the dining room for lunch the residents were served rice with brown chunks of meat, brown gravy on top, steamed broccoli with cauliflower, and cupcakes for dessert.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 11/12/2024

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


Administrator (or Representative)

11/3/2024
Date

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 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

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 3 of 7 sampled residents (Resident 1 [R1], Resident 3 [R3], and Resident 7 [R7]). This failure placed the residents at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included...

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Record review of the facility's untitled and undated document, under the section titled, "managed risk evaluations procedure", showed the evaluations were to be completed by a trained staff person that include the registered nurse, licensed practical nurse, resident care coordinator, and a qualified assessor. The documents showed medical equipment risk should be completed up on admission and when the service plan was updated.

Record review of the facility provided document titled, "Service Plans", undated, showed the service plan review and care conference guide showed smoking evaluations needed to be updated.

R1

Record review of R1's face sheet, dated 10/22/2024, showed R1 moved into the facility on [REDACTED] /2023, with multiple medical diagnoses that included [REDACTED]

Record review of R1's Service Agreement (facility's version of the negotiated service agreement and assessment in one document), dated 10/11/2024, showed R1 had poor short and long-term memory. R1 was alert and disoriented. R1 could not follow simple instructions. R1 was unaware what day, season, or year it was. R1 required two persons full assistance with transfers and used a wheelchair to get around. Care staff were to be aware that R1 could become combative in the middle of transferring and staff were to anticipate to complete a safe transfer.

In an observation on 10/29/2024 at 11:27 AM, inside R1's room next to the right side of their bed was a pole that connected from the ceiling down to the ground, a transfer pole.

Record review of R1's medical chart, on 10/29/2024 at 3:10 PM, showed there were no medical device assessments for R1's transfer pole completed for review.

In an interview on 10/29/2024 at 3:51 PM, inside R1's bedroom, R1 was sitting in a stationary chair talking to a white and brown stuffed dog. R1 was unable to answer if they used their transfer pole to help transfer.

In an interview on 10/30/2024 at 10:05 AM, Staff M, Medication Aide, stated all residents that used a wheelchair required to staff members to help them transfer. Staff M stated R1 has a transfer pole in their room beside their bed. At times R1 used the transfer pole but would only be able to stand with the two staff assistance and stand for a few moments before they got too weak and needed to sit down.

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Record review of an email sent to the Department on 10/30/2024 at 12:44 PM, showed the facility did not have a transfer pole assessment for R1 available for review.

R3

Record review of R3's, untitled and undated document, showed it had been R3's resident information sheet. R3 moved into the facility on [REDACTED]/2023. The risk factor section showed R3 had not been identified as a smoker.

Record review of R3's "Service Agreement", dated 10/19/2024, showed R3 would occasionally ask to go outside for a cigarette. R3 can smoke with an escort in the designated smoking areas only. R3 had cigarettes in the medication technician room. The document had been signed by R3's Resident Representative, Staff A, Administrator, and Staff B, Lead Medication Aide.

Record review of R3's, "Pre-Admission Smoking Risk Evaluation", dated 04/10/2023, showed R3 had not been a smoker. The cognitive concerns, functional risk factors, medications that can impair alertness, awareness, strength, and safety, and concerns based on history were blank. In blue ink there had been a diagonal line drawn through the document.

Record review of R3's, "Resident Alerts", dated 09/01/2024 at 7:32 PM, showed Staff Q, Medication Aide, wrote except for smoke breaks R3 had been in their room.

Record review of R3's "Resident Alerts", dated 09/02/2024 at 4:11 PM, showed Staff M, Medication Aide, wrote R3 asked to smoke.

In an interview on 10/30/2024 at 11:14 AM, Staff B, Lead Medication Aide, confirmed R3 smoked. Staff B said they had been unsure about which facility staff member would be responsible to complete updated smoking risk evaluations for the residents.

Record review of an email sent to the Department on 11/07/2024 at 4:35 PM, showed Staff A, Administrator, replied that a smoking evaluation should be completed when a resident's smoking status changed.

R7

Record review of R7's "Resident Info [information] Sheet", undated, showed R7 moved into the facility on [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] t, and at times ability to care out activities of daily living needs), history of falls, and bowel and bladder incontinence (a person's inability to control loss of urine or bowel)).

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In an observation on 10/29/2024 at 11:24 AM, inside R7's room, on R7's bed was a side rail on the left and right side of the upper part of the bed and a trapeze that was hung up on the frame and unable to use.

Record review of R7's Service Agreement, dated 09/11/2024, showed R7 could be very resistant during activities of daily living care (ADL's) needs that required more staff assistance. R7 required full assistance by staff with their ADL's. R7 liked to walk around the facility. As of 05/29/2024 R7 was walking less and required more use of their wheelchair. R7 required two-person assist with all transfers related to their poor gait (balance) and history of falls. R7 often became agitated if they felt they were being rushed. R7 was independent with bed mobility and used a trapeze (a device that connects to the bed frame that has a triangle that hangs down that a person can grab and help move themselves in bed independently) to help assist themselves up if needed.

Record review of R7's medical chart, on 10/29/2024 at 3:20 PM, showed there were no medical device assessments for R7's siderails or trapeze bar completed for review.

In an observation and interview on 10/30/2024 at 9:42 AM, R7 was in bed in their room. R7's bed had the left and right siderails up on the upper part of their bed. R7's trapeze triangle bar was hung up on the bar, inaccessible for R7 to grab and use. R7 was asked if they used the siderails and trapeze bar that was on their bed to help them move around and was unable to answer the question and noted to have word salad (meaningless speech that lacks logical structure).

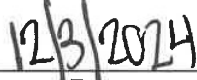
In an interview on 10/30/2024 at 10:05 AM, Staff M, Medication Aide, stated R7 required two staff caregivers to assist them with their ADL's and transfers. Staff M stated at times R7 required three caregivers to help R7 transfer if they experienced resistive and combative behaviors. In an interview on 10/30/2024 at 1:31 PM, Staff B, Lead Medication Aide, stated R7 did not have an assistive device assessment for their trapeze bar or their bed siderails. Staff B stated they started employment at that facility in November 2023 and had not seen R7 use the trapeze bar or the siderails. Staff B stated R7 was unable to be cued by staff to use the two assistive devices to help with moving in bed or lift their body up.

Record review of an email sent to the Department on 10/30/2024 at 12:44 PM, showed the facility did not have a Trapeze bar nor siderail assessment for R7 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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 10/22/2024

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

 Administrator (or Representative)	 Date
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WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor and document residents well-being after not receiving prescribed medications and treatments for 2 of 7 sampled residents (Resident 2 [R2] and Resident 3 [R3]) after their medications were unavailable for administration. This failure placed both residents at risk for medical complications.

Findings included...

Record review of the facility provided document titled, "Missing or unavailable medication procedure", undated, showed if a medication had not been delivered from the pharmacy, step five showed the resident would be placed on alert charting to monitor for side effects of the resident not receiving the medications. Step ten said if a resident missed a dosage of medication, it must be written in the progress note on the side effects of the missed medications and what steps were being done to obtain the medication. No resident should ever miss a dosage of medication. It was the facility's responsibility to obtain the medications. All medication aides should re-order resident medications 7-10 days before it ran out. The facility staff were to alert the nurse and resident care coordinator prior to running out of medications.

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Record review of R2's "Service Agreement", dated 10/02/2024, under R2's medical care management section showed the medications aides were to administer R2's medications and treatments per the physician orders. The medications aides were to reorder medications in a timely manner and store the medications. R2 was to wear their oxygen at all times. R2 had a concentrator in their room and portable tanks when they were out of the facility.

Record review of R2's MAR (Medication Administration Record), dated 08/01/2024 – 08/31/2024, showed R2 had an order for oxygen. The facility staff were to check and make sure that resident wore oxygen at two liters. R2 would wear their concentrator in their room and the portable outside of their room. The exceptions section for R2 showed on 08/22/2024 at 9:31 AM and 11:49 AM that R2's medication had not been available, and it had been waiting on delivery due to R2 had been out of oxygen tanks. On 08/23/2024 at 8:53 AM and 11:24 AM showed that R2's medication had not been available, and it had been waiting on delivery due to R2 had been out of oxygen tanks.

Record review of R2's MAR, dated 10/01/2024 – 10/29/2024, showed R2 had an order for oxygen. The facility staff were to check and make sure that resident wore oxygen at two liters. R2 would wear their concentrator in their room and the portable outside of their room. The exceptions section for R2 showed on 10/08/2024 at 8:15 AM that R2's medication had not been available, and it had been waiting on delivery due to R2 had been out of oxygen tanks. On 10/09/2024 at 10:10 AM and 12:15 PM showed that R2's medication had not been available, and it had been waiting on delivery.

Record review of R2's, "Resident Alerts", dated 08/01/2024 – 10/29/2024, showed R2 had not been placed on alert from when they missed their oxygen medication due to it had not been available, and it had been waiting on delivery.

Record review of R2's, "Resident Progress Notes", dated 08/01/2024 – 10/29/2024, showed R2 did not have any progress notes to review about when they missed their oxygen medication due to it had not been available, and it had been waiting on delivery.

In an interview on 10/30/2024 at 10:55 AM, Staff B, Lead Medication Aide, said the medication aides were responsible for ordering and keeping correct medications for R2 at all times. Staff B confirmed R2 was supposed to have their oxygen on at all times. Staff B said R2 used a concentrator when they were inside of their room and used portable oxygen when they were out in the community. Staff B said R2 should have had notes about the missed oxygen in their progress notes and alert charting notes. Staff B said in general if any resident missed a medication they would be placed on alert charting.

R3

Record review of R3's "Service Agreement", dated 10/19/2024, showed R3 was a diabetic (a disease that caused high levels of blood sugar). R3's medical care management section showed that the medications aides were to reorder medications in

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a timely manner and store the medications.

Record review of R3's MAR, dated 08/01/2024 – 08/31/2024, showed R3 had an order for Fiasp Flextouch (short acting insulin to help lower high blood sugars quickly) inject 20 units under the skin three times daily before meals. The exemption section showed on 08/02/2024 at 12:38 PM and 5:00 PM, medication had not been available, and it had been waiting on delivery. On 08/03/2024 at 4:45 PM it showed awaiting clarification. On 08/04/2024 at 8:16 AM, 12:13 PM, and 4:24 PM medication had not been available, and it had been waiting on delivery. On 08/05/2024 at 8:13 AM and 12:59 PM, medication had not been available, and it had been waiting on delivery. On 08/06/2024 at 8:04 AM and 4:32 PM medication had not been available, and it had been waiting on delivery. On 08/07/2024 at 7:44 AM and 12:36 PM medication had not been available, and it had been waiting on delivery.

Record review of R3's MAR, dated 10/01/2024 – 10/31/2024, showed R3 had an order for Fiasp Flextouch inject 20 units under the skin three times daily before meals. The exemption section showed on 10/23/2024 at 12:33 PM the medication had not been available, and it had been waiting on delivery.

Record review of R3's, "Resident Alerts", dated 08/01/2024 – 10/29/2024, showed R3 had not been placed on alert from when they missed their Fiasp Flextouch medication.

Record review of R3's, "Resident Progress Notes", dated 08/01/2024 – 10/29/2024, showed R3 did not have any progress notes to review about when they missed their Fiasp Flextouch medication. In an interview on 10/30/2024 at 11:14 AM, Staff B said R3 should have been placed on alert for their missed dosages of medications.

In an interview on 10/30/2024 at 4:39 PM, Staff A, Administrator, said if a resident missed multiple medications, then they would be put on alert charting.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/22/2024.

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

Boule
Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her

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medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 1 of 7 sampled residents (Resident 3 [R3]) refused their medications. This failure placed the residents at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

Record review of the facility untitled and undated policy, showed when to notify the doctor and they could be faxed 24 hours a day. The doctor should be notified where there was a refusal of medication.

R3

Record review of R3's Primary Healthcare Providers Initial Orders, dated 04/25/2024, showed if R3 refused their medication three consecutive times the provider would be notified.

Record review of R3's "Service Agreement", dated 10/19/2024, showed the facility staff were to notify R3's doctor if they refused their medications or treatments.

Record review of R3's MAR, dated 08/01/2024 – 08/31/2024, showed R3 had an order to apply Ketoconazole (antifungal treatment that treats skin infections) on both feet daily. The exceptions section showed on 08/23/2024 – 08/25/2024 R3 refused their Ketoconazole medications. R3 had an order for Interdry (a prescribed cloth to absorb moisture) to be applied under breasts and groin twice daily. The exceptions section showed on 08/09/2024 – 08/11/2024, 08/17/2024 – 08/19/2024, and 08/23/2024 – 08/25/2024 that R3 refused their Interdry medications.

Record review of R3's MAR, dated 10/01/2024 – 10/29/2024, showed R3 had an order to apply Ketoconazole on both feet daily. The exceptions section showed on 10/04/2024 – 10/06/2024 and 10/18/2024 – 10/20/2024 that R3 refused their Ketoconazole medications. R3 had an order for Interdry to be applied under breasts and groin twice daily. The exceptions section showed on 10/04/2024 – 10/08/2024, 10/12/2024 –

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10/14/2024, 10/18/2024 – 10/21/2024, and 10/26/2024 – 10/28/2024 R3 refused their Interdry medications.

Record review of R3's medical chart on 10/30/2024 showed there were no faxes to R3's doctor about their refused medications to review.

On 10/30/2024 at 11:10 AM the Department requested all R3's fax notifications to review for the month of October 2024.

As of 11/08/2024 the Department had not received any of R3's fax notifications for the month of October 2024 to review.

On 11/07/2024 at 2:12 PM, the Department requested all R3's fax notifications to review for the month of August 2024.

Record review of an email sent to the Department on 11/07/2024 at 2:34 PM, showed Staff A stated they facility did not have any fax notifications to provide for R3 related to when they refused their medications for the month of August 2024.

In an interview on 10/30/2024 at 11:14 AM, Staff B, Lead Medication Aide, said R3 refused their treatments often. Staff B said the facility policy was that if a resident missed three consecutive dosages that they would notify the resident's doctor. Staff B said if the resident had a history of refusal, then they would notify the doctor every time a resident refused their medication.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) <u>12/22/2024</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Boule</u> Administrator (or Representative)	<u>12/3/2024</u> Date

WAC 388-78A-2464 Background checks Process Background authorization form. Before the assisted living facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must:

(1) Require the person to complete a DSHS background authorization form; and

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 4 sampled staff's (Staff C and Staff D) Washington state name and date of birth background check was submitted before initiating their employment. This failure placed 32 of 32 residents at risk of receiving care by an individual with a disqualifying history.

Findings included...

Staff C

Record review of the facility's Employee HR [human resources] List, undated, showed Staff C, Caregiver, was hired at the facility on 08/26/2024.

Record review of an email sent to the Department on 10/31/2024 at 11:34 AM, showed Staff C's first day of employment at the facility was on 08/27/2024.

Record review of the Staff C's Background Check Authorization Form showed Staff C signed and dated the form on 09/11/2024. This was completed 14 days after the required time.

Record review of Staff C's Interim Washington State Name and Date of Birth background check, dated 09/11/2024, showed that was completed 14 days after the required time.

Staff D

Record review of the facility's Employee HR List, undated, showed Staff D, Caregiver, was hired at the facility on 07/02/2024.

Record review of an email sent to the Department on 10/31/2024 at 11:34 AM, showed Staff D's first day of employment at the facility was on 07/08/2024.

Record review of an email sent to the Department on 10/30/2024 at 3:05 PM, showed Staff D was not employed at the facility on 04/12/2024 through 07/02/2024.

Record review of Staff D's background check records showed Staff D had an Interim Washington State Name and Date of Birth background check completed on 02/16/2024. There were no other Washington State Name and Date of Birth background checks provided that were completed after Staff D was rehired at the facility on 07/02/2024.

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with first day of employment on 07/08/2024.

In an interview on 11/08/2024 at 3:33 PM, Staff A, Administrator, said the office manager and administrator were responsible for ensuring background checks were completed for new staff.

Plan/Attestation Statement

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

Boule
Administrator (or Representative)

11/3/2024
Date

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

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

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 3 of 3 sampled staff (Staff A, Staff E and Staff F) completed their continued education units (CEU). This failure placed all 32 of 32 residents at risk of receiving care and services from untrained and unqualified staff.

Findings included...

WAC 388-112A-0611 "Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (i) A certified home care aide; (ii) A long-term care worker who is exempt from the 70-hour home care aide basic

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training under WAC 388-112A-0090 (1) and (2); (iii) A certified nursing assistant" [CC2] WAC 388-110-220 "(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must: (d) Ensure that each staff who works directly with residents has at least six hours of continuing education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112[A]..."

Record review of the facility's Employee HR [human resources] List, undated, showed Staff A, Administrator, was hired at the facility on 01/17/2022 with their birthday on September 13th.

Record review of Staff A's Relias certificates of completion, dated 09/13/2023 through 09/13/2024, showed Staff A had only completed 6.25 hours.

Record review of the facility's Employee HR List, undated, showed Staff E, Medication Aide, was hired at the facility on 04/29/2016 with their birthday on December 22nd.

Record review of Staff E's Relias certificates of completion, dated 12/22/2022 through 12/22/2023, showed Staff E had only completed three hours of CEU that focused on dementia specialty per the facilities contract requirements.

Record review of the facility's Employee HR List, undated, showed Staff F, Medication Aide, was hired at the facility on 05/04/2017 with their birthday on July 12th.

Record review of all Staff F's Relias certificates of completion showed 5.0 CEUs completed 11/13/2022 and 11/14/2022 and 20 minutes of HIPAA training completed 10/13/2024. All other training documents provided showed training prior to 2021. There were no CEUs provided that reflected training between 07/12/2023 to 07/12/2024 for Staff F.

In an interview on 10/30/2024 at 11:45 AM, Staff A, Administrator, said the facility administrator is responsible for on-boarding new staff.

In an interview on 10/30/2024 at 1:31 PM, Staff B, Lead Medication Aide, stated all staff required to complete continued education, completed the required trainings through the facility electronic system Relias.

In an email received by the Department on 11/08/2024 at 2:08 PM, Staff A said all CEU records for staff had been provided.

In an interview on 11/08/2024 at 3:33 PM, Staff A acknowledged the facility staff sampled did not have the required CEU completed for review.

Plan/Attestation Statement

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CSoule
Administrator (or Representative)

12/3/2024
Date

WAC 388-78A-2210 Medication services.

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

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 7 sampled residents (Resident 1 [R1]) received their medications as prescribed. This failure placed R1 at risk for medical complications and decreased quality of life.

Findings included...

Record review of R1's face sheet, dated 10/22/2024, showed R1 moved into the facility on 10/23/2023, with multiple medical diagnoses that included [REDACTED].

Record review of R1's Service Agreement (facility's version of the negotiated service agreement and assessment in one document), dated 10/11/2024, showed R1 had poor short and long-term memory. R1 was alert and disoriented. R1 could not follow simple instructions. R1 was unaware what day, season, or year it was. Staff were required to assist R1 with their medications. R1 as unaware what medication they took, why they took them, but were able to place them in their mouth and swallow them whole. The facility medication assistants were to administer, order, and store all of R1's medications. R1 was at high risk for dehydration that lowered R1's blood pressure. The

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medication aides were to offer R1 fluids often. Medication aides were to monitor R1's blood pressure daily per R1's medication orders and notify R1's physician if R1's vital signs (a group of medical signs that incident a body's vital function that includes a person's blood pressure, breathing rate, temperature, and heart beat/pulse) were out of parameters.

Record review of R1's Medication Administration Record (MAR), dated 08/01/2024 through 08/31/2024, showed R1 had an order for quetiapine fumarate (prescribed medication to help reduce behaviors and treat mental health conditions) take one tablet two times daily in the AM and night. R1 had an order for trazadone (a prescribed medication to help treat sad mood, anxiousness, and lack of sleep) take one tablet at bedtime and to hold the medication if R1's systolic blood pressure (the top number of the blood pressure reading) was below 90. R1 had an order for R1's blood pressure to be checked two times daily and R1's trazadone and quetiapine orders were to be held if R1's systolic blood pressure was below 90. Review of the documented blood pressure readings showed on 08/21/2024 for the night medication pass, R1's blood pressure was 76/51. Review of R1's trazadone and quetiapine fumarate administrations showed R1 was administered their quetiapine and trazadone on 08/21/2024 night pass administration.

Record review of R1's MAR, dated 09/01/2024 through 09/30/2024, showed R1 had an order for quetiapine fumarate take one tablet two times daily in the AM and night and trazadone take one tablet at bedtime and to hold the medication if R1's systolic blood pressure was below 90. R1's blood pressure was to be checked two times daily and R1's trazadone and quetiapine orders were to be held if R1's systolic blood pressure (BP) was below 90. Review of R1's blood pressure readings showed on 09/24/2024 at night R1's BP reading was 86/65, on 09/28/2024 in AM, R1's BP reading was 87/70, and on 09/30/2024 R1's BP reading was 80/60. Review of R1's administrations for quetiapine and trazadone showed R1 was administered both medication when R1's BP was out of the physician prescribed parameters.

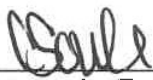
In an interview on 10/30/2024 at 1:31 PM, Staff B, Lead Medication Aide, stated the resident care coordinator completed routine resident MAR audits to ensure all medications were administered as prescribed. Staff B stated they were acting as the RCC and has been completing the resident MAR audits. Staff B stated if a residents medication was held, the initials of the medication aide would be circled. Staff B stated the medication aide would then document why the medication was circled on the medication/pass notes. Staff B acknowledged that R1's medications were not always held when R1's BP was below the prescribed physician parameters.

Plan/Attestation Statement

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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 care as agreed upon in the negotiated service agreement for 3 of 7 sampled residents (Resident 2 [R2], Resident 4 [R4] and Resident 7 [R7]). This failure impacted R2's, R4's, and R7's quality of life by not having their care needs met.

Findings included...

R2

Record review of R2's "Service Agreement", dated 10/02/2024, under R2's medical care management section showed the medications aides were to administer R2's medications and treatments per the physician orders. The medications aides were to reorder medications in a timely manner and store the medications. R2 were to always wear their oxygen. R2 had a concentrator in their room and portable tanks when they were out of the facility. The eating section showed R2 had a regular mechanical soft diet (a diet that consisted of soft and easy to chew and swallow foods). R2 should have soft foods due to their sensitive teeth.

Record review of R2's Fax from their provider, dated 07/01/2024, showed the provider said to ensure R2 wore their oxygen at all times when they were out of their room.

Record review of R2's MAR (Medication Administration Record), dated 08/01/2024 – 08/21/2024, showed R2 had an order for oxygen. The facility staff were to check and make sure that resident wore oxygen at two liters. R2 would wear their concentrator in their room and the portable outside of their room. The exceptions section for R2 showed on 08/22/2024 at 9:31 AM and 11:49 AM that R2's medication had not been available, and was waiting on delivery due to R2 was out of oxygen tanks. On 08/23/2024 at 8:53 AM and 11:24 AM that R2's medication was not available, and was waiting on delivery due to R2 was out of oxygen tanks.

Record review of R2's MAR, dated 10/01/2024 – 10/29/2024, showed R2 had an order for oxygen. The facility staff were to check and make sure that resident wore oxygen at two liters. R2 would wear their concentrator in their room and the portable outside of their room. The exceptions section for R2 showed on 10/08/2024 at 8:15 AM that R2's medication was not available, and was waiting on delivery due to R2 was out of oxygen tanks. On 10/09/2024 at 10:10 AM and 12:15 PM that R2's medication was available,

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and was waiting on delivery.

Record review of R2's "Dietary Communication", undated, showed R2 had a change in their service plan. R2 had a regular diet and in handwritten letters with a circle around it showed R2 needed soft foods. A "Dietary Services List", undated, had been under the "Dietary Communication" form and it showed R2 had a regular diet. R2 should have soft foods due to sensitive teeth.

In an observation on 10/30/2024 at 10:26 AM, R2 sat in the dining room at the table to eat their breakfast. R2 was not wearing their oxygen. R2's oxygen had been placed on their walker behind their chair.

In an observation and interview on 10/30/2024 at 10:36 AM, R2 sat in the dining room at the table to eat their breakfast. On R2's plate was eggs, crust from toast, and half eaten solid thin sausage patty. Staff O, Caregiver, had been observed in the area and when asked about R2's diet they said they thought R2 had a regular diet not a mechanical soft diet. Staff O said they would have to check R2's service agreement to confirm. At 10:53 AM R2 had been observed to not wear their oxygen.

In an interview on 10/30/2024 at 10:55 AM, Staff B, Lead Medication Aide, said the medication aides had been responsible to order and always keep correct medications for R2. Staff B confirmed R2 was supposed to always wear their oxygen. Staff B said R2 used a concentrator when they were inside of their room and used portable oxygen when they were out in the community. Staff B clarified R2 did not run out of their concentrator oxygen in August 2024 and October 2024 just their portable oxygen. Staff B said R2 did not like to wear their oxygen when they are aggravated and would rip off the oxygen. Staff B said R2 had a PRN (as needed) medication for agitation. Staff B said if they had a hard time getting R2 to wear their oxygen they typically offered a PRN medication which would be successful. The Department informed Staff B that from 10:26 AM – 10:53 AM R2 was observed to not wear their oxygen. Staff B said the facility staff should attempt to try and encourage R2 to wear their oxygen. Staff B said when R2 wore their oxygen they felt better. Staff B confirmed R2's service agreement dated 10/02/2024 showed that R2 had a mechanical soft diet. Staff B said they were unsure about the kitchens process on how they prepared mechanical soft diets. Staff B said toasted bread would not be considered a mechanical soft diet. Staff B said they thought a sausage patty could be considered a mechanical soft diet.

In an observation on 10/30/2024 at 12:20 PM, R2 was observed in the dining room for lunch and was not wearing their oxygen.

In an interview on 10/30/2024 at 1:31 PM, Staff G, Dietary Manager, said R2 was on a mechanical soft diet. Staff G said they thought sausage would be considered a mechanical soft diet. Staff G said toast would not be considered a mechanical soft diet. The Department informed Staff G that at breakfast on 10/30/2024 it appeared R2 had been served toast. Staff G said they prepared toast for some residents and buttered bread for others. Staff G said they had worked with the dietary aides at the facility because sometimes there were miscommunications. Staff G said they were unsure what residents received what plate once it left the kitchen. Staff G referenced R2's "Dietary Communication" and noted that the form they had did not indicate R2 had a mechanical soft diet.

In an observation on 10/30/2024 at 2:04 PM, R2 had been observed in the dining room

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amongst other residents. R2 was not wearing their oxygen.

In an interview on 10/30/2024 at 4:39 PM, Staff A, Administrator, stated they did not think a sausage patty would be considered a mechanical soft diet.

R4

Record review of R4's "Resident Info Sheet," undated, showed that R4 moved into the facility on [REDACTED]/2024.

Record review of R4's Service Agreement, completed 09/03/2024, showed R4 took showers daily after breakfast with instructions for staff to complete shower sheets. Under the task description section for bathing included stand-by assist allowing privacy but not leaving the apartment during showering, instructions to notify the resident care coordinator/registered nurse of any changed in ability or preference, and for staff to complete shower sheets. On the signature page it said "Signing below indicates that the services are to be provided to the Resident as outlined in the Service Agreement."

On 11/08/2024 at 1:36 PM, the Department requested the shower log for R4 for August, September, and October.

On 11/08/2024 at 2:03 PM, the Department received the shower log for R4 for the dates of 07/23/2024 through November 8th, 2024.

Record review of the undated shower log titled "Admin History for R4," showed R4 refused their shower on 07/23/2024, 08/24/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/15/2024, 10/19/2024, 10/22/2024, 10/25/2024, and 11/02/2024.

Record review of the undated shower log titled "Admin History for R4," showed a note for 11/05/2024 that stated no shower sheet was given to the medication aide. R4's shower status for 11/05/2024 was unknown.

Record review of the undated shower log titled "Admin History for R4," showed R4 missed their shower on 10/08/2024.

In an observation and interview on 10/30/2024 at 12:13 PM, Staff B, showed the Department the white binder in the staff breakroom that Staff B said is used as a communication log for staff to document and was a shift report to caregivers.

Record review of the communication binder's monthly log for September showed handwritten notes from caregivers indicating R4 did not receive a shower on 09/03/2024, 09/04/2024, 09/05/2024 (due to no hot water), 09/13/2024, 09/25/2024, and 09/27/2024.

On 10/30/2024 at 12:20 PM Staff B said all care refusals get reported from the caregivers to the medication aides for consistent refusals of care or when there was a care refused three times in a row. Staff B said those reports then prompt the medication aide to send a notification to PCP, RN, admin and family.

In an interview on 10/31/2024 at 4:45 PM, Collateral Contact 2, R4's POA, said they had not received notification when R4 has missed or refused their showers.

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Records reflected that R4 did not receive a shower 18 different days from 07/23/2024 through 11/08/2024 and that R4's POA was not notified of this deviation from the signed service agreement.

R7

Record review of R7's "Resident Info [information] Sheet", undated, showed R7 moved into the facility on [REDACTED] 2023 with multiple medical diagnoses that included [REDACTED]

Record review of R7's Service Agreement, dated 09/11/2024, showed R7 could be very resistant during activities of daily living care (ADL's) needs that required more staff assistance. R7 required full assistance by staff with their ADL's. R7 liked to walk around the facility. As of 05/29/2024 R7 was walking less and required more use of their wheelchair. R7 required two-person assist with all transfers related to their poor gait (balance) and history of falls. R7 often became agitated if they feel they were being rushed. R7 was independent with bed mobility and used a trapeze (a device that connects to the bed frame that has a triangle that hangs down that a person can grab and help move themselves in bed independently) to help assist themselves up if needed. R7 typically did not sleep through the night. R7 was to have a bed alarm on their bed anytime R7 was in bed. Staff were to increase the checks on R7 during the morning and night hours to assist them. Staff were to ensure that the pressure alarm was plugged in and turned on. R7 wore compression socks during waking hours. R7 required full assistance with dressing tasks. Staff were to put R7's compression socks on in the AM, take off at bedtime, and wash them by hand and hang them to dry at bedtime. R7 had a history of early morning falls. R7 was to use a walker but often would forget to use it. Staff were to discourage R7 to ambulate without assistance. R7 required full assistance from staff to trim and file their fingernails.

In an observation on 10/30/2024 at 9:42 AM, R7 was lying in their bed in their room. There was no alarm on the bed or attached to R7. R7 had bright yellow socks without any compression socks on.

In an interview on 10/30/2024 at 10:05 AM, Staff M, Medication Aide, stated R7 did not use an alarm on their bed. R7 required two staff members to assist them with their activities of daily living needs.

In an interview on 10/30/2024 at 12:30 PM, Staff M stated R7 did not come to the dining room for lunch today and was being fed in bed in their room.

In an interview and observation on 10/30/2024 at 1:17 PM, R7 was lying in bed, and had their clothes changed from observation of the resident at 9:42 AM. R7 was wearing bright yellow mid-calf length socks without any gripping material on the bottoms of the feet. Observation of all four sides of R7's bed showed there was no pressure alarm or any other alarm that was attached to the bed or R7. Staff T, Caregiver, stated R7 wore ted hose. Staff T stated the bright yellow socks were the only socks R7 had. Staff T stated R7 did not use an alarm and acknowledged there was no alarm on R7's bed or one on R7 themselves. R7 was observed to have longer fingernails with some of the

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nails broken, unleveled with jagged edges, and brown matter underneath the nail.

In an interview on 10/30/2024 at 1:29 PM, Staff B stated all nail care for the residents were to be completed by the caregivers on the residents' shower days. Staff B stated R7 did not use a bed alarm and would not have one on their bed.

In an observation on 10/30/2024 at 2:22 PM, R7 was lying in bed and observed to have both of their legs hanging off the left side of their bed towards the window with both of their feet flat on the ground. R7 did not have an alarm on their bed or attached to themselves when they laid in bed.

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Boule</u> Administrator (or Representative)	<u>12/3/2024</u> Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to obtain medications for 3 of 7 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3] and Resident 4 [R4]). This failure resulted in the residents not receiving their medications as ordered and placed the residents at risk for unmet care needs and medical complications associated with not receiving medications as ordered.

Findings included...

Record review of the facility provided document titled, "Missing or unavailable medication procedure", undated, showed if medications were not delivered from the pharmacy, then the following steps must be taken. Step 1 would be to notify the nurse or the resident care coordinator before the first missed dosage. Step 2 would be to contact the pharmacy about an emergency 3 day supply. Step 3 would be to notify the medical doctor of the missed medication not available and why. Step 4 would be to

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request a hold from the medical doctor until the medication arrived. Step 5 would be to place the resident on alert charting to monitor for side effects of the resident not receiving the medication. Step 6 would be to notify the family or power of attorney of the medication issue. Step 7 would be to request the family follow up with the medical doctor if a refill order had been needed. Step 8 would be to fill out an incident report if a medication dose was missed. Step 9 would be to document in the pharmacy log and the electronic medication administration records why the medication had been unavailable. Facility staff were to write a story and not just "not available". Step 10 was if a resident missed a dosage the facility staff must write a progress note on the side effects of the missed medication and what steps were being done to obtain the medication. "No resident should ever miss dose of medication. It is our responsibility to obtain medications." All medication aides were to follow medication refill procedure and re-order all medications 7-10 days prior to running out. The facility staff were to alert the nurse or the resident care coordinator prior to running out of medications.

R1

Record review of R1's face sheet, dated 10/22/2024, showed R1 moved into the facility on [REDACTED] /2023, with multiple medical diagnoses that included [REDACTED].

Record review of R1's Service Agreement (facility's version of the negotiated service agreement and assessment in one document), dated 10/11/2024, showed R1 had poor short and long-term memory. R1 was alert and disoriented. R1 could not follow simple instructions. R1 was unaware what day, season, or year it was. Staff were to order R1's medication through the facility's house pharmacy. Staff were required to assist R1 with their medications.

Record review of R1's Fax, dated 10/22/2024, showed R1 had a rash on their buttocks that had gotten increasingly worse. R1's physician ordered clotrimazole-betamethasone to R1's buttocks two times daily. R1's physician signed and dated the order on 10/23/2024.

Record review of R1's MAR, dated 10/01/2024 through 10/31/2024, showed R1 had an order for clotrimazole-betamethasone cream to be applied to R1's buttocks area two times daily for a rash. Review of the administrations for dates 10/24/2024 night pass through 10/29/2024 AM pass showed the clotrimazole-betamethasone cream was not administered five of ten administrations. Review of the MAR pass notes showed the facility had not received the cream and were waiting on delivery.

Record review of R1's medical chart, on 10/29/2024 at 3:10 PM, showed there were no physician notification that R1's clotrimazole-betamethasone cream was not available for administration and R1 missed five of ten doses.

R2

Record review of R2's "Service Agreement", dated 10/02/2024, under R2's medical care management section showed the medications aides were to administer R2's medications and treatments per the physician orders. The medications aides were to reorder medications in a timely manner and store the medications. R2 was to wear their oxygen at all times. R2 had a concentrator in their room and portable tanks when they

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were out of the facility.

Record review of R2's MAR (Medication Administration Record), dated 08/01/2024 – 08/31/2024, showed R2 had an order for oxygen. The facility staff were to check and make sure that resident wore oxygen at two liters. R2 would wear their concentrator in their room and the portable outside of their room. The exceptions section for R2 showed on 08/22/2024 at 9:31 AM and 11:49 AM that R2's medication had not been available, and it had been waiting on delivery due to R2 was out of oxygen tanks. On 08/23/2024 at 8:53 AM and 11:24 AM that R2's medication was not available, and was waiting on delivery due to R2 being out of oxygen tanks.

Record review of R2's MAR, dated 10/01/2024 – 10/29/2024, showed R2 had an order for oxygen. The facility staff were to check and make sure that resident wore oxygen at two liters. R2 would wear their concentrator in their room and the portable outside of their room. The exceptions section for R2 showed on 10/08/2024 at 8:15 AM that R2's medication had not been available, and it had been waiting on delivery due to R2 was out of oxygen tanks. On 10/09/2024 at 10:10 AM and 12:15 PM showed that R2's medication was not available, and was waiting on delivery.

Record review of R2's "Resident Alerts", dated 08/01/2024 – 10/29/2024, showed R2 had not been placed on alert from when they missed their oxygen medication due to it had not been available, and it had been waiting on delivery.

Record review of R2's, "Resident Progress Notes", dated 08/01/2024 – 10/29/2024, showed R2 did not have any progress notes to review about when they missed their oxygen medication due to it had not been available, and it had been waiting on delivery.

In an interview on 10/30/2024 at 10:55 AM, Staff B, Lead Medication Aide, said the medication aides had been responsible to order and keep correct medications for R2 at all times. Staff B confirmed R2 was supposed to have their oxygen on at all times. Staff B said R2 used a concentrator when they were inside of their room and used portable oxygen when they were out in the community. Staff B said the facility staff were to notify them if they had issues with ordering a resident's medication and that they would be responsible to follow up. Staff B said for the month of August 2024 they were not yet in the interim role of resident care coordinator, and they would not have completed audits on resident's medications. Staff B said none of the medication aides reported concerns about ordering R2's medications to them for the month of October 2024. Staff B said they were the facility staff member who realized R2 did not have any portable oxygen for the month of October. Staff B clarified R2 did not run out of their concentrator oxygen just their portable oxygen. Staff B said they did not think R2 missed oxygen in August and October had been a pattern because the facility had issues with the oxygen provider. Staff B said the facility staff should have re-ordered R2's portable oxygen when they had one or two portable containers left. Staff B said the facility staff attempts to order medications should be documented. Staff B reviewed R2's progress notes and alert charting notes and confirmed they did not see any facility staff documentation of attempts to reorder R2's oxygen.

The Department requested that Staff B provide evidence related to the statement that the facility had issues with R2's oxygen provider.

In an interview on 10/30/2024 at 4:39 PM, Staff A, Administrator, had been requested to

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provide documentation that the facility staff had attempted to reorder R2's oxygen and that it had been R2's oxygen provider as to why there had been a delay in R2's medication being ordered.

As of 11/08/2024 the Department had not received any documentation to support the statement the facility had issues with R2's oxygen provider.

R3

Record review of R3's "Service Agreement", dated 10/19/2024, showed R3 was a diabetic (a disease that caused high levels of blood sugar). R3's medical care management section showed that the medications aides were to reorder medications in a timely manner and store the medications.

Record review of R3's MAR, dated 08/01/2024 – 08/31/2024, showed R3 had an order for Fiasp Flextouch (short acting insulin to help lower high blood sugars quickly) inject 20 units under the skin three times daily before meals. The exemption section showed on 08/02/2024 at 12:38 PM and 5:00 PM, medication was not available, and was waiting on delivery. On 08/03/2024 at 4:45 PM it showed awaiting clarification. On 08/04/2024 at 8:16 AM, 12:13 PM, and 4:24 PM medication was not available, and was waiting on delivery. On 08/05/2024 at 8:13 AM and 12:59 PM, medication was not available, and was waiting on delivery. On 08/06/2024 at 8:04 AM and 4:32 PM medication was not available, and was waiting on delivery. On 08/07/2024 at 7:44 AM and 12:36 PM medication was not available, and was waiting on delivery.

Record review of R3's MAR, dated 10/01/2024 – 10/31/2024, showed R3 had an order for Fiasp Flextouch inject 20 units under the skin three times daily before meals. The exemption section showed on 10/23/2024 at 12:33 PM the medication was not available, and was waiting on delivery.

Record review of R3's "Resident Alerts", dated 08/01/2024 – 10/29/2024, showed R3 had not been placed on alert from when they missed their Fiasp Flextouch medication.

Record review of R3's, "Resident Progress Notes", dated 08/01/2024 – 10/29/2024, showed R3 did not have any progress notes to review about when they missed their Fiasp Flextouch medication.

In an interview on 11/07/2024 at 1:13 PM, Staff N, Director of Nursing Services, Stated Staff B, Lead Medication Aide, was the acting resident care coordinator for the facility during the Departments full inspection as the primary resident care coordinator was out on an extended leave.

On 10/29/2024, the Department requested R4's information sheet, medication administration record for August 1, 2024, through October 29th, 2024, all Negotiated Service Agreements, and all assessments on file for R4.

On 10/29/2024 at 4:07 PM, the Department received R4s were received by the Department to review.

Record review of R4's "Resident Info Sheet," undated, showed that R4 moved into the facility on [REDACTED]/2024. The form indicated R4 received delegated nursing services.

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Record review of R4's Service Agreement, completed 09/03/2024, showed medication services for R4. Task descriptions noted included staff to administer all medications per MD order, communicate with PCP and other HCPs, medications ordered through house pharmacy (LINCOLN), monitor resident for proper medication ingestion, Staff to administer inhalers/nebulizers as prescribed/needed, and notify RCC/RN of any changes in ability.

Record review of R4's Medication Administration Record(MAR), dated 08/01/2024 through 09/30/2024 showed an order for Proctofoam-HC(pain relieving ointment) to be applied topically (to the skin) three times per day. The MAR showed the medication was not given 41 days, 18 of those due to lack of availability. The dates the medication was not administered due to lack of availability were: 08/01/2024, 08/02/2024, 08/04/2024, 08/06/2024, 08/12/2024, 08/13/2024, 08/14/2024, 08/18/2024, 08/19/2024, 08/21/2024, 08/25/2024, 08/27/2024, 08/28/2024, 08/29/2024, 08/30/2024, 09/03/2024, 09/04/2024, and 09/06/2024. "

Record review of the MA, dated 08/01/2024 through 09/30/2024, showed the only medication notes listed for incidences when the medication was not available included "Still waiting for prior auth from insurance," "reordered again," and "not on cart." The note that said, "reordered again," was the last note entry for the month of September and occurred on 09/06/2024.

Record review of the document titled Resident Progress Note, undated, showed a note from 08/11/2024 that said R4 had been missing both the Proctofoam-HC (pain relieving ointment) and Fluticasone Propionate HFA since R4 moved in on [REDACTED]/2024.

Record review of the document titled Resident Progress Notes, undated, showed a note from 09/06/2024 that said staff contacted R4's physician and they had not heard back about the prior authorization for the medications with a plan to meet with R4's wife to discuss other options.

Record review of the document titled Resident Progress Notes, undated, showed a note from 10/21/2024 that said staff reached out to R4's physician to obtain orders to discontinue Proctofoam-HC (pain relieving ointment) and Fluticasone from the medication administration record, removing it from R4's medication list.

No other documents were provided to the Department to review that showed timely efforts to obtain medications for R4.

In an interview on 10/30/2024 at 12:20 PM, Staff B, Lead Medication Technician, said the medication technicians are responsible for re-ordering medications for residents.

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

Plan/Attestation Statement

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 12/22/2024

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

Balle

Administrator (or Representative)

12/3/2024

Date