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

01/10/2025

Caring Places Management, LLC
Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

RE: Easthaven Villa # 2144

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 52888 (Completion Date 01/10/2025) and 49160 (Completion Date 10/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/10/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

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.

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:

(a) Orientation and safety;

(e) Continuing education.

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

The Department staff who did the On Site verification:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just

Jody Just, 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 #: 2144	Compliance Determination # 49160
Plan of Correction	Easthaven Villa	Completion Date
Page 1 of 12	Licensee: Caring Places Management, LLC	10/28/2024

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

The department completed data collection for an unannounced on-site follow-up on 10/22/2024 and 10/22/2024 of:
Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following SOD dated: 10/28/2024

The following sample was selected for review during the unannounced on-site visit: 7 of 71 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

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

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

11/08/2024
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.

Statement of Deficiencies	License #: 2144	Compliance Determination # 49160
Plan of Correction	Easthaven Villa	Completion Date
Page 2 of 12	Licensee: Caring Places Management, LLC	10/28/2024

Administrator (or Representative) 11/13/24 Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 2 of 3 sampled assisted living residents (Resident 3 [R3] and Resident 4 [R4]) rooms. This failure resulted in staff not having access to hand hygiene supplies, and placed all 37 of 37 assisted living residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Record review of the Centers of Disease Control (CDC) document titled, "about handwashing", dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other person's hands or common objects. Hands were to be washed often.

Record review of the CDC's document titled, "clinical safety: hand hygiene for healthcare workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare personnel from being infected from germs received from the patient. Healthcare workers were to clean their hands before touching a patient, before moving from work from soiled to clean, after touching a patient or patient's surrounding, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare works were to wash their hands with soap and water when their hands were visibly soiled.

Record review of the facility provided policy titled, "hand washing", dated 09/17/2024, showed hand washing was the single most important measure for preventing the

spread of infection and disease. All staff would be responsible for carrying out the hand washing policy. Staff would wash their hands after personal body function, before and after helping resident with personal care tasks of daily living, whenever staff changed from doing a "dirty" task to a "clean" task, and whenever hands were obviously soiled. The use of gloves did not replace hand washing. Under the section titled, "procedure", showed staff were to wet hands with running water, apply soap, lather hands by rubbing them together with the soap and scrub for 20 seconds. Staff were to rinse hands well under running water and then dry their hands using a clean towel or air dry them.

Record review of the facility's "Plan of Correction", dated 08/05/2024, showed under the deficiency section WAC 388 78A 2610 (1)(2)(c). The actions section showed handwashing supplies would be available in the resident's rooms. The person responsible section showed it was the housekeeping staff, the Resident Care Coordinator, and the administrations responsibility. The due date showed 09/19/2024 and it showed the task had been completed on 08/12/2024.

R3

In an interview and observation on 10/22/2024 at 1:46 PM, R3's bathroom showed a container of bacterial hand soap. R3 said the facility did not supply them hand soap and that they purchased and supplied the soap on their own.

R4

In an observation and interview on 10/22/2024 at 1:52 PM, inside R4's bathroom, there was no facility provided soap available for staff to use. R4 stated the soap that was in the bathroom was their personal soap. R4 stated the staff washed their hands all the time in the bathroom after they helped them to the bathroom and taking their gloves off.

In an interview on 10/22/2024 at 2:57 PM, Staff A, Administrator, said the facility put new soap and paper towel dispensers up and had them filled with supplies in the resident rooms. Staff A declined to come with the Department to visually see the resident rooms that lacked soap.

This is an uncorrected and recurring deficiency previously cited on 08/05/2024 for subsections (1)(2)(c) and 02/07/2023 for subsection (1).

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 12/12/24 .

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

Statement of Deficiencies	License #: 2144	Compliance Determination # 49160
Plan of Correction	Easthaven Villa	Completion Date
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Administrator (or Representative) 11/11/24 Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to have their respiratory protection program updated for 2 of 2 facility buildings (Assisted Living building and Memory care building). This failure placed all 71 of 71 residents and staff safety at risk in the event of an infectious disease outbreak.

Findings included...

Record review of the dear provider letter number 2023-014, dated 03/30/2023, showed that the Secretary of Health announced the order that required wearing a face covering in long term care facilities had ended on 04/03/2023. Despite that the order had ended the individuals in long-term care facilities, including residents, staff, and visitors, were required to continue to follow the Department of Health (DOH) and Centers of Disease Control and Prevention (CDC) guidance. Facilities were asked to revise their policies to reflect the updated guidance by 05/01/2023. Facilities may create their own policies that require staff and ask residents and visitors to wear a face covering, as long as they were at least as stringent as DOH and CDC guidance. Respiratory Protection Program (RPP) requirements were not changed by the ending of the Secretary of Health's order, nor would they change when the federal public health emergency ended on 05/11/2023. Staff would still be required to wear N95 respirators around individuals with suspected or confirmed COVID-19, and an RPP was required anytime a respirator was used in a long-term care facility. An RPP must include medical clearance, fit testing, training, written policies, and documentation.

Record review of the dear provider letter number 2022-040, dated 11/09/2022, showed that on 09/08/2022 the Washington state's Governor announced that the state of emergency due to the COVID-19 pandemic would end on 10/31/2022. All long-term care COVID response plans would no longer be effective beginning 10/27/2022. Facilities must continue to meet national standards for infection prevention.

"WAC 296-842-12005 Develop and maintain a written program. Exemption: This section does NOT apply to respirator use that is voluntary. See WAC 296-842-11005 for voluntary use program requirements. (1) Develop a complete worksite-specific written respiratory protection program that includes the applicable elements listed in Table 3. The program must cover each employee required by this section to use a respirator. Note: Pay for respirators, medical evaluations, fit testing, training, maintenance, travel

costs, and wages. (2) Keep your program current and effective by evaluating it and making corrections. (a) Make sure procedures and program specifications are followed and appropriate. (b) Make sure selected respirators continue to be effective in protecting employees. For example, if changes in work area conditions, level of employee exposure, or employee physical stress have occurred, you need to reevaluate your respirator selection. (c) Have supervisors periodically monitor employee respirator use to make sure employees are using them properly. (e) When developing your written program include applicable elements listed in Table 3. Table 3 Required Elements for Required-Use Respirator Programs • Selection: – Procedures for respirator selection – A list specifying the appropriate respirator for each respiratory hazard in your workplace – Procedures for issuing the proper type of respirator, if appropriate • Medical evaluation provisions • Fit-test provisions and procedures, if tight-fitting respirators are selected • Training provisions that address: – Respiratory hazards encountered during: - Routine activities -Infrequent activities, for example, bimonthly cleaning of equipment - Reasonably foreseeable emergencies, for example, rescue, spill response, or escape situations – Proper use of respirators, for example, how to put on or remove respirators, and use limitations. Note: You do NOT need to repeat training on respiratory hazards if employees have been trained on this in compliance with other rules such as WAC 296-901-140, Hazard communication. • Respirator use procedures for: – Routine activities – Infrequent activities – Reasonably foreseeable emergencies • Maintenance: – Procedures and schedules for respirator maintenance covering: - Cleaning and disinfecting - Storage Required Elements for Required-Use Respirator Programs - Inspection and repair - When to discard respirators – A cartridge or canister change schedule IF air-purifying respirators are selected for use against gas or vapor contaminants AND an end-of-service-life-indicator (ESLI) is not available. In addition, provide: - The data and other information you relied on to calculate change schedule values (for example, highest contaminant concentration estimates, duration of employee respirator use, expected maximum humidity levels, user breathing rates, and safety factors) • Procedures to ensure a safe air quantity and quality IF atmosphere-supplying respirators (air-line or SCBA) are selected • Procedures for evaluating program effectiveness on a regular basis."

Record review of the Department of Labor and Industries Division of Occupational Safety and Health article titled, "General Coronavirus Prevention Under Stay Safe- Stay Healthy Order", dated 09/15/2021, showed the directive provided enforcement policy when evaluating workplace implementation of social distancing, facial coverings, and respiratory protection, sanitation, and sick employee practices as required under the Governor's stay home- stay health order.

Record review of the Mayo Clinic's article titled, "How well do face masks protect against COVID-19?", dated 11/04/2023, showed respirators such as nonsurgical N95's gave the most protection. Kn95's and medical masks proved the next highest level of protection. The KN95 masks meet certain international standards. It offers more protection than a medical mask does. The N95 mask meets the United States quality standards and offer the highest level of protection.

Record review of the facility's "respiratory protection program [RPP] for use by healthcare facilities during the COVID-19 [Corona Virus Disease 2019- an infectious communicable disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death] pandemic", dated

04/2021, showed according to state and federal regulations, workplaces with workers that were required to wear fit-tested respirators must have an established "respiratory protection program". "The Template has been further modified by Caring Places Management to comply with Oregon state regulations." Under the section titled, "selection of respirators" showed the employees would select from filtering respirators known as N95 or KN95. Under the section titled, "respirator training", showed the facility's sister facility's employee training document was located in appendix E. The RPP showed the facility followed "DOSH Directive 1.70 states that "workers within three feet of a patient or equipment during an aerosol generating procedure must wear a fit-tested N95 filtering facepiece respirator or more protective respirator". Unlike Directive 11.80, Directive 1.70 does not reference or refer to additional engineering controls or PPE [personal protective equipment]." The DOSH directive was put in place during the governor's COVID-19 pandemic emergency proclamation. The RPP showed Staff H, Former Administrator, was the facility's respirator program administrator. The respirator administrator was responsible to oversee the development of the respiratory program and to make sure it was carried out at the workplace. The administrator would regularly make sure procedures were followed, respirator use was monitored, and respirators continue to provide adequate protection when job conditions change.

Record review of an email sent to the Department on 10/23/2024 at 2:44 PM, showed the facility respirator protection program that was provided was the most updated version.

In an interview on 10/28/2024 at 9:52 AM, Staff A, Administrator, stated they were the respiratory program administrator for the facility.

This is an uncorrected deficiency previously cited on 08/05/2024 for subsection 388-78a-2040-1.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 12/12/24 .

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

Administrator (or Representative) 11/11/24 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 buildings (assisted living building and memory care building). These failures placed 71 of 71 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions.

Findings included...

Record review of the facility's "Plan of Correction", dated 08/05/2024, showed under the deficiency section WAC 388 78A 3090 (a)(b). Under the actions section showed the handrail broken in memory care was in Wally way. Maintenance was to repair the handrail and do visual checks through the memory care unit and repair as needed. It showed the person responsible had been maintenance. The plan of correction showed the due date was 09/19/2024 and it had been completed on 09/19/2024. The actions section showed there were light fixtures in a resident room that had black specks in it. The plan of correction showed the light had been cleaned and going forward the maintenance staff and housekeeping would check for light fixture cleanliness when rooms were cleaned. The person responsible showed it had been maintenance and housekeeping. The due date showed the task had been due 09/19/2024 and it had been completed 09/12/2024. The actions section showed there were holes in the wall in a resident's room. The plan of correction showed the walls had been repaired and going forward housekeeping would alert maintenance of any holes in resident rooms or walls that needed repair. The person responsible showed it had been maintenance and all staff. The due date showed the task had been due 09/19/2024 and it had been completed 08/05/2024.

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

Record review of the facility's "Maintaining Equipment" policy, undated, showed the facility and the equipment used to provide services were to be regularly maintained to ensure aesthetic appeal, proper function, and safety for both the residents and staff. Regularly scheduled maintenance would be performed to ensure that the facility equipment functioned at a high level and was well maintained.

Record review of an email sent to the facility on 10/22/2024 at 12:32 PM, from the Department, showed the last three months of maintenance work orders were requested for review.

Memory Care

In an observation on 10/22/2024 at 12:35 PM, in the memory care unit, on the hallway

named "Wally Way", the handrail halfway up the wall on the right side of the hallway that was at the doorway of the resident shower and toilet room had been broken. The handrail had been completely broken off the bracket that was secured to the wall.

Resident 1 (R1)

In an observation on 10/22/2024 at 11:42 AM, inside R1's studio apartment on the light on the ceiling in the middle of the room, was noted to have lots of black particles in the light cover. One of the black particles had what looked like wings of a bug.

Resident 2 (R2)

In an observation on 10/22/2024 at 11:26 AM, inside R2's apartment, on the right side of R2' room behind their bedside table and reclining chair closest to the window halfway up the wall were two apple sized holes in the wall that exposed white powdery substance in the wall material. The light on the ceiling in the middle of the room, was noted to have lots of black particles in the light cover. One of the black particles had what looked like wings of a bug.

In an interview on 10/22/2024 at 11:20 AM, Staff E, Resident Care Coordinator said they were unsure if work orders had been submitted to get R2's hole in their room fixed because the facility did not have a maintenance supervisor. Staff E said for emergent issues other maintenance staff from sister facilities helped as needed. Staff E said Staff D, Maintenance, helped fill in as well. At 11:31 AM, Staff E said Staff G, Caregiver, was a caregiver at the facility who helped with maintenance as well.

Assisted Living

In an observation on 10/22/2024 at 1:23 PM, the activity room in the assisted living building showed that the left side cupboard had been missing a wooden handlebar.

In an observation on 10/22/2024 at 1:46 PM, room 114 in the assisted living room had been unlocked. Inside of the room there was a bed frame horizontally placed in the middle of the room and walkway, a mattress was on the ground, there was a five-gallon bucket of all-purpose Kilz 2 superior's exterior primer paint. There were various nails and screws on the floor, windowsill, bathroom, and through the apartment. There were wooden materials in multiple areas on the ground and bathroom. There were two electrical outlets that were not covered, one outlet had exposed wires. On the wall by the bathroom door there were two outlet areas that did not have face plates that expose wires and holes in the wall.

In an interview on 10/22/2024 at 2:23 PM, Staff F, Office Manager, stated the facility did not have a maintenance supervisor. Staff F said Staff G picked up two to three maintenance shifts a week. Staff F said Staff G worked on emergency maintenance issues and general maintenance for the facility. Staff F said Staff D was a very part time staff member for the facility. Staff F said maintenance staff from their sister facilities could come help with emergency maintenance as well.

In an observation and interview on 10/22/20224 at 2:30 PM, Staff A, Administrator, and the Department went to the activities room. Staff A said they had not had plans in place to fix the missing handlebar on the left side of the cupboard. Staff A said they focused their attention on fixing other areas within the facility. At 2:34 PM, Staff A said the door

to room 114 should not have been unlocked due to the hazards within the room. At 2:36 PM Staff A observed the broken handrail in the memory care unit in the hallway Wally Way. Staff A acknowledged that the handrail had still been broken. At 2:38 PM, Staff A acknowledged that R1's room had bugs in the light fixture. Staff A acknowledged that R2's room had bugs in the light fixture and that the holes in their wall were present. Staff A said the facility staff were to notify maintenance when there was a cleaning concern or a needed repair and submitted on a maintenance request work order.

Record review of the facility provided maintenance request work orders, dated 07/30/2024 through 10/11/2024, showed there were no work orders completed for any repairs or maintenance attention for R1's room, R2's room, and memory care Wally Way hallway's handrail for review.

This is an uncorrected deficiency previously cited on 08/05/2024.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 12/12/24 .

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

Administrator (or Representative) 11/11/24 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:

(a) Orientation and safety;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure staff completed their continuing education for 2 of 2 staff reviewed (Staff B and Staff C). This failure placed all 71 of 71 residents at risk for being cared for by untrained 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 below. (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; (iii) A certified nursing assistant; (b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC."

WAC 246-980-110 Continuing education. "(1) A home care aide must demonstrate completion of twelve hours of continuing education per year as required by RCW 74.39A.341. The required continuing education must be obtained during the period between renewals. Continuing education is subject to the provisions of chapter 246-12 WAC, Part 7. (2) Verification of completion of the continuing education requirement is due upon renewal. If the first renewal period is less than a full year from the date of certification, no continuing education will be due for the first renewal period."

Record review of the facility's "Plan of Correction", dated 08/05/2024, showed under the deficiency section had been WAC 388 78A 2474 (2) (b). The actions section showed the facility would ensure that all staff would have a minimum of 12 hours of CEU's (continuing education units) by their birthdate each year. The facility alleged to be back in compliance with the regulation on 09/19/2024.

Record review of the facility's, "Employee HR [Human Resources] List", undated, showed Staff B, Caregiver was hired at the facility on 04/21/2008. Staff B's birthday was [redacted].

Record review of Staff B's "Relias Transcript", dated 10/23/2024, showed Staff B completed 7.75 hours of CEU's. Staff B needed 4.25 hours to complete their required CEU's. There were no other CEU's completed by Staff B for review.

Record review of the facility staff schedule, dated 09/09/2024 through 10/17/2024, showed that Staff B worked 15 shifts during the timeframe.

Record review of the facility's, "Employee HR List", undated, showed Staff C, Medication Aide, was hired at the facility on 04/22/2013. Staff C's birthday was [redacted].

Record review of Staff C's "Relias Transcript", dated 10/23/2024, showed Staff C completed six hours of CEU's. Staff C needed 6 hours to complete their required CEU's. There were no other CEU's completed by Staff C for review.

Record review of the facility staff schedule, dated 09/09/2024 through 09/27/2024, showed Staff C worked three shifts during the timeframe.

Record review of an email sent to the Department on 10/24/2024 at 11:03 AM, showed Staff A, Administrator, said the facility followed the WAC guidelines related to CEU's.

In an interview on 10/28/2024 at 9:52 AM, Staff A, Administrator, stated Staff F, Business Office Manager, tracked all the employee trainings through their electronic learning program. Staff A stated Staff F puts their trainings on a training tracker and ensures employees complete their training by their birthday every year.

Statement of Deficiencies	License #: 2144	Compliance Determination # 49160
Plan of Correction	Easthaven Villa	Completion Date
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This is an uncorrected deficiency previously cited on 08/05/2024 for subsection 388-78a-2474-2e.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 12/12/24 .

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

Administrator (or Representative) 11/11/24 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 and interview, the facility failed to maintain safe water temperatures between 105 and 120 degrees in 1 of 2 buildings (Assisted Living building) reviewed. This failure placed all 37 of 37 assisted living residents, visitors, and staff at risk of injury from unsafe water temperatures and decreased quality of life.

Findings included...

Record review of the facility's "Plan of Correction [POC]", dated 08/05/2024, showed under the deficiency section WAC 388 78A 2950 (6). The actions section showed the water temperature would be checked and recorded monthly. If water temperatures were found outside of the allowable range, the hot water would be adjusted and retested accordingly. The maintenance and the administration were responsible to ensure hot water temperatures were within the required range. The POC showed the facility alleged to be back in compliance with the regulation on 09/19/2024. The POC showed the facility completed the monthly test on 09/02/2024.

Record review of the facility provided document titled, "Temperature Log", dated 09/06/2024, showed in the memory care unit room 232 had a water temperature of 104 degrees Fahrenheit (F), room 210 had a water temperature of 102 degrees F, and room 207 had a water temperature of 100 degrees F.

In an observation on 10/22/2024 at 1:09 PM, the unlocked public bathroom located across from the dining room in the assisted living building had a water temperature of 124.0 degrees F.

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In an observation on 10/22/2024 at 1:26 PM, the unlocked public bathroom located across from the kitchen in the assisted living building had a water temperature of 124.8 degrees F.

In an interview on 10/22/2024 at 2:25 PM, Staff A, Administrator, said that the water temperature in the building was taken once a month. Staff A said Staff D, Maintenance, comes to the facility on a weekly basis. Staff A said it had not been reported that there had been a concern with the facility water temperatures. Staff A acknowledged the water temperatures in the building had been over 120 degrees F.

In an interview on 10/22/2024 at 2:57 PM, Staff A acknowledged the water temperatures in the unlocked staff bathroom and public bathrooms that exceeded the 120-degree F threshold had been a concern.

This is an uncorrected deficiency previously cited on 08/05/2024.

Plan/Attestation Statement

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for the unannounced on-site full inspection on 07/16/2024 and 08/05/2024 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

The following sample was selected for review during the unannounced on-site visit: 9 of 73 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

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.

Stacie Dilley IDR PM for Reg 3E
Residential Care Services

October 04, 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.

Administrator (or Representative) 10/10/2024 Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the care for 1 of 1 resident (Resident 6 [R6]) was provided in a dignified manner. The facility failed to address and resolve 6 of 9 residents (Resident 14 [R14], Resident 1 [R1], Resident 16 [R16], Resident 17 [R17], Resident 18[R18], and Resident 19[R19]) grievances. These failures resulted in Resident 6 not receiving dignified care, and placed the all of the other six residents at risk for experiencing decreased quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

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

RCW 70.129.140 (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Record review of the Department of Social and Health Services document, titled, "Fundamentals of Caregiving 3rd Edition", dated 08/2023, under the section titled, "Caregiver's Role in Toileting, privacy, dignity, and independence", showed toileting was a very private matter. No how routine it may become for the caregiver, it was a very vulnerable and defenseless time for a resident. When assisting a resident with toileting, do everything you can to give the resident privacy and maintain their dignity.

Record review of the facility's policy, titled, "Grievances and Complaints", undated,

showed if a resident or their representative had a grievance or a complaint that they were encouraged to bring it to the attention of facility management whether it was through resident council or through facility staff. Facility staff would document the complaint on the appropriate form with the name of the person who received the information and the date. The form would be turned into Staff A, Administrator, who would route it to the appropriate staff member to follow up. The facility management would investigate the complaint and findings would be documented. The resident or representative would be verbally informed of the results within 10 non-weekend days of the report being filed.

Record review of the facility's "Resident Council" document, dated 05/09/2024, showed handwritten notes that documented male residents had been inappropriate in the dining room which effected other residents' participation. There was a note that facility staff needed to report concerns to Staff A, Administrator. There was a note that residents expressed there needed to be more handicap access on the facility sidewalks. There was a note that residents thought the dining room door to the outside should be electronic. There was a note that confrontation in activities needed to stop. There were no documented notes to review of how and when the facility staff followed up on the residents' concerns they expressed.

Record review of the facility's "Resident Council" document, dated 07/04/2024, showed handwritten notes that documented residents were served too much pork and they wanted more variety of food. Residents wanted more fresh fruit accessible to them. Residents expressed concerns about the handwashing and hand sanitizers in the facility. There was a note that the vents in the laundry room needed to be cleaned. Residents expressed concern that Staff R, Maintenance Supervisor, did not follow up on tasks that needed to be completed. Residents expressed concern that the facility windowsills were dirty. Residents expressed concerns that the activity room needed to be cleaned. There were no documented notes to review of how and when the facility staff followed up on the residents' concerns they expressed.

R6

Record review of R6's untitled and undated document that showed R6's demographics, showed R6 moved into the facility on [redacted]/2021 with multiple medical diagnoses that included [redacted].

Record review of R6's Service Agreement Quarterly Update, undated, showed R6 was dependent on staff for all dressing needs. R6 was unable to sit on the toilet safely and needed to be changed lying down in bed. R6 was unable to assist in toileting and peri care tasks. Staff were to assist R6 with incontinent care three to four times during each shift.

In an observation on 07/18/2024 at 3:52 AM, the Department knocked on R6's bedroom door. Staff U, Caregiver, opened the door with gloved hands. Staff U did not say that they were busy or providing care to R6 prior to opening the door. When Staff U opened the door, upon looking inside R6's room, R6 was observed lying in bed on their back. R6 did not have any pants on with their bare legs exposed. R6 had a brief that was fasted on the left side but on the right side of R6 it was unfastened that exposed R6's peri area. Staff U stated they were in the middle of providing care to R6 and would be done shortly and shut the door.

R14

Record review of R14's Service Agreement Quarterly update, dated 01/23/2024, under the section Medical Care Management, showed R14 suffered from depression and would spend time isolating to their room when upset with others. Staff were to encourage R14 to attend activities of choice. Under the section titled, "behaviors", showed R14 had a recent conflict with another female during a Bingo activity. R14 was encouraged to keep a distance from the other female resident during meals and activities.

Record review of R14's progress note, dated 06/26/2024, showed Staff C, Resident Care Coordinator, and administrator spoke with R14 that afternoon regarding a disagreement they had with another resident during a women's luncheon. R14 stated the other resident stated yelling at them for no reason. R14 was asked to stay away from the other resident, especially during activities.

Record review of R14's progress note, dated 07/14/2024, showed R14 talked with the medication technician around 5:20 PM about concern with a few residents in the facility. R14 stated they felt other female residents were harassing them. R14 expressed that the two female residents were playing bingo with R14 the date prior (07/13/2024) and one of the residents continued to call her a bitch. R14 stated the other resident continued to antagonize the situation and encouraged other residents to insult R14. R14 stated that every time they would pass by the other residents in the dining room or where they would always talk about R14 and yell at R14 to slow down. R14 stated that another resident that they get along with had expressed that the other residents that have been bothering her were encouraging other people to mess with R14.

In an interview on 07/17/2024 at 12:13 PM, R14 stated they felt they were being retaliated and isolated within their room and the facility. R14 stated there were two female residents, R16 and R18 that gang up and harass them. R14 stated recently they were at bingo and R18 called her "cunt and bitch" during the activity. R14 stated they told Staff A, Administrator, about R18 calling them those names and were told to stay away from R18. R14 stated they stay in their room now and do not participate in activities. R14 stated they do not want to go to activities in fear of getting in trouble and just do not come out of their room.

In an interview on 07/19/2024 at 10:48 AM, Staff C stated that R14 and R18 do not like each other. Staff C stated if R14 and R18 were in the same vicinity they fight. Staff C stated both R14 and R18 have been talked to and both residents were asked to stay away from each other.

In an observation on 07/19/2024 at 1:15 PM, in the activity room dining tables there was activity of bingo being conducted. R16 was calling the bingo numbers for the bingo session. It was observed that R18 was playing. R14 was not participating in the activity. Staff C stated they were aware that during the last bingo session in the last week, R14 and R18 "got into it".

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted]

[redacted] and [redacted].

Record review of R1's "Service Agreement", dated 06/11/2024, showed R1 had good short term and long-term memory. R1 did not have a reported history of anxiety (excessive worry).

In an interview and observation on 07/19/2024 at 11:36 AM, R1 reported a maintenance concern about their bedroom door handle had been broken and they could not pull their door handle down since they moved into the facility. R1 said they had reported their concern to multiple facility staff members which included Staff A, Administrator and Staff R, Maintenance Supervisor. R1 said originally, they had been informed that their door handle would be replaced. R1 said Staff R said their door handle was not broken and they were not strong enough to operate their door. R1 said Staff R gave them a skinny black L shaped tool to use alongside their key to try and open their door. R1 showed the Department what appeared to be an allen wrench. R1 had locked their door and attempted to use their key and the allen wrench to open it. R1 tried multiple times to turn the key inside of the lock to open the door but was unsuccessful. The Department licensor locked the door and stepped outside of R1's bedroom. After multiple attempts R1's door was unable to be dislodged using R1's key and allen wrench. R1 expressed concern that they had to leave their door unlocked due to not being able to open it. R1 reported at times facility staff members locked their door and then R1 was not able to get back inside. R1 reported at one time a facility staff member could not open their door and used a credit card to dislodge the locked door. R1 reported that it concerned them that anyone could easily open their door. R1 reported a dining service concern about when they ordered alternative meals from the kitchen. R1 said they attempted to order soup and a sandwich from the alternative menu. R1 said they were informed they could only order one item off the menu. R1 expressed concern that a bowl of soup did not fill them up and they went hungry. R1 said they talked to Staff S, Dietary Manager, today about their concern. R1 reported that Staff S said that if a resident ordered an alternative item off the menu, they were supposed to be served the main sides with it. R1 said they informed Staff S when they ordered off the alternative menu, they did not receive fruit, sides, vegetables, or a dessert with it. R1 reported there was a lack of variety when it came to food served at the facility. R1 said they wanted beef hot dogs and the facility had been unable to accommodate their preference.

In an interview on 07/19/2024 at 11:50 AM, Staff M, Caregiver, said sometimes R1's apartment doors lock got stuck and would be difficult to open. Staff M noted they had a master key they were able to use to enter, which was a different type of key that R1 used.

In an interview on 07/22/2024 at 9:55 AM, Staff R said that they were aware R1 had issues with their door lock. Staff R said R1 had anxiety and when R1 reported concerns with their door lock they tried to address it. Staff R said R1 did not have the hand strength to unlock their door.

In an interview on 07/22/2024 at 9:10 AM, Staff A said that they were aware R1 had issues with their door lock. Staff A said the facility took R1's lock to the locksmith to get it rekeyed. Staff A said they thought R1 had been too weak to operate their door handle accurately. Staff A said they were not aware that Staff M had given R1 an allen wrench tool to use because R1 still had problems with their lock. Staff A said they were not aware facility staff members had opened R1's door with a credit card.

Group Meeting

In a resident group interview on 07/17/2024 at 10:00AM, R17 said that if residents wanted to order an alternative meal, they were required to do so 2 hours in advance. R16 said facility staff members did not inform residents what would be served as the alternative meal. R1 reported that one of the facility's cooks had informed R1 that they were not their personal chef. R1 reported food that was supposed to be hot was served cold. R18 said the cornbread they served was hard. R18 said one resident threw the cornbread and the biscuit bounced off the ground. R17 said they served a lot of rice and macaroni. R1 said they were served a lot of chicken. R16 said they were served more carbohydrates than fruits and vegetables. R1 said one time they missed dinner and informed Staff Y, Cook, they missed dinner. Staff Y told R1 they had already thrown away dinner and served them one chicken finger and fig newtons. R1 expressed concerns that what was served was not enough to fill them. R1 said facility staff members would not knock before entering their room. R17 said facility staff members would knock as they entered their room. R17 said facility staff members did not wait for them to say come in before they entered their room. R19 said an unknown agency staff member had knocked on their door and entered when they were undressed. R19 said the agency staff member saw them undressed and then left their room. R16 expressed concern about the back side of the assisted living building. R16 said there was not a ramp accessible for residents who used wheelchairs to get off the sidewalk. R16 said they would have to go around the front of the facility to access the ramp. R17 said they used an electric wheelchair. R17 said there were not handicap accessible exits off the sidewalk on the back side of the assisted living building. R17 expressed a concern with accessing the outside area through the dining room door. R17 said they had to shove the door open with their electric wheelchair in order to get through. R17 put out their left arm and showed a scabbed area that was approximately 1 inch long. R17 said the injury occurred 3 weeks ago when they tried to open the dining room door. R16 said facility staff members were supposed to be available to help residents get through the dining room doors to the outside area. R17 said if they reported a missing item facility staff members did not always follow up. R17 said they reported to Staff A that they had fingernail polish remover and a pair of sport earrings missing. R17 said Staff A informed them "you need to keep the door closed." R18 expressed concern that they had multiple items had gone missing. R17 said they had issues with their door and the facility staff were supposed to change their lock. R19 expressed concern the outside windows of the facility were dirty. R17 said they had not had their room cleaned for almost 2 weeks because Staff N, Housekeeper, missed it last Thursday on 07/11/2024. R16 expressed concerns with the activity room cleanliness. R16 said the activity room counters, tables, and handrails were not regularly cleaned. R1 reported Resident 20 (R20) had talked inappropriately in common areas 5 days ago. R1 said R20 talked about sexually explicit topics related to performing oral sex and past sexual experiences. R1 said the conversation made them embarrassed and they did not want to hear it. R1 said they reported it to Staff A, Administrator, and was informed if R20 did this one more time they would take action. R19 said R20 talked about a medical procedure where the surgeon had to enter through their genitals in the gazebo outside. R17 said they thought R20's inappropriate talk had rubbed off on Resident 21 (R21). R17 said R21 is touchy feely and will tell R17 they loved them and talked in a sexually explicit way. R17 said R21 lifted their shirt and made comments about how they knew R17 wanted to see their body. R16 said they saw R21 rubbing against R17. R16 said they had heard R20 and R21 talk in sexually explicit ways. R17 said they reported their concerns to Staff A. R17 said Staff A and Staff E, Licensed Practical Nurse followed up

with them at a later time. R17 said Staff E gave them permission to physically punch R21 if needed. R17 said they had an interaction with R21 and informed R21 they better not say anything inappropriate because they had permission to punch them.

In an interview on 07/22/2024 at 9:10 AM, Staff A said they did not have a grievance log or any other documented grievances they could provide. Staff A said they used resident council meeting minutes to follow up on resident grievances. Staff A said if a resident expressed a grievance, they would follow up with the department head the concern was about and the department head would follow up as needed. Staff A said they did not document their conversations with the department heads.

In an interview on 07/19/2024 at 10:13 AM, Staff N, Housekeeper, said if they had to call out for their shift the other facility staff members would not cover the cleaning Staff N was responsible to complete that day. Staff N said if they knew they would be off in advance then they would attempt to complete 2 days of cleaning within 1 day. Staff N said they were supposed to clean the activity room on Tuesdays and Thursdays. Staff N said sometimes on Tuesdays they did not have enough time to clean the activity room so they would make sure to clean it on Thursday.

In an observation on 07/16/2024 at 1:48 PM, outside of the assisted living building on the sidewalk showed there were two uneven parts of the pathway that had faded orange paint around the uneven area.

In an observation on 07/22/2024 at 9:53 AM, Resident 16 [R16] had been observed to exit the dining room door to go outside. R16 used a walker and had to turn around to exit the door using their back in order to clear the door. There was an unknown female facility staff member standing at the table in front of the dining room. The unknown facility staff member did not offer to open and hold the door for R16.

In an interview on 07/19/2024 at 11:56 AM, Staff C, Resident Care Coordinator, said they had observed R17's arm and confirmed it had scabbed over. Staff C said R17 did not report their injury when they scraped their arm getting through the dining room door that led to the outside.

In an interview on 07/22/2024 at 10:48 AM, Staff C said they were aware R21 had a weird sense of humor and could make residents uncomfortable at times. Staff C said R17 had recently reported a comment R21 made that made them uncomfortable.

This is a recurring deficiency previously cited on 02/16/2022.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) 10/10/2024 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor the resident's well- being after a fall, after a prescribed medication was not available, and after a change in residents condition for 3 of 9 sampled residents (Resident 7 [R7], Resident 4[R4], and Resident 1[R1]). This failure placed the residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy titled, "Resident Alerts", undated, showed all incidents, changes of conditions, changes in medications required enhanced monitoring of the resident and potential changes in care. If a resident experienced a change of condition the facility staff would record observations until the resident returned to their baseline or the change became the new baseline. Facility staff were to record details of the changes, resident's thoughts on the change, objective findings, staff responses and interventions to promote independence. If a resident experienced a non injury fall, they would record observations every shift for twenty-four hours. If the resident were unstable, they'd continue for an additional forty-eight hours and record observations of resident's ability to ambulate, transfer, injury, skin tear, discoloration of skin, headache, dizziness, sleepiness, or confusion. Facility staff were to watch for contributions to falls such as constipation, pain, need to void, etc (etcetera). If a resident had a fall with injury facility staff were to record observations every shift for 3 days. They would record residents' ability to ambulate, transfer, injury, skin tear, discoloration of skin, headache, dizziness, sleepiness, or confusion. Facility staff were to watch for contributions to falls such as constipation, pain, need to void, etc. If a resident had a medication or procedure the facility staff were to record observations every shift for 3 days which included specific side effects to the medication, outcome, and the nurses or medical

doctors' instruction.

R7

Record review of R7's untitled and undated document showed they moved into the facility on [redacted]/2023 with multiple medical diagnoses which included [redacted], and [redacted].

Record review of R7's, "Resident Progress Note", dated 05/10/2024, showed Staff O, Lead Medication Aide, documented that R7 was found in their room laying on their left side. Staff O wrote that it appeared R7 slid out of their wheelchair, and they would be placed on alert to monitor for any injuries.

Record review of R7's "Resident Alerts", dated 05/10/2024 at 9:40 PM, showed Staff P, Medication Aide, wrote R7 did not have a change in their baseline. There were no other documented alert notes for R7 to review.

Record review of R7's "Resident Alerts", dated 05/11/2024, at 5:43 PM, showed Staff P wrote R7 had no visible markings on their left side, and they would continue to monitor for injuries. There were no other documented alert notes for R7 to review.

Record review of R7's "Resident Alerts", dated 05/12/2024, at 4:01 PM, showed Staff Q, Medication Aide, wrote R7 was at their baseline with no signs of injury. There were no other documented alert notes for R7 to review.

Record review of R7's "Resident Alerts", dated 05/13/2024, at "11:15:36 AM", showed Staff D, Resident Care Coordinator, wrote that R7 was at their baseline since their fall, no injuries were observed, and R7 would be taken off alert charting.

Record review of R7's, "Resident Progress Note", dated 05/31/2024, at 2:15 PM, showed Staff D labeled the progress note as a "change of condition" and wrote R7 was in their wheelchair hunched over while their chest touched their thighs. Staff D and an unknown facility medication aide assisted R7 into their recliner chair where R7 continued to hunch over. Staff D called Staff E, Licensed Practical Nurse, into the room and they assisted R7 to their bed. R7 was left to nap with increased safety checks. Staff D re-entered residents' room at 4:30 PM, to see if R7 wanted dinner. R7 easily woke up and staff assisted R7 into their wheelchair. R7 was noted to hold themselves upright with out assistance. There were no documented alert notes for R7 to review.

Record review of R7's, "Resident Progress Note", dated 06/06/2024, showed Staff E wrote a hospital discharge planner wants to send R7 back to the facility. Staff E wrote R7 had pneumonia (infection that affected the lungs) and was treated with antibiotics. Staff E wrote they went to the hospital and noted the hospital took R7 off their behavior medication and that R7 was not eating. The hospital staff were unable to assess R7's transfer status because R7 refused. R7 was changed to a pureed diet and thick liquids due to swallowing ability was unknown.

Record review of R7's "Resident Alerts", dated 06/02/2024 at "5:17:24 PM", Staff Q wrote R7 was out of the facility. R7 was on alert because their toenail lifted.

Record review of R7's "Resident Alerts", dated 06/03/2024 at "10:13:52 AM", Staff D wrote R7 would be taken off of alert charting for their toenail due to R7 being admitted to the hospital.

Record review of R7's, "Resident Progress Note", dated [redacted]/2024, showed Staff D, wrote R7 re-admitted into the facility after being in the hospital since [redacted]/2024 due to pneumonia, loose stools, and dehydration. R7 returned with medication changes. R7 returned with a pureed diet and mildly thick liquids. R7 was referred to hospice. R7 would be placed on alert charting to monitor their acclimation back into the community. There were no documented progress notes or alert notes for R7 to review that explained why R7 was admitted into the hospital.

R4

Record review of R4's Resident Info Sheet", undated, showed R4 moved into the facility on [redacted]/2022. R4 had multiple medical diagnoses which included [redacted], and [redacted].

Record review of R4's "Resident Progress Notes", dated 05/02/2024, showed R4 had fallen from their walker getting into bed. R4's middle lower back had been observed to have an abrasion and redness. R4 had been placed on alert.

Record review of R4's "Resident Alerts" dated 05/02/2024 – 05/05/2024, showed R4 was put on alert on 05/02/2024 due to a fall with injury. The resident alert noted that facility staff were to record observations every shift for 3 days related to residents' ability to transfer, ambulate, injury, skin tear, discoloration of skin, headache, dizziness, sleepiness, and confusion. The facility staff were to watch for contributors to falls. There were no documented resident alert charting notes to review on 05/03/2024 regarding R4's fall with injury that happened on 05/02/2024.

Record review of R4's "Resident Alerts" dated 05/30/2024, showed record observations every shift for twenty-four hours and if unstable then continue for an additional forty-eight hours. In typed red font showed "Resident had another fall on 06/02 no injuries at this time..."

Record review of R4's "Resident Progress Notes", dated 06/04/2024, showed R4's primary care provider responded to R4's fall on 06/02/2024 that the facility were to continue to monitor R4 as needed. "Resident remained on alert for staff to monitor from 05/30 alert." There were no documented resident alert charting notes to review on 06/03/2024 and onward regarding R4's non injury fall that happened on 06/02/2024.

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted].

Record review of R1's "Service Agreement", dated 06/11/2024, showed R1 preferred staff assisted them and managed their medications. R1 used inhalers and could operate

them when cued.

Record review of R1's June MAR, dated 06/01/2024 – 06/30/2024, showed that R1 had an order for fluticasone propionate and to inhale 2 puffs twice daily for their COPD. R1 missed 1 dosage of their medication on 06/21/2024. R1 missed 2 dosages of their medication on 06/22/2024 – 06/30/2024.

Record review of R1's July MAR, dated 07/01/2024-07/14/2024, showed R1 had an order for fluticasone propionate and to inhale two puffs twice daily for their COPD. R1 missed one dosage of their medication on 07/01/2024 – 07/02/2024. R1 missed two dosages of their medication on 07/03/2024 – 07/05/2024. R1 missed one dosage of their medication on 07/06/2024.

Record review of R1's "Resident Progress Notes", dated 06/23/2024, showed an unknown facility staff member placed R1 on alert for being out of their fluticasone medication.

Record review of R1's "Resident Alerts", dated 06/23/2024 – 07/06/2024, showed R1 had not been placed on alert the day they missed their first dosage of the fluticasone propionate on 06/21/2024. There were no documented alert charting notes to review from 06/27/2024 – 06/29/2024. There was only one documented alert charting note to review on 07/03/2024.

In an interview on 07/19/2024 at 11:36 AM, R1 said they had not had their fluticasone propionate inhaler for an extended period. R1 said historically they used their fluticasone propionate inhaler for 2 puffs in the morning and 2 puffs in the evening. R1 said the facility staff informed them to use their nebulizer instead of the inhaler. R1 expressed concern with using their nebulizer because in the past they had been hospitalized due to overdosing on too many nebulizer treatments. R1 expressed frustration with the need to use their nebulizer treatment due to it being quick acting and not lasting as long as their fluticasone propionate inhaler.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said if a resident were placed on alert charting it would be expected there would be a minimum of 2-3 charting notes per day. Staff C said some facility staff members worked double shifts and completed their charting notes at the end of the day instead of completing two charting notes throughout the day. Staff C said they were unsure if R1 stayed on alert the entire duration of when they missed their fluticasone propionate medication.

This is a recurring deficiency previously cited on 06/14/2023, 02/07/2023, 02/16/2022, and 08/18/2021.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/12/2024 .

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

Administrator (or Representative) — Date: 10/10/24

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 ensure that the residents Service Agreement (facility's version of the negotiated service plan) were followed and implemented for 1 of 1 sampled memory care residents (Resident 6 [R6]). This failure resulted in R6 experiencing discomfort and placed R6 at risk for injury, unmet care needs, and decreased quality of life.

Findings included...

Record review of the facility's document titled, "Service Plan Content/Wording", undated, showed service plans were written to tell staff about what the resident could do, what the resident's preferences were, and then what the staff were responsible to do for the resident.

Record review of R6's untitled and undated document that showed R6's demographics, showed R6 moved into the facility on [redacted]/2021 with multiple medical diagnoses that included [redacted].

Record review of R6's Health Assessment, dated 06/04/2024, showed R6 makes needs known through facial expression and some words. R6 would moan, groan, or have facial grimacing with transfers or care when R6 was in pain.

Record review of R6's Service Agreement Quarterly Update, undated, that was provided as the working care plan, showed R6 used a broda wheelchair (specialized wheelchair to help with positioning and skin integrity) for repositioning, comfort, and safety. R6 had a recent decrease in ability to transfer and would lock their legs. R6 could bear weight most days for a pivot transfer with gait belt. Staff were to remove arm and food rest to the wheelchair prior to transferring. R6's wheelchair was to be placed right up to the bed and R6 would be pivoted to the wheelchair. Staff were to alert the resident care

coordinator (RCC) if R6 could not bear weight. Under the section titled, "transfers", showed R6 requested two staff members with a gait belt to pivot transfer to the wheelchair. R6 was to wear non-skid shoes prior to all transfers. If R6 was unable to bear weight, staff were to leave R6 in bed and alert the RCC. Under the section titled, "eating", showed R6 would feed some days and somedays required staff to feed her meals. Staff were to sit R6 in a 90-degree angle in the wheelchair to eat.

In an observation and interview on 07/18/2024 at 4:23 PM, Staff U, Caregiver, and Staff V, Caregiver, were in R6's room to transfer R6 to their broda wheelchair for dinner. Staff U removed the arm rest from the broda wheelchair. Staff U did not remove the footrest on the broda wheelchair. Staff U and Staff V both assisted R6 up to the side of the bed in a sitting position. R6 had a difficult time sitting upright on the side of the bed and required full assistance from Staff U. Staff V put a gait belt around R6's upper waist area and secured it. Staff U and Staff V were on either side of R6. Staff U positioned the wheelchair next to the bed that was a foot away from the edge of the bed. Staff U and Staff V counted to three and assisted R6 with standing up one hand on the gait belt and one hand on R6's arm. Staff U and Staff V started to move R6 towards the broda wheelchair when R6 was unable to move her legs. Staff U assisted R6 to turn and when Staff U and Staff V attempted to assist R6 into the broda wheelchair. R6's right outer calf area hit the footrest pad on the wheelchair causing Staff U and Staff V from getting closer to the wheelchair to sit R6 down. Staff U stated they needed to sit R6 back down on the bed and did. Staff U stated "that was the first time R6 had ever stood up". When Staff U was asked how they typically transfer R6, Staff U stated they would grab the gait belt that was around R6 and grab under R6's thigh area and lift R6 up. Staff U and Staff V then each grabbed the gait belt, and then each grabbed under R6's thigh and lifted R6 up. Staff U and Staff V carried R6 to the broda wheelchair and sat R6 down on the wheelchair cushion. When Staff U and Staff V lifted R6 up off of the bed, R6 began yelling and trying to grab things with their arms. R6's face was grimacing during the transfer. When R6 was assisted down on the wheelchair cushion it was on the edge and required Staff U and Staff V to assist R6 back into the wheelchair further. R6 was transferred in only socks and no shoes.

In an observation on 07/18/2024 at 5:11 PM, in the memory care unit's dining room, R6 was sitting at the dining room table. Staff W, Caregiver, sat down at the table with R6 and began to feed R6 tomato and cucumber slices from their dinner plate. R6's broda wheelchair was observed to be tilted back and not at a 90-degree angle. R6 was observed to try to lean forward towards the table and would fall back into the wheelchair's cushioned back.

In an interview on 07/19/2024 at 12:17 PM, Staff D, Resident Care Coordinator, stated all memory care residents working care plans were in the employee breakroom for the caregivers to review. Staff D stated caregiver were to look at the working care plans (facilities service agreements) every day to ensure they know of any updates made for the residents. Staff D stated the caregivers were to follow and provide the resident care as the working care plan showed.

This is a recurring deficiency previously cited on 10/12/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/2024

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 2 of 2 buildings (Assisted Living Building and Memory Care Building) for staff and residents to use. Additionally, the facility failed to implement proper infection control hand washing measures when job tasks were changed for 4 of 4 observed staff (Staff Y, Staff U, Staff V, and Staff Q) during resident care. These failures resulted in a break in hand hygiene practices, staff not having access to hand hygiene supplies, and placed all 73 of 73 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Record review of the Centers of Disease Control (CDC) document titled, "about handwashing", dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other

person's hands or common objects. Hands were to be washed often.

Record review of the CDC's document titled, "clinical safety: hand hygiene for healthcare workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare personnel from being infected from germs received from the patient. Healthcare workers were to clean their hands before touching a patient, before moving from work from soiled to clean, after touching a patient or patient's surrounding, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare works were to wash their hands with soap and water when their hands were visibly soiled.

Record review of the facility provided untitled and undated document that was the facility's policy for hand washing, showed hand washing was the single most important measure for preventing the spread of infection and disease. All staff were responsible for carrying out the hand washing policy. Staff would wash their hands after personal body function that included blowing or wiping nose, after handling items with body fluids and housekeeping tasks, before handling medication, before and after helping a resident with personal care tasks of daily living, before handling any food, whenever you change from doing a "dirty" task to a "clean" task, dietary employee's hands must be washed at the kitchen sink upon reentry in the kitchen, whenever hands were obviously soiled. The use of gloves does not replace hand washing. Under the section titled, "procedure", showed once an employee got their hands completely wet, soap would be applied. The employee would wash hands with soap for one full minute and then rinse. Once hands were completed rinsed the employee was to dry hands well with paper towels and then turn the water off with paper towel and discard.

Hand Washing Supplies

In an observation on 07/16/2024 at 12:54 PM, in the assisted living building, the hand sanitizer device outside of the game room blvd (boulevard) showed it was empty. When the device was pumped multiple times no hand sanitizing solution was dispensed.

In an observation on 07/16/2024 at 1:26 PM, in the assisted living building in the drink and snack bar area the sink did not have any soap or paper towels available for use.

In an observation on 07/16/2024 at 2:07 PM, in the memory care activity room with the garden box, the public sink did not have any soap or paper towels available for use.

In an interview on 07/17/2024 at 10:30 AM, Resident 16 expressed concern that the activity room in the assisted living building did not have hand sanitizer available in the community to use.

In an observation on 07/17/2024 at 11:07 AM, the hand sanitizer device outside of the assisted living building activities room in the hallway showed a blinking red light and was empty. When the device was pumped multiple times no hand sanitizing solution was dispensed.

In an observation on 07/17/2024 at 11:56 AM, in the assisted living kitchen at the back

door leading out into the courtyard, halfway up the wall was a hand sanitizer machine. The Department put their hand under the hand sanitizer with no hand sanitizer dispensed. The hand sanitizer machine was empty.

In an observation on 07/17/2024 at 12:54 PM, a male visitor that was taking a tour with Staff B, Regional Director of Operations, put their hand under the hand sanitizer dispensing machine that was at a breeze way where the assisted living dining room enters a hallway. The hand sanitizer did not dispense any hand sanitizer into their hand. The male visitor was not observed to rub their hands together but had lowered their arms and hands to their sides and continued their tour without use of hand sanitizer.

In an observation on 07/18/2024 at 3:55 PM in Resident 6's bathroom, there were no paper towels for use.

In an observation and interview on 07/18/2024 at 3:09 PM, inside Resident 3's (R3) bathroom there was no soap available for use that had been provided by the facility. R3 stated that their daughter had bought the soap that was at the bathroom and the kitchenette sink for R3 to use. At 3:09 PM, the sink that was in the kitchenette area did not have facility provided soap or paper towels for staff to use.

In an observation on 07/18/2024 at 4:57 PM, outside of the memory care unit door in the lobby area, Staff E, Licensed Practical Nurse, was observed to put their palm of hand under the hand sanitizer dispensing machine. The machine did not dispense any hand sanitizer. Staff E stated that the machine was out. Staff U was observed to look around the lobby area for another hand sanitizer machine and did not locate one. Staff U exited the memory care building without use of hand sanitizer or washing their hands.

In an observation on 07/18/2024 at 5:21 PM, in the lobby area outside of the memory care building, the hand sanitizer machine remained empty. The Department placed their hand under the hand sanitizer machine without any hand sanitizer dispensed.

In an observation on 07/19/2024 at 10:08 AM, the hand sanitizer device outside of the assisted living building activities room designated for sewing, painting, and crafting showed it was empty. When the device was pumped multiple times no hand sanitizing solution came out.

In an observation on 07/19/2024 at 10:36 AM, inside Resident 2's bathroom, there was no facility provided hand soap available for use.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said a lot of the hand sanitizer devices on the walls in the facility were broken. Staff C said the hand sanitizer solution that originally went into the container's formula changed and it no longer worked for the sanitizer dispensers the facility had.

In an observation on 07/19/2024 at 12:17 PM, in the lobby area outside of the memory care building, the hand sanitizer machine remained empty. The Department placed their hand under the hand sanitizer machine without any hand sanitizer dispensed.

In an observation on 07/19/2024 at 12:29 PM, in the activity room of the memory care building where the garden boxes were located, the sink remained without any soap or paper towels for use.

In an interview on 07/22/2024 at 9:10 AM, Staff A, Administrator, said the facility could not find hand sanitizer solution to refill the sanitizer dispensers within the facility.

Hand Washing

In an observation on 07/17/2024 at 11:43 AM, Staff Y, Cook, exited the kitchen, reaching into their pant pocket, pulled out a bottle and then sprayed something from the bottle into their nose. Staff Y put the bottle back into the pants pocket and then sat down at a dining room table with the residents. Staff Y was not observed to wash their hands or use hand sanitizer after touching their nose.

In an observation on 07/18/2024 at 3:52 PM, the Department knocked on R6' bedroom door. Staff U, Caregiver, opened the door and was holding the door opened with blue disposable gloved hands. Staff U stated they were providing care for R6 and would be done shortly and shut the door. At 3:55 PM in R6's bathroom sink, it was noted the sink was dry with no paper towels available for use.

In an observation on 07/18/2024 at 4:07 PM, Staff U opened the door and came out of Resident 23's (R23) room. Staff U was wearing blue disposable gloves on both hands. Staff U had opened R23's door with one gloved hand and was holding a tied-up bag of trash with the other gloved hand. Staff U exited R23's room walked down the hallway, used their gloved hand and pushed the code on the laundry room door and entered the room. Staff U immediately exited the laundry room door with bare hands and proceeded to walk down another hallway. Staff U was not observed to use hand sanitizer or wash their hands with soap and water.

In an observation on 07/18/2024 at 4:23 PM, Staff U and Staff V, Caregiver, entered R6's room and both put on disposable gloves on both hands. Staff U and Staff V were not observed to use hand sanitizer or wash their hands with soap and water prior to putting the gloves on. Staff U and Staff V physical lifted and assisted R6 into their wheelchair. At 4:32 PM, Staff U removed their disposable gloves from both hands and discarded them in the trash in R6's room. Staff U grabbed R6's wheelchair and began pushing R6 out of the room. Staff U just outside of R6's room stopped and then wiped sweat on their forehead with the back of their hand. Staff U was not observed to wash their hands with soap and water or use hand sanitizer after the removed their gloves or prior to pushing R6 in their wheelchair. Staff U pushed R6 in the wheelchair to the dining room with their bare hands and not observed to wash their hands during the entire observation. Staff V removed their gloves and discarded in R6's trash can, walked to the laundry room door, pushed in the code on the keypad on the door, and then entered the laundry room. Staff V was not observed to wash hands or use hand sanitizer before touching the laundry room door keypad. At 4:45 PM, Staff V and Staff U both stated they did not have any hand sanitizer on them for them to use to wash their hands.

In an observation and interview on 07/18/2024 at 5:00 PM, Staff Q, Medication Aide, put on gloves on both of their hands. Staff Q opened the medication cart drawer and removed an insulin pen. Staff Q applied the screw top needle to the insulin pen. Staff Q removed their gloves. Staff Q then put on a new pair of disposable gloves, opened a different medication drawer and removed a larger green container. Staff Q opened the container and removed white powder substance. Staff Q grabbed Resident 25's (R25) dark yellow cup of juice and poured the white powder inside and stirred it. Staff Q then removed their gloves and handed R25 the cup with the mixed white powder in apple juice. At 5:07 PM, Staff Q removed their gloves and stood at the medication cart

watching R25 drink their juice. Staff Q was not observed to use hand sanitizer after removing their gloves for the second time. There was no observed container of hand sanitizer on the medication cart observed for use. As of 5:19 PM, Staff Q was not observed to wash their hands or use hand sanitizer during the entire undisrupted observation from 5:00 PM until 5:19 PM.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said the expectation for facility staff members to wash their hands was to wash them in between entering a resident's room and when staff removed their gloves. Staff C stated staff should wash their hands at all the normal times. Staff C stated most of the hand sanitizer machines throughout the facility were broken and they were never required to enforce staff to use hand sanitizer.

In an interview on 07/19/2024 at 12:17 PM, Staff D, Resident Care Coordinator, stated all staff were to wash their hands before and after care, before meals being served, when visibly dirty, and all the time.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the memory care facility failed to investigate, document investigative actions and findings after becoming aware of an allegation of sexual abuse for 1 of 4 memory care residents (Resident 5 [R5]), reviewed. This failure placed R5 at risk for further sexual abuse due to the memory care facility

failing to implement appropriate measures to prevent future occurrences.

Findings included...

Record review of the Assisted Living Facility Guidebook Partners in Protection, dated 2018, under the section titled, "the investigation process" showed all alleged incidents of abuse must be thoroughly investigated. The investigation was to be completed to determine what occurred and to make necessary changes to provision of care and services to prevent reoccurrence. A thorough investigation was a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse occurred and how to prevent further occurrences.

Record review of the facility's policies and procedures titled, "resident incidents and investigations", undated, showed "all incidents require a thorough Quality Assurance Investigation to determine what occurred, to determine if any abuse has occurred, and to implement measures, as needed, to prevent recurrence." Staff must immediately report and investigate all incidents in accordance with state regulations and facility policy using tools in the electronic facility system. If an incident involved a resident, any staff member may initiate an investigation, using the form in the facility's electronic system but it was the responsibility of the resident care coordinator to complete the investigation. The nurse was to review and investigate further as required to recommend preventative measures and to sign off on the investigation. The administrator had final review, completion and sign off responsibilities. Prompt response to an incident was critical for protection of the resident and the collections of accurate data.
Record review of R5's document that was a list of her demographics that was undated, showed R5 moved into the facility on [redacted]/2023. R5 had multiple medical diagnoses that included [redacted] and [redacted]).

Record review of R5's "resident alerts", dated 07/07/2024 at 10:02 PM, showed R5 had come to the dining room very panicked saying that a man tried to rape them and was in their room. R5 reported that Resident 15 (R15) was in their room. The medication technician documented that R15 was removed from R5's room. R5 continued to tell the medication technician that R15 tried to rip their clothes off and rape them. The medication technician documented that one hour after R5 reported this incident, R15 had walked up close to R5, and R5 began to point at R15 and stated that was the man that tried to rape her.

Record review of the facility's "event List", dated 05/01/2024 through 07/14/2024, showed there was no documented incident for R5's allegation of R15 attempt of rape recorded.

Record review of an email sent to the Department on 07/18/2024 at 2:48 PM, showed Staff A documented that there was no investigation conducted for the incident that occurred on 07/07/2024 with R5 and R15.

In an interview and observation on 07/18/2024 at 4:13 PM, R5 reported to the Licensor that there was a male that attempted to rape and threated to kill them in their room. R5 was noted to raise their voice, talked with their hands, and had exaggerated facial expression when they explained about the incident. R5 stated they kept their door

locked from that incident.

In an interview on 07/19/2024 at 12:17 PM, Staff D, Resident Care Coordinator, stated they were called the evening on 07/07/2024 by the caregiver about the allegation of rape that R5 reported. Staff D stated the caregiver did not report all the details that were documented. Staff D stated they did not inform the caregiver to report the incident to the Department Complaint Resolution Unit (CRU) line or contact law enforcement. Staff D stated the incident should have been reported to the Departments CRU and law enforcement. Staff D stated an incident report or incident investigation was not completed for the allegation R5 reported on 07/07/2024. Staff D stated an incident and investigation should have been completed.

This is a recurring deficiency previously cited on 06/14/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report to the Complaint Resolution Unit (CRU) and law enforcement for 2 of 9 sampled memory care and assisted living residents (Resident 5 [R5] and Resident 16 [R16]). This failure to notify CRU and law enforcement placed all 73 of 73 memory care and assisted living residents at risk of unreported abuse and prevented the department and law enforcement from evaluating facility systems in place to protect residents.

Findings included...

Record review of the Department of Social and Health Services book, "Assisted Living Guidebook", dated February 2018, showed facilities were required to report 24 hours a day, seven days a week to the Departments CRU hotline via phone or online for any reasonable cause to believe violations involving abuse or neglect. Under the section titled, "what to report", showed when any act, when there was reasonable cause to believe the act caused a fear of imminent harm, or where there was reasonable cause to believe violations had occurred involving abuse were to be reported to the department. Law enforcement were contacted when there was reason to suspect that sexual assault or physical assault against a resident had occurred.

Record review of the facility's policies and procedures titled, "abuse, neglect, and exploitation", undated, showed the community would not tolerate verbal, physical, mental, or sexual abuse of any resident by any staff member, other resident, or visitor to the community. Any staff member that had a reasonable cause to believe that an incident of abuse, neglect of a vulnerable adult has occurred would notify the Department of Social and Health Services (DSHS) hotline number. Any staff member that had reason to suspect an incident of sexual or physical assault has occurred would report to the DSHS hotline and law enforcement as soon as the resident was protected from further harm.

Record review of R5's document that was a list of her demographics that was undated, showed R5 moved into the facility on /2023. R5 had multiple medical diagnoses that included and .

Record review of R5's "resident alerts", dated 07/07/2024 at 10:02 PM, showed R5 had come to the dining room very panicked saying that a man tried to rape them and was in their room. R5 reported that Resident 15 (R15) was in their room. The medication technician documented that R15 was removed from R5's room. R5 continued to tell the medication technician that R15 tried to ripe their clothes off and rape them. The medication technician documented that one hour after R5 reported this incident, R15 had walked up close to R5, and R5 began to point at R15 and stated that was the man that tried to rape her.

Record review of the facility's "event List", dated 05/01/2024 through 07/14/2024, showed there was no documented incident for R5's allegation of R15 attempt of rape recorded.

In an interview and observation on 07/18/2024 at 4:13 PM, R5 reported to the Licensor that there was a male that attempted to rape her and threated to kill them in their room. R5 was noted to raise their voice, talked with their hands, and had exaggerated facial expression when they explained about the incident. R5 stated they kept their door locked from that incident.

In an interview on 07/19/2024 at 12:17 PM, Staff D, Resident Care Coordinator, stated they were called the evening on 07/07/2024 by the caregiver about the allegation of rape that R5 reported. Staff D stated the caregiver did not report all the details that were documented. Staff D stated they did not inform the caregiver to report the

incident to the Department CRU line or contact law enforcement. Staff D stated the incident should have been reported to the Departments CRU and law enforcement.

R16

Record review of R16's "Investigation", dated 05/16/2024, showed Staff A, Administrator observed that the outside bushes had been broken off to the point to where there were no more leaves. Staff A asked R16 if they cut the bushes and R16 admitted they had. Staff A explained that the lawn maintenance had been responsible to maintain the bushes. Later that morning Staff A received an email "[Staff A], I cut those bushes because you wouldn't cut them. Those bushes were just like [unknown resident], and [Resident 17's], and [Resident 13's] bushes. Actually, you cut down their bushes and cleaned them up. Furthermore, dug up some, along with chopping them down. I have asked you two months ago to cut my bushes so that I can see and have sun and air. You constantly said you would. You are making me an example and I'm very concerned about you calling me out; when you allowed others to have bushes cut. Constantly, you call me out on stuff. You are constantly making me feel as if, I am the problem. I'm not your problem and stop bulling me." Staff B, Regional Director Operations, and Staff D, Resident Care Coordinator electronically signed the document.

Record review of the Department database showed the incident where R16 accused Staff A of bullying them had not been reported to the Department.

This is a recurring deficiency previously cited on 02/22/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

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:

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 5 of 8 sampled Residents (Resident 6[R6], Resident 3[R3], Resident 1 [R1], Resident 9[R9], and 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...

R6

Review of R6's untitled and undated document that listed R6's demographics showed R6 moved into the facility on [redacted]/2021.

Record review of R6's Resident Admission Agreement, dated 12/16/2021, showed the Medicaid payment policy was documented on the third page of the agreement under the section titled, "Rate Adjustments. The Medicaid payment policy was not on its own separate page.

R3

Review of R3's untitled and undated document that listed R3's demographics showed R3 moved into the facility on [redacted]/2024.

Record review of R3's Resident Admission Agreement, dated [redacted]/2024, showed the Medicaid payment policy was documented on the third page of the agreement under the section titled, "Rate Adjustments" and above the section titled, "Assisted Living Services". The Medicaid payment policy was not on its own separate page.

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024.

Record review of R1's Resident Admission Agreement, dated 04/22/2024, showed the Medicaid payment policy was documented on the third page of the agreement under the section titled, "Rate Adjustments" and above the section titled, "Assisted Living Services". The Medicaid payment policy was not on its own separate page.

R9

Record review of R9's "Resident Info [information] Sheet", undated, showed R9 moved into the facility on [redacted]/2023.

Record review of R9's Resident Admission Agreement, dated [redacted]/2023, showed the Medicaid payment policy was documented on the third page of the agreement under the section titled, "Rate Adjustments" and above the section titled, "Assisted Living Services". The Medicaid payment policy was not on its own separate page.

R7

Record review of R7's untitled and undated document showed they moved into the facility on [redacted]/2023.

Record review of R7's Resident Admission Agreement, dated [redacted]/2023, showed the Medicaid payment policy was documented on the third page of the agreement under the section titled, "Rate Adjustments" and above the section titled, "Assisted Living Services". The Medicaid payment policy was not on its own separate page.

In an interview on 07/22/2024 at 10:06 AM, Staff B, Regional Director of Operations, stated the Medicaid policy was supposed to be on its own separate page. Staff T, Registered Nurse Oversite , stated the corporate office had dealt with this multiple times and were aware that the Medicaid policy was required to be on its separate page with 14 font.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

RCW 70.129.150 Disclosure of fees and notice requirements -- Deposits.

(1) Prior to admission, all long-term care facilities or nursing facilities licensed under chapter 18.51 RCW that require payment of an admissions fee, deposit, or a minimum stay fee, by or on behalf of a person seeking admission to the long-term care facility or nursing facility, shall provide the resident, or his or her representative, full disclosure in writing in a language the resident or his or her representative understands, a statement of the amount of any admissions fees, deposits, prepaid charges, or minimum stay fees. The facility shall also disclose to the person, or his or her representative, the facility's advance notice or transfer requirements, prior to admission. In addition, the long-term care facility or nursing facility shall also fully disclose in writing prior to admission what portion of the deposits, admissions fees, prepaid charges, or minimum stay fees will be refunded to the resident or his or her representative if the resident leaves the long-term care facility or nursing facility. Receipt of the disclosures required under this subsection must be acknowledged in writing. If the facility does not provide these disclosures, the deposits, admissions fees, prepaid charges, or minimum stay fees may not be kept by the facility. If a resident dies or is hospitalized or is transferred to another facility for more appropriate care and does not return to the original facility, the facility shall refund any deposit or charges already paid less the facility's per diem rate for the days the resident actually resided or reserved or retained a bed in the facility notwithstanding any minimum stay policy or discharge notice requirements, except that

the facility may retain an additional amount to cover its reasonable, actual expenses incurred as a result of a private-pay resident's move, not to exceed five days' per diem charges, unless the resident has given advance notice in compliance with the admission agreement. All long-term care facilities or nursing facilities covered under this section are required to refund any and all refunds due the resident or his or her representative within thirty days from the resident's date of discharge from the facility. Nothing in this section applies to provisions in contracts negotiated between a nursing facility or long-term care facility and a certified health plan, health or disability insurer, health maintenance organization, managed care organization, or similar entities.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure written acknowledgment of the facility disclosure of services was received and signed for 1 of 7 sampled residents, Resident 2 [R2]) This failure resulted in 1 of 7 residents and their resident representative's being uneducated about their rights and responsibilities while living at the facility.

Findings included...

Record review of R2's untitled and undated document that listed R2's demographics showed R2 admitted to the facility on [redacted]/2023.

During an on-site inspection on 07/16/2024 through 07/22/2024, the facility was unable to provide a signed receipt that R2 received and reviewed the facilities disclosure of services.

In an interview on 08/05/2024 at 1:22 PM, Staff A, Administrator, stated the administrator was responsible to ensure all newly admitted residents received the facility's disclosure of services and sign a receipt they received a copy.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

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

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

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

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

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

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

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

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

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

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

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

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

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

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

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

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

(b) Developmental disability;

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

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

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

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

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

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

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

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

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a 14-day assessment for 3 of 3 sampled residents (Resident 1[R1, Resident 8 [R8], and Resident

3 [R3]). This failure placed the residents at risk for having unmet care needs.

Findings included...

Record review of the facility provided document titled, "Service Plan Content/Wording", undated, showed "14 day assessment (WA [Washington] only) is hand written on printed service plan and updates put in CC [CommuniCare facility's electronic record] updates put in CC and printed in 14 days".

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted], and [redacted].
The facility was unable to provide a completed 14-day assessment for R1.

Record review of R1's "14 and 30-Day Service Plan Reviews", undated, showed R1's 14-day review dated 05/09/2024, showed there were no changes to R1's service plan. R1's 30-day review, dated 05/25/2024, showed R1 could shower and complete activities of daily living independently. The document was signed off by Staff C, Resident Care Coordinator.

R8

Record review of R8's untitled and undated document that listed R8's demographics showed R8 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R8's Service Agreement 14/30 day evaluation, dated 04/29/2024, showed it was signed and dated by the guardian on 04/29/2024. The service agreement evaluation was completed 88 days past the required 14 day review on 02/15/2024.

Record review of an email sent to the Department on 07/18/2024 at 2:50 PM, showed R8 had a routine health assessment completed on 04/11/2024. The assessment was not signed or dated by the assessor for review.

R3

Review of R3's untitled and undated document that listed R3's demographics showed R3 moved into the facility on [redacted]/2024.

Record review of R3's Service Agreement Initial evaluation, dated [redacted]/2024, showed it was signed and dated with an effective date of [redacted]/2024.

Record review of R3's Service Agreement 30 day assessment, dated 07/05/2024, showed it was unsigned and undated with an no effective date documented for review.

Record review of an email sent to the Department on 07/22/2024 at 3:52 PM , showed Staff A, Executive Director, stated the service agreements were residents service

agreements and evaluations together.

As of 07/22/2024 at 5:00 PM, the facility was unable to provide the Department a health assessment or a service agreement that was completed for R3 within 14 days of R3's admission to the facility on 06/04/2024.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said Staff E, Licensed Practical Nurse, completed health assessments and service agreements for the residents. Staff C said they would go with Staff E when they completed the initial health assessment prior to the resident moving into the facility. Staff C said they were not aware Staff E was supposed to complete a 14-day health assessment. Staff C said they had a 14- and 30-day service plan review they completed for the resident service agreements, and they thought that was the same thing.

In an interview on 07/19/2024 at 1:23 PM, Staff E said they were responsible for completed assessments. Staff E said they completed health assessments initially before the resident moved in and the next assessment they completed would be at 30-days. Staff E said they did not complete 14-day assessments.

In an interview on 07/24/2024 at 10:44 AM, Staff E said health assessments were on a different document then the resident service agreements. Staff E said they signed and dated health assessments whereas Staff A and Staff C would sign and date resident service agreements .

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 10/10/24

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

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

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

(iii) On-going assessments of the resident;

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

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to have the Resident Service Plans (facility's version of the Negotiated Service Agreements) show the care and services necessary to meet the residents needs for 7 of 9 sampled residents (Resident 7 [R7], Resident 1 [R1], Resident 6 [R6], Resident 8 [R8], Resident 5 [R5], Resident 9[R9], and Resident 4 [R4]). This failure placed the residents at risk for unmet care needs and care and services not being provided per the negotiated service agreements.

Findings included...

Record review of the facility's document titled, "Service Plan Content/Wording", undated, showed service plans were written to tell staff about what the resident could do, what the resident's preferences were, and then what the staff were responsible to do for the resident.

R7

Record review of R7's untitled and undated document showed they moved into the facility on [redacted]/2023 with multiple medical diagnoses which included [redacted], and [redacted].

Record review of R7's working "Service Agreement", undated, showed under the bathing section it showed R7 could not tolerate sitting up in bed and hospice provided bed baths. R7's service agreement did not include what days and times hospice would provide bed baths. R7's service agreement noted R7 no longer got out of bed. Under the activities section it showed facility staff would position R7's reclining chair to look out the window. The service agreement indicated if R7 looked upset facility staff would direct R7 to the pet station. There were no updated preferences to review of how staff could support R7 participation with activities while they were bed bound. Under the housekeeping and laundry section did not include what days and times the services would be offered.

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted] and [redacted].

Record review of R1's "Resident Progress Notes", dated 06/04/2024, written by Staff C, Resident Care Coordinator, showed R1's primary care provider (pcp) ordered hydrocortisone (medicated cream that can treat skin issues that cause redness, itching, and rashes) as needed for hard stools and hemorrhoids (swollen veins in the rectum that caused discomfort and bleeding). R1's pcp approved R1 to keep the medicated cream inside of their apartment.

Record review of R1's "Service Agreement", date effective 06/11/2024, showed under the medical care management section showed R1 preferred the facility staff to manage their medications. R1's service agreement did not reflect they kept medicated creams inside of their apartment. The housekeeping and laundry section did not include what days and times the services would be provided. The service agreement was signed by R1, Staff A, Administrator, and Staff C.

R6

Record review of R6's untitled and undated document that showed R6's demographics, showed R6 moved into the facility on [redacted]/2021 with multiple medical diagnoses that included [redacted].

Record review of R6's Health Assessment, dated 06/04/2024, showed the assessment was completed by Staff E, Licensed Practical Nurse. Staff E documented that R6 had swallowing issues and required to be on a pureed diet. Staff were to feed R6 when they were unable to feed self at meals.

Record review of R6's Service Agreement Quarterly Update, undated, that was provided to the Department as the working care plan, showed R6 was on a regular finger food diet to easily eat. There was nothing in the working care plan that showed R6 required any adaptive devices to assist R6 at meals with eating.

In an observation and interview on 07/18/2024 at 4:23 PM, in R6's room it was noted that R6's left side of the bed was up against the wall and R6 could only get out of the right side. R6 had a fall matt that was on the ground on the right side of the bed. These were not documented in R6's working care plan for the caregivers to review.

In an observation and interview on 07/18/2024 at 5:11 PM, in the memory care unit's dining room R6 was sitting at the dining room table. Staff W, Caregiver, sat down at the table with R6 and began to feed R6. R6 was observed to have a white plate with a line down the middle that sat in a black dish and a teal cup with a lid and reusable straw. Staff W stated R6 used a non-slip divided plate so R6 could grab their food and the cup so R6 does not spill their drinks. This was not documented on R6's working care plan for the caregivers to review.

R8

Record review of R8's untitled and undated document that showed R8's demographics, showed R8 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R8's Health Assessment, dated 04/11/2024, that was unsigned by the

assessor, showed R8 did not have any swallowing issues. Staff were to cut up their food and cue R8 to finish their meals.

Record review of R8's Service Agreement Quarterly Update, undated, that was provided to the Department as the working care plan, showed R8 needed more cueing and motivation to complete their activities of daily living. Under the section titled, "eating", showed R8 was on a regular diet, cut up and required cue's. Under the section titled, "hygiene and grooming", showed R8 was a very well-kept person and liked to stay that way. R8 required reminders to complete hygiene tasks regularly. R8 had an electric razor that they required assisting with using on showers days to keep themselves clean shaven.

In an observation on 07/18/2024 3:38 PM, R8 was lying down in bed in their room. R8 was observed to had large amount of gray facial hair in the mustache and beard area.

In an observation on 07/18/2024 at 5:10 PM, R8 was sitting in the dining room at dining room table. R8 was served a plate that had a whole bread roll, a solid one piece of chicken strip, and corns with peas. The roll or the chicken strips was not cut up, and the caregiver left after providing the plate to R8 without offering to cut R8's food up.

In an interview on 07/24/2024 at 12:28 PM, Collateral Contact 1 (CC1), Guardian of R8, stated R8 often grows a facial hair for long period of times. CC1 stated that the spouse of R8 would come in every so often and will assist R8 with shaving their facial hair.

R5

Record review of R5's untitled and undated document that showed R5's demographics, showed R5 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted].

Record review of R5's Service Agreement Change of Condition- Move to Memory Care, undated, that was provided to the Department as the working care plan, under the section titled, "miscellaneous" showed that R5 had a small dog. R5 was able to care for the dog without any assistance.

In an observation on 07/18/2024 at 4:13 PM, inside R5's room there was no dog present or with R5.

In an interview on 07/18/2024 at 4:10 PM, Staff X, Life Enrichment Assistant, stated R5 did not have a dog anymore. Staff X stated R5 was unable to take care of the dog.

In an interview on 07/19/2024 at 12:17 PM, Staff D, Resident Care Coordinator, stated resident beds against the wall could be considered a restraint. Staff D stated they had not been putting if a resident's bed was up against the wall.

R9

Record review of R9's "Resident Info [information] Sheet", undated, showed R9 moved into the facility on [redacted]/2023. R9 had multiple medical diagnoses which included [redacted] and [redacted].

Record review of R9's "Resident Progress Notes", dated 05/10/2024, showed the hospice visit note indicated R9 had an unstageable pressure wound and tolerated wound care.

Record review of R9's "Resident Progress Notes", dated 06/11/2024, written by Staff E, Licensed Practical Nurse, showed R9's wound on their buttocks had not improved. R9 had a bone sticking out of the middle of the wound. Staff E noted R9 had been resistive to repositioning and sat on their buttocks in their recliner frequently.

Record review of R9's "Resident Progress Notes", dated 05/28/2024, showed R9 received an order from hospice for partial bed rails on their hospital bed.

Record review of R9's "Service Agreement", dated 05/16/2024, under the skin care section showed R9 had an open area on their coccyx (the last bone at the bottom of your spine) and that the hospice nurse treated it routinely. The service agreement did not include what days, times, and how hospice treated R9's coccyx wound. The sleeping section did not include that R9 used a hospital bed or that they had partial bed rails on their bed. The bathing section showed R9 was on hospice and hospice provided bath aid twice weekly. R9's service agreement did not include what days and times hospice would provide bathing assistance. The housekeeping section did not include what days the service would be provided. The service agreement was signed by Staff A, and Staff C. There was a handwritten note that said "POA [power of attorney] unavailable made aware of changes 05/16/2024".

R4

Record review of R4's "Service Agreement", dated 06/26/2024, under the bathing section showed R4 needed assistance with transferring in and out of the shower with stand by assistance. The service agreement did not indicate what day and times R4 preferred to shower. The service agreement did not include R4's preference to have their bed against the wall. The housekeeping section did not include what days the service would be provided. The service agreement was signed by R4's representative, Staff C, and Staff A.

In an interview and observation on 07/18/2024 at 2:33 PM, R4's bed had been observed to be against the wall preventing R4 from exiting the right side of their bed. R4 said they preferred their bed to be against the wall. R4 said they did not have set shower days and times of when they were supposed to shower.

In an interview on 07/19/2024 at 1:23 PM, Staff E, Licensed Practical Nurse, said the facility did not incorporate a resident's preference to have their bed against the wall in the resident's service agreements. Staff E said this was something the facility should include to indicate that the bed being against the wall was not a restraint (purposely limiting or obstructed a person's ability to move).

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 3 sampled pets (Resident 13's [R13] pet) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of disease transmittable to humans. This failure placed 41 of 41 assisted living residents and all staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility's policy and procedure titled, "Resident Pets", dated 05/05/2024, showed it was a list of rules the residents had to follow to ensure their pet could remain at the facility. There was nothing in the policy that explained the criteria or requirements for veterinary exams or vaccinations for review.

Record review of R13's pet hospital preventative care history report, dated 11/11/2019, showed they had a black and white cat. The document showed the cat was due to go back to the veterinary for more vaccinations on 05/09/2020, 12/02/2019, and 11/10/2020. The document showed the recommended next comprehensive exam date was on 05/01/2020. There were no other pet records provided for R13's cat for review.

In an observation on 07/17/2024 at 3:14 PM, on R13 door to their apartment was a sign that showed, "please don't let the cat out".

In an interview on 07/17/2024 at 3:19 PM, Staff K, Office Manager, stated R13's cat remained living at the facility with R13. Staff K stated the facility did not have any updated vaccination or veterinary documentation for R13's cat for review. Staff K stated Staff A and themselves were responsible to ensure that the pet vaccination and exams

were up to date.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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:

Based on record review and interview, the facility failed to develop and implement a system to ensure 4 of 4 sampled staff members (Staff A, Staff I, Staff H, and Staff J) were screened for tuberculosis (TB, a communicable disease) with the required two step skin testing. This failure placed all 73 of 73 residents and staff at risk of TB infection.

Findings included...

Record review of the Centers for Disease Control and Prevention (CDC) web site article titled, "Clinical Testing Guidance for Tuberculosis: Health Care Personnel", dated 12/15/2023, showed CDC recommends all United States health care personnel should be screened for TB upon hire. TB screening programs should include anyone working or volunteering in health care settings, included long-term care facilities.

Record review of the CDC web site article titled, "Testing for Tuberculosis: Skin Test", dated 04/22/2024, showed the health care provider may perform a two-step TB skin test if they were a health care worker. Under the section, "Two-step TB skin test", showed the two-step TB skin test can lower the chance that a boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the reaction to 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)."

Record review of the facility's policies and procedures (P&P) titled, "Tuberculosis Testing P&P [Washington]", dated 07/19/2024, showed each staff person must be screened for TB within three days of employment. The policy showed staff included any assisted living facility employee or temporary employee, excluding volunteers and contractors. Each community would create a system to ensure that testing was completed in complaint as required by the regulation.

Record review of the facility document titled, "Employee HR [human resources] List", undated, showed Staff A, Administrator, was hired at the facility on 11/14/2022.

Record review of Staff A's document titled, "initial two-set tuberculin skin test report form", undated, showed Staff A's first step TB test was given on 03/01/2023 by Staff E, Licensed Practical Nurse. Staff A's first step TB test was administered 104 days after the required time.

Record review of the facility document titled, "Employee HR [human resources] List", undated, showed Staff I, Caregiver, was hired at the facility on 04/19/2024.

Record review on 07/17/2024 of Staff I's employee file showed there were no TB testing results completed for review.

Record review of the facility document titled, "Employee HR [human resources] List", undated, showed Staff H, Caregiver, was hired at the facility on 04/18/2024.

Record review of Staff H's document titled, "initial two-set tuberculin skin test report form", undated, showed Staff H's first step TB test was given on 06/16/2024 by Staff E, Licensed Practical Nurse. Staff H's second step TB test had not been given.

Record review of the facility document titled, "Employee HR [human resources} List", undated, showed Staff J, Cook, was hired at the facility on 02/12/2024.

Record review of Staff J's document titled, "initial two-set tuberculin skin test report form", undated, showed Staff J's first step TB test was given on 06/19/2024 by Staff E, Licensed Practical Nurse. Staff J's first step TB test was administered 125 days after the required time. Staff J's second step TB test was given on 07/16/2024. Staff J's second
step TB test was administered six days past the required time.

In an observation and interview on 07/16/2024 at 1:24 PM , Staff H was observed to walk into the facility in street clothing and pushed a stroller with a child inside of it. Staff H approached Staff K, Office Manager, and stated they needed to meet with Staff E. Staff K stated Staff H was at the facility to initiate their TB test.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, stated Staff E was responsible to complete new employee's TB testing.

In an interview on 07/19/2024 at 1:23 PM, Staff E, said they completed TB testing for the new employees at the facility. Staff E said the first step of TB testing was supposed to take place within 3 days of the employees hire date. Staff E said they did not work at the facility full time. Staff E said Staff K needed to inform them when new employees were hired so they could coordinate completing TB testing.

In an interview on 07/22/2024 at 9:12 AM, Staff A, Administrator, stated Staff E was responsible to complete new employee's TB testing within three days of the new employee's date of hire. Staff A stated the second step was to be completed one to three weeks after the first step was given.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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;

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 3 of 3 areas (facility survey binder, assisted living game room, and charting room) in the Assisted Living building. This failure placed 41 of 41 assisted living residents at risk for exposure of confidential records.

Findings included...

Record review of the facility's policy titled "Confidentiality of Resident Information", undated, showed "All resident information will be held in the strictest confidence by this facility and will be accessible only to authorized staff... All private records shall be kept in either the Nurses Station or Front Office. This area or location shall be accessible only to authorized staff..."

State Survey Binder

During an onsite visit at the facility on 07/16/2024, at 12:37 PM, the white binder labeled "[facility] state survey", had inspection citation results for review.

Record review of a document inside the state survey binder titled, "Resident/Staff List Confidential Information Do Not Disclose to Public", dated 05/12/2021, showed there were seven residents first and last names listed and nine staff members first and last names listed with their job title for review.

Record review of a document inside the state survey binder titled, "Resident/Staff List Confidential Information Do Not Disclose to Public", dated 11/09/2020, 11/23/2020, and 03/15/2021, showed it had 14 residents first and last names listed for review. The document had 13 staff member's first and last names list with their job titles for review.

In an observation and interview on 07/16/2024 at 12:41 PM, Staff A, Administrator, stated Staff K, Office Manager, kept the survey binder up to date. Staff A was shown the two documents titled, "Resident/Staff List Confidential Information Do Not Disclose to Public". Staff A stated those documents were not to be in the survey binder for review. Staff A removed the documents from the survey binder.

Assisted Living Game Room

Record review of the facility notice untitled, and undated, showed the paper was inside of the laundry room taped onto the cabinet and it read "Attention Staff: Supplies that are ordered for each resident on Medicaid through [company name] to include briefs ... and any other monthly supplies that may be included in the order must be clearly labeled with their name and room number and stored in their apartment... These supplies can not be stored in the laundry room or old activity room..."

In an observation on 07/16/2024 at 1:34 PM, inside of the game room in the corner under a table that had a brown tablecloth draped over the table partially exposed 3 boxes of XL (extra-large) briefs with Resident 11's name on the outside of the box. There was 1 box of briefs with Resident 12 's name on the outside of the box. Staff K, Office Manager, said the boxes with residents identifying information on it might be inside of the room due to an overflow of supplies.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said there should not be resident briefs inside of the game room.

Charting Room

In an interview on 07/16/2024 at 1:03 PM, Staff K, Office Manager, said the charting room contained all of the residents' charts.

In an observation on 07/19/2024 at 1:47 PM, the chart room located next to the reception desk door was opened. The door had been propped open with a metal framed chair. There were no facility staff inside of the room. There were residents within the vicinity of the charting room.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 10/10/24

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies for 2 of 2 buildings (assisted living building and memory care building). This failure placed 73 of 73 residents at risk for access to and risk of ingesting potentially toxic materials.

Findings included...

Assisted Living Building

In an observation on 07/19/2024 at 1:50 PM, room 114 hallway door was unlocked as well as the door inside of the room that lead to the outside courtyard. Inside of room 114 contained zep premium carpet shampoo.

In an observation on 07/22/2024 at 9:36 AM, in the hallway next to the treatment room showed on a dolly there was premium carpet shampoo, urine odor and stain remover, spot blaster (cleaning chemical), N1 712 fresh orange airborne odor eliminator (spray that neutralizes air).

Memory Care Building

In an observation on 07/16/2024 at 1:46 PM, the memory care beauty salon door was unlocked. Inside of the unlocked drawer had 10 individual packages 10 millimeters of redken brews shampoo and conditioner. There was one package of point twenty-five fluid ounces of tea tree shampoo. There was a 10-ounce bottle of rose body wash that
had been opened.

R8

Record review of R8's untitled and undated document that listed R8's demographics showed R8 moved into the facility on [redacted]/2024 with multiple medical diagnosis that included [redacted].

In an observation on 07/18/2024 at 3:38 PM, inside of R8's bathroom showed a 7-ounce bottle of green after shave, a 7.5-ounce bottle of dawn dish soap on top of the soap dispenser attached to the wall. In R8's bedroom area showed a 2-drawered table had a sixteen-ounce bottle of Cetaphil lotion. On the bedside table by the window was an 8.8-ounce container of Hawaiian aloha Febreze air freshener and 4-ounce spray bottle of guitar detailer.

In an interview on 07/17/2024 at 9:30 AM, Staff L, Cook, said chemicals should be locked up within the facility.

In an interview on 07/19/2024 at 10:13 AM, Staff N, Housekeeper, said they were unsure if the chemicals in the assisted living building were supposed to be kept locked. Staff N said they normally tried keeping the chemicals they used on their housekeeping cart.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said they were unsure if the chemicals in the assisted living building were supposed to be kept locked. Staff C said Staff N kept cleaning chemicals on their housekeeping cart.

In an interview on 07/22/2024 at 9:55 AM, Staff R, Maintenance Supervisor, said cleaning chemicals used in the facility did not need to be locked up.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain fire safety per the state fire marshal regulations and failed to ensure fit testing was completed per Washington state regulations for 2 of 2 facility buildings (Assisted Living and Memory Care) reviewed. These failures placed 73 of 73 residents, staff, and visitors' life and safety at risk in the event of a fire and spread of infectious disease.

Findings included...

State Fire Marshall regulation code IFC 906.2 2015,2018
"Portable fire extinguishers shall be selected, installed, and maintained in accordance with this section and NFPA 10.
Exceptions: 1. The distance of travel to reach an extinguisher shall not apply the travel distance to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2. Thirty-day inspections shall not be required, a nd maintenance shall be allowed to be once every three years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA10.
3. In Group 1-3, portable fire extinguishers shall be permitted to be located at staff locations."

"Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke

barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

Record review of the facility's "Routine Maintenance Schedule", undated, showed that fire extinguishers were supposed to be tested and recertified on a monthly basis.

Record review of the facility's "Maintaining Equipment", undated, showed the facility and the equipment used to provide services were to be regularly maintained to insure aesthetic appeal, proper function, and safety for both the residents and staff. Regularly scheduled maintenance would be performed to ensure that the facility equipment functioned at a high level and was well maintained.

Record review of the dear provider letter number 2023-014, dated 03/30/2023, showed that the Secretary of Health announced the order that required wearing a face covering in long term care facilities had ended on 04/03/2023. Despite that the order had ended the individuals in long-term care facilities, including residents, staff, and visitors, were required to continue to follow the Department of Health (DOH) and Centers of Disease Control and Prevention (CDC) guidance. Facilities were asked to revise their policies to reflect the updated guidance by 05/01/2023. Facilities may create their own policies that require staff and ask residents and visitors to wear a face covering, as long as they were at least as stringent as DOH and CDC guidance. Respiratory Protection Program (RPP) requirements were not changed by the ending of the Secretary of Health's order, nor would they change when the federal public health emergency ended on 05/11/2023. Staff would still be required to wear N95 respirators around individuals with suspected or confirmed COVID-19, and an RPP was required anytime a respirator was used in a long-term care facility. An RPP must include medical clearance, fit testing, training, written policies, and documentation.

Record review of CDC's document titled, "Types of Masks and Respirators", updated 05/11/2023, showed COVID-19 community levels was replaced with COVID-19 (Corona Virus Disease 2019- an infectious communicable disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) hospital admission levels to guide prevention decisions.

Record review of CDC's document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", dated 05/08/2023, showed with the end of the federal COVID-19 Public Health Emergency (PHE) on 05/11/2023, CDC was no longer receiving data needed to publish Community Transmission levels for SARS-CoV-2. This metric informed CDC's recommendations for broader use of source control in healthcare facilities to allow for earlier intervention, to avoid strain on a healthcare system, and to better protect individuals seeking care in these settings. Source control was recommended more broadly as described in CDC's core infection prevention control by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high). Under the section titled, "Assisted Living, Group Homes and Other Residential Care Settings (excluding nursing homes)", showed follow community

prevention strategies based on COVID-19 hospital admission levels, similar to independent living, retirement communities or other non-healthcare congregate settings.

WAC 296-842-14005 "Provide medical evaluations.
Medical Evaluation Process
Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:
(a) Are required to use respirators; or
Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:
(a) Whether or not the employee is medically able to use the respirator;
(b) Any limitations of respirator use for the employee;
(c) What future medical evaluations, if any, are needed;
(d) A statement that the employee has been provided a copy of the written recommendation"

"WAC 296-842-12005 Develop and maintain a written program. Exemption: This section does NOT apply to respirator use that is voluntary. See WAC 296-842-11005 for voluntary use program requirements. (1) Develop a complete worksite-specific written respiratory protection program that includes the applicable elements listed in Table 3. The program must cover each employee required by this section to use a respirator. Note: Pay for respirators, medical evaluations, fit testing, training, maintenance, travel costs, and wages. (2) Keep your program current and effective by evaluating it and making corrections. (a) Make sure procedures and program specifications are followed and appropriate. (b) Make sure selected respirators continue to be effective in protecting employees. For example, if changes in work area conditions, level of employee exposure, or employee physical stress have occurred, you need to reevaluate your respirator selection. (c) Have supervisors periodically monitor employee respirator use to make sure employees are using them properly. (e) When developing your written program include applicable elements listed in Table 3. Table 3 Required Elements for Required-Use Respirator Programs • Selection: – Procedures for respirator selection – A list specifying the appropriate respirator for each respiratory hazard in your workplace – Procedures for issuing the proper type of respirator, if appropriate • Medical evaluation provisions • Fit-test provisions and procedures, if tight-fitting respirators are selected • Training provisions that address: – Respiratory hazards encountered during: - Routine activities -Infrequent activities, for example, bimonthly cleaning of equipment - Reasonably foreseeable emergencies, for example, rescue, spill response, or escape situations – Proper use of respirators, for example, how to put on or remove respirators, and use limitations. Note: You do NOT need to repeat training on respiratory hazards if employees have been trained on this in compliance with other rules such as WAC 296-901-140, Hazard communication. • Respirator use procedures for: – Routine activities – Infrequent activities – Reasonably foreseeable emergencies • Maintenance: – Procedures and schedules for respirator maintenance covering: - Cleaning and disinfecting - Storage Required Elements for Required-Use Respirator Programs - Inspection and repair - When to discard respirators – A cartridge or canister change schedule IF air-purifying respirators are selected for use against gas or vapor contaminants AND an end-of-service-life-indicator (ESLI) is not available. In addition, provide: - The data and other information you relied on to calculate change schedule values (for example, highest contaminant concentration estimates, duration of employee respirator use, expected maximum humidity levels, user breathing rates, and safety factors) • Procedures to ensure a safe air quantity and quality IF atmosphere-

supplying respirators (air-line or SCBA) are selected • Procedures for evaluating program effectiveness on a regular basis."

Respiratory Protection Program

Record review on 07/18/2024 of the facility's fit testing record binder showed there was a document titled, "COVID-19 Infection Control Plan", revised date 01/2021, showed the document was developed upon each employer's exposure risk assessment and aimed to eliminate or otherwise minimize worker exposure to COVID-19. All job assignments or worker tasks requiring the use of personal protective equipment (including respirators) necessary to minimize employee exposure to COVID-19. All community staff were required to put on appropriate personal protective equipment (PPE) in accordance with the governing licensing authority as well as the guidance from the local health department and Occupational Safety and Health Administration (OSHA). All new employees are trained on this requirement during new employee orientation and trained on proper donning (putting on) and doffing (taking off) of requisite PPE. Since the beginning of the pandemic, the facility implemented measures in an effort to meet health department and center of disease control (CDC) guidance regarding face coverings and masks in the community. The community staff were required to wear surgical masks in the community. The exceptions were limited and follow the guidance of Washington state labor and industries and CDC guidance. The facility trained all new employees on existing infection control policies and procedures during their new employee orientation onboarding. The facility's COVID-19 managers relay the infection control policies and procedures to all of the facility staff. The policy was based on COVID-19 and did not include other facility hazards that would require the staff and what specific staff to use the N95 respirators. The facility's respiratory protection program did not have they updated information and still reflected the pandemic that had ended.

In an interview on 07/18/2024 at 2:24 PM, Staff A, Administrator, stated the policy and respiratory protection program filed in the facility's fit testing record binder, was the most updated respiratory protection policy for the Department to review.

Record review of Staff H, Caregiver, personnel file showed there were no annual fit testing or medical clearance results documented for review.

Record review on 07/18/2024 of the facility's fit testing records provided to the Department showed Staff H did not have any documentation that showed Staff H had been fit tested for an N95 respirator and completed a medical clearance to use an N95 respirator.

Record review of an email sent to the Department on 07/17/2024 at 5:37 PM, showed that Staff A, Administrator, stated Staff H did not have their completed annual fit testing or medical clearance to review.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, stated that Staff K, Office Manager had been responsible for facility staffs completed annual fit testing and medical clearances.

In an interview on 07/19/2024 at 11:28 AM, Staff K, Office Manager, stated they completed all staff fit testing for an N95 respirators. Staff K stated they complete all new staff's N95 medical clearance and fit testing of N95 respirator within 14 days of the

new employee being hired.

Fire Extinguisher

In an observation on 07/17/2024 at 11:52 AM, the large silver Class K fire extinguisher that was secured on the wall by the back door of the kitchen, showed there was no tag on the fire extinguisher to identify when it was last serviced and checked.

In an interview and observation on 07/19/2024 at 10:15 AM, Staff R, Maintenance Supervisor, stated all fire extinguishers were recently serviced by ATS. Staff R stated they checked the fire extinguishers monthly. Staff R was showed the Class K (type of fire extinguisher required to be in a kitchen to be available for anytime of fire including gas) fire extinguisher. Staff R was unable to find the tag on the Class K fire extinguisher that showed when it was serviced, and last monthly check was completed. Staff R then found the class K fire extinguisher that was under the dishwasher. The tag was dry and wrinkled. The class K fire extinguisher's tag showed the last documented monthly check had a date of May 2024.

In an observation on 07/19/2024 at 11:36 AM, in the office managers desk area in the windowsill was a red fire extinguisher that was free standing. The fire extinguisher was not secured in a stand or to the wall.

In an interview on 07/19/2024 at 12:11 PM, Staff R stated they were unaware if the fire extinguishers were required to be secured to a stable stand or surface.

Fire Doors

In an interview on 07/16/2024 at 1:03 PM, Staff K, Office Manager, said some of the residents propped open their doors in order to try and get the air-conditioned air from the hallway to circulate inside of their rooms.

In an observation on 07/16/2024 at 1:27 PM, the dining room showed the kitchen door had been propped open with a wooden wedge that was under the bottom of the door frame with a yellow caution wet floor sign over the wooden wedge.

In an observation on 07/16/2024 at 2:33 PM, outside of the assisted living building showed the door to the kitchen was propped open with a white kick stand that was attached to the bottom of the door. In front of the door showed a free-standing fan that was placed on the ground.

In an observation on 07/17/2024 at 9:11 AM, outside of the assisted living building showed the door to the kitchen was propped open with a white kick stand that was attached to the bottom of the door. In front of the door showed a free-standing fan that was placed on the ground.

In an observation on 07/19/2024 at 12:10 PM, Resident 22's room was propped open with a wooden wedge that was shoved under the bottom of the door.

In an interview on 07/19/2024 at 12:11 PM, Staff R stated the doors in the facility were not be propped open unless they were connected to the magnetic system that was controlled by the fire alarm system.

In an observation on 07/19/2024 at 12:51 PM, the door to a bathroom with the plaque label "staff bathroom", showed when the door was shut, it would not close completely and latch.

In an observation on 07/19/2024 at 1:47 PM, the chart room located next to the reception desk door was opened. The door had been propped open with a metal framed chair.

In an observation on 07/22/2024 at 9:38 AM, outside of the assisted living building showed the door to the kitchen was propped open with a white kick stand that was attached to the bottom of the door. In front of the door showed a free-standing fan that was placed on the ground.

In an interview and observation on 07/22/2024 at 9:55 AM, room 114 hallway door was opened and had a grey rubber stopper wedged underneath the door preventing it from closing. Staff R, Maintenance Supervisor was inside of the room. Staff R said as far as they knew doors inside of the facility were not supposed to be propped open because they were fire doors. Staff R stated some residents kept rocks outside of their outside exit doors to use to hold them open.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

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 buildings (assisted living building and memory care building). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean for 1 of 1 facility reviewed. These failures placed 73 of 73 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

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

Record review of the facility's "Maintaining Equipment", undated, showed the facility and the equipment used to provide services were to be regularly maintained to ensure aesthetic appeal, proper function, and safety for both the residents and staff. Regularly scheduled maintenance would be performed to ensure that the facility equipment functioned at a high level and was well maintained.

Record review of the facility's "Routine Maintenance Schedule" undated, showed under lawn care the edging would take place on a monthly basis. The trees and shrubs would be pruned annually. The laundry dryer vents, and bathroom vents would be vacuumed quarterly.

Record review of the facility's "[facility name] Housekeeping Schedule", undated, showed the activities room would be cleaned Tuesday's and Thursday's.

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted] and [redacted].

Record review of R1's "Service Agreement", dated 06/11/2024, showed R1 had good short term and long-term memory. R1 did not have a reported history of anxiety (excessive worry).

In an interview and observation on 07/19/20024 at 11:36 AM, R1 reported a maintenance concern about their bedroom door handle had been broken and they could not pull their door handle down since they moved into the facility. R1 said they had reported their concern to multiple facility staff members which included Staff A, Administrator and Staff R, Maintenance Supervisor. R1 said originally, they had been informed that their door handle would be replaced. R1 said Staff R said their door handle was not broken and they were not strong enough to operate their door. R1 said Staff R gave them a skinny black L shaped tool to use alongside their key to try and open their door. R1 showed the Department an allen wrench. R1 had locked their door and attempted to use their key and the allen wrench to open it. R1 tried multiple times to turn the key inside of the lock to open the door but was unsuccessful. The Department licensor locked the door and stepped outside of R1's bedroom. After multiple attempts R1's door was unable to be dislodged using R1's key and the allen wrench. R1 expressed concern that they had to leave their door unlocked due to not

being able to open it. R1 reported at times facility staff members locked their door and then R1 was not able to get back inside. R1 reported at one time a facility staff member could not open their door and used a credit card to dislodge the locked door. R1 reported that it concerned them that anyone could easily open their door.

In an interview on 07/19/2024 at 11:50 AM, Staff M, Caregiver, said sometimes R1's apartment doors lock got stuck and would be difficult to open. Staff M noted they had a master key they were able to use to enter, which was a different type of key that R1 used.

In an interview on 07/22/2024 at 9:55 AM, Staff R said that they were aware R1 had issues with their door lock. Staff R said R1 had anxiety and when R1 reported concerns with their door lock they tried to address it. Staff R said R1 did not have the hand strength to unlock their door.

In an interview on 07/22/2024 at 9:10 AM, Staff A said that they were aware R1 had issues with their door lock. Staff A said the facility took R1's lock to the locksmith to get it rekeyed. Staff A said they thought R1 had been too weak to operate their door handle accurately. Staff A said they were not aware that Staff M had given R1 an allen wrench tool to use because R1 still had problems with their lock. Staff A said they were not aware facility staff members had opened R1's door with a credit card.

Assisted Living Building

In a resident group interview and observation on 07/17/2024 at 10:00AM, R17 expressed a concern with accessing the outside area through the dining room door. R17 said they had to shove the door open with their electric wheelchair in order to get through. R17 put out their left arm and showed a scabbed area that was approximately 1 inch long. R17 said the injury occurred 3 weeks ago when they tried to open the dining room door. R16 said facility staff members were supposed to be available to help residents get through the dining room doors to the outside area. R17 said they had issues with their door and the facility staff were supposed to change their lock. R16 expressed concerns with the activity room cleanliness. R16 said the activity room counters, tables, and handrails were not regularly cleaned.

In an observation and interview on 07/16/2024 at 1:10 PM, the independent activities room, showed the white vent outside of the bathroom was covered in a brown substance. The bathroom inside of the activities room under the sink had a 5-gallon container of water. Staff K, Office Manager said the water under the bathroom sink was emergency drinking water. Staff K said the water could have been expired.

In an interview on 07/19/2024 at 10:13 AM, Staff N, Housekeeper, said if they had to call out for their shift the other facility staff members would not cover the cleaning Staff N was responsible to complete that day. Staff N said if they knew they would be off in advance then they would attempt to complete two days of cleaning within one day. Staff N said they were supposed to clean the activity room on Tuesdays and Thursdays. Staff N said sometimes on Tuesdays they did not have enough time to clean the activity room so they would make sure to clean it on Thursday.

In an interview on 07/22/2024 at 9:10 AM, Staff A said if Staff N was not able to work for the day other facility staff members would cover the scheduled cleaning.

In an observation on 07/19/2024 at 10:05 AM, the laundry room showed the vent above the dryer had grey fuzz protruding out of the vent that dangled approximately 4 centimeters from the vent.

In an observation on 07/22/2024 at 9:50 AM, the laundry room showed the vent above the dryer had grey fuzz protruding out of the vent that dangled approximately 4 centimeters from the vent.

In an interview on 07/19/2024 at 12:35 PM, Staff N, Housekeeper, said they had worked for the facility for 3 years and had never personally cleaned the vents within the facility.

In an observation on 07/16/2024 at 1:26 PM, inside the activity room under the countertop were cabinets and drawers. One of the cabinet doors handles were missing.

In an observation on 07/16/2024 at 1:31 PM, in the assisted living dining room near the drink bar, the juice machine was available for residents to use. Near the spout that the juice was dispensed out of, there were lots of thick brown sticky substance.

In an observation on 07/16/2024 at 1:39 PM, in the assisted living facility clean area of the laundry room, the countertop edge trim had lifted and exposed raw wood of the counter. The trim had lifted halfway of the length of the countertop causing the lifted trim to be closed inside one of the bottom cabinets under the countertop.

In an observation on 07/16/2024 at 1:46 PM, outside the back of the assisted living building the sidewalk that was next to a tree, had two areas that were unlevel surfaced areas of the sidewalk. On two areas of the unleveled sidewalk there was faded orange that had been spray painted and broken cement.

In an observation on 07/19/2024 at 1:50 PM, empty room 114 hallway door was unlocked as well as the door inside of the room that lead to the outside courtyard. Inside of room 114 contained zep premium carpet shampoo, multiple tools, window blinds, ladders, various cans of paint and primer, and various chemicals. Both doors to the room were unlocked and accessible for any residents to access.

In an interview on 07/22/2024 at 9:10 AM, Staff A said they received a quote on the estimated cost it would fix to smooth out the uneven pathway on the back side of the assisted living building. Staff A said the home office would have to approve the project before they continued. Staff A said at this time there was not a plan in place on when the pathway would be fixed. Staff A said the facility had researched handicap accessible wheelchair ramps for the backside of the assisted living building. Staff A said the facility would have to pour concrete in order to make a ramp. Staff A said there was not a plan in place on if or when a ramp would be made.

In an interview on 07/22/2024 at 9:55 AM, Staff R, Maintenance Supervisor, laughed and said they assumed they were responsible to clean vents in the facility. Staff R said they did not use a schedule, they cleaned the vents when it was needed.

In an interview on 07/22/2024 at 9:10 AM, Staff A, Administrator, said Staff R had been responsible to clean the facility vents. Staff A was unsure on how often Staff R was supposed to complete cleaning the vents.

Memory Care Building

In an observation on 07/17/2024 at 12:12 PM, inside of the memory care's kitchen the ice machine showed on the inside of it on the black surface was a white substance that covered the backside of the machine.

In an observation and interview on 07/16/2024 at 1:57 PM, in the memory care unit, on the hallway named, "Wally Way", the handrail halfway up the wall on the right side of the hallway that was at the doorway of the resident shower and toilet room was broken. Staff K, Office Manager, lifted up the handrail that was completely broken off of the bracket that was secured to the wall. Staff K stated, "it looked like it was glued at one point." Staff K stated that the handrail was not safe for the residents to use.

In an observation and interview on 07/16/2024 at 2 PM, Staff K had walked into the memory care unit's laundry room door, when Staff K walked about from the door, the door slammed shut. Staff K stated, "that was a little hard".

In an observation on 07/16/2024 at 2:05 PM, in the sensory room, there was a pungent smell that resembled urine present.

In an observation and interview on 07/16/2024 at 2:09 PM, in the activity room with the raise flower bed, upon opening a drawer near the refrigerator, there was a strong pungent odor of urine. Inside the drawer was a rectangle white plastic bin. Inside the bottom of the white plastic bin was dark brown and yellow dried substance that had a strong pungent odor that resembled urine. Staff K stated that was "pee" in the white rectangle plastic bin when they were asked what the brown and yellow substance was. Staff K stated the facility was aware of a few male residents that urinated in random areas of the facility.

In a generalized tour of the memory care building on 07/17/2024 at 12:09 PM, on the "daisy drive" labeled hallway, there was a pungent smell that resembled urine present near Resident 24's (R24) room.

In an observation and interview on 07/17/2024 at 2:08 PM, outside of the memory care in the fenced in area showed on the concrete walking path were two orange cones with thick black tape on the bottom outer rim of the cones that stuck to the ground. When looking inside the cone from hole on the top, showed there were three silver bolts sticking out above ground level. Staff K, Office Manager, said a picnic table used to be bolted onto the concrete. Staff K said to their knowledge the bench broke over 4 months ago and there was not a current plan on how to fix the walking path.

In an observation on 07/18/2024 at 3:55 PM, inside Resident 6's room, the light on the ceiling in the middle of the room, was noted to have lots of black particles in the light cover. One of the black particles had what looked like wings of a bug. On the wall a quarter the way up from the ground behind R6's head of the electrical bed and under the window the outlet wall cover was broken that exposing the electrical outlet and a hole in the wall. R6's electric bed was plugged into the electrical outlet that had the broken outlet cover. On the wall a quarter way up from the ground the electrical outlet by R6's bedroom door, part of the plate was broken and exposed a hole into the wall. R6's bottom wooden front part of the dresser drawer was broken off and was leaning up against the frame unsecured.

During a generalized tour of the memory care building on 07/18/2024 at 3:36 PM, there was a strong pungent odor that resembled urine at the corner by the activity room, daisy drive and main street labeled hallways.

In an observation on 07/18/2024 at 4:20 PM, inside Resident 23's apartment behind the bedside table and reclining chair closest to the window halfway up the wall were two apple sized holes in the wall that exposed white powdery substance in the wall material.

During a generalize tour of the memory care building on 07/18/2024 at 3:50 PM, there was a strong pungent smell that resembled urine that remained by R24's room.

In an interview on 07/22/2024 at 9:10 AM, Staff A, Administrator, said they were aware there were two orange cones with duct tape outside of the memory care unit. Staff A said there used to be a bench on top of the bolts. Staff A said the bench broke approximately 1 month ago. Staff A said they had a phone call with home office about replacing the bench. Staff A said there was not a current plan in place to fix the bench.

In an observation on 07/17/2024 at 9:18 AM, in the activity room with the raise flower bed, inside the drawer near the refrigerator, the rectangle white plastic bin remained inside with the strong pungent smell that resembled urine and dried yellow and brown substance remained.

In an observation on 07/18/2024 at 3:00 PM, in the activity room with the raise flower bed, inside the drawer near the refrigerator, the rectangle white plastic bin remained inside with the strong pungent smell that resembled urine and dried yellow and brown substance remained.

Exterior of the Facility

In an observation on 07/16/2024 at 1:48 PM, outside of the assisted living building on the sidewalk showed there were two uneven parts of the pathway that had faded orange paint around the uneven area.

In an observation on 07/16/2024 at 2:21 PM, outside in the area of the trash compactor area, there were five shower chair benches stored, a mattress, a food serving bar that was on wheels, a vacuum, a plastic teal chair, and wooden bed frame pieces that were stored around the fenced in area.

In an observation and interview on 07/16/2024 at 2:26 PM, inside the facility garage storage area in "zone 3 section 3", there were multiple dressers, cabinets, boxes, fall matts, wheelchairs, multiple mattresses, and other miscellaneous items that were stacked on top each other as tall as the rails on the ceiling for the garage door. The items were stacked the entire length of the garage area. The items impeded walkways. Staff K, said that the shed was where all the sister communities stored their personal protective equipment and extra items.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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

Administrator (or Representative) — Date: 10/10/24

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 follow and implement safe food handling and storing practices for 2 of 3 areas reviewed (assisted living kitchen and memory care kitchen). These failures placed 73 of 73 assisted living and memory care residents at risk for receiving food that was at risk for exposure to food-borne illnesses.

Findings included...

WAC 246-215-03526
"Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).
(1) Except when packaging food using a reduced oxygen packaging method as specified under WAC 246-215-03540, and except as specified in subsections (5) and (6) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than twenty-four hours must be clearly marked to indicate the date or day by which the food must be consumed on the premises, sold, or discarded when held at a temperature of 41ºF (5ºC) or less for a maximum of seven days. The day of preparation must be counted as day one.
(2) Except as specified in subsections (5) through (7) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant must be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four hours, to indicate the date or day by which the food must be consumed on the premises, sold, or discarded, based on the temperature and time requirements specified in subsection (1) of this section and:
(a) The day the original container is opened in thefood establishment is counted as day one; and
(b) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on foodsafety.
(3) A refrigerated,ready-to-eat, time/temperature control for safety food ingredient or a

portion of a refrigerated,ready-to-eat, time/temperature control for safety food that is combined with additional ingredients or portions offood must retain the date marking of the earliest-prepared or first-prepared ingredient.
(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:
(a) Using a methodapproved by the regulatory authority for refrigerated,ready-to-eat, time/temperature control for safety foodthat is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;
(b) Marking the date or day of preparation, with a procedure to discard thefood on or before the last date or day by which the foodmust be consumed on the premises, sold, or discarded as specified under subsection (1) of this section;
(c) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or
(d) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authorityupon request."

Washington Administrative Code (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 246-215-02310 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 246-215-03342 "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."

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; (b) At least every twenty-four hours for iced tea dispensers and CONSUMER self-service UTENSILS such as tongs, scoops, or ladles;

(c) Before restocking CONSUMER self-service EQUIPMENT and UTENSILS such as condiment dispensers and display containers; and (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."

Record review of the facility's policy titled, "Food Storage and Handling", undated, showed food should be protected at all times from potential or real contamination. If food was removed from the original container it should be stored in a clean, labeled, and covered container.

Record review of the facility's policy titled, "Food Services Sanitation and Storing Food", undated, showed proper hand washing would be practiced. Food workers would properly wash their hands after contaminating their hands. Handwashing sinks would have soap and paper towels available. Food supplies would be wholesome and free from spoilage.

Record review of the facility's policy titled "Hand Washing", undated, showed all staff were responsible to follow the handwashing policy. Staff would wash their hands before handling food, whenever they changed from a dirty task to a clean task, or when they were obviously soiled. Dietary staff must wash their hands upon reentry in the kitchen. The use of gloves did not replace hand washing.

Ice machine

In an observation on 07/17/2024 at 11:30 AM, in the assisted living kitchen, there was an ice machine. Upon opening the lid there was an abundance of ice. Upon looking into the ice machine in the back on the white flap near the top there was large amounts of dots and areas of black and pink. Staff S, Dietary Manager, was asked if the black and pink substance was able to be removed. Staff S whipped with a white paper towel the white flap on the ice machine. The black and pink substance was removed and turned the white paper towel black and pink. Staff S stated the staff in the kitchen cleaned the ice machine every month. Staff S was unable to provide documentation that showed when the last time the ice machine was cleaned. Staff S stated they were unsure when the ice machine was due to be cleaned again.

In an interview on 07/22/2024 at 10:06 AM, Staff B, Regional Director of Operations, stated the ice machine in the assisted living facility kitchen did not have a cleaning system in place.

Assisted Living Kitchen

In an observation on 07/17/2024 at 9:57 AM, in the refrigerator by the door that entered the hallway, there was a clear Ziplock with a bag of round white meat inside. There was no label on the bag to identify what the food was. The date opened was 07/16 (date as written on bag).

In an interview and observation on 07/17/2024 at 11:31 AM, Staff S, Dietary Manager, stated that periodically throughout the week the cooks check the foods in the kitchen to ensure they were dated, labeled, and not expired. Staff S stated that all food were to be dated on the date that they were opened and labeled. Staff S stated an item in the refrigerator once it was opened was good for three days and on day three the item was thrown out.

Memory Care Kitchen

Record review of the facility notice untitled, and undated, showed a paper was inside of the memory cares kitchen taped to the refrigerator in handwritten letters "Put dates on items before you put back in refrigerator, please."

In an interview and observation on 07/17/2024 at 9:30 AM, Staff L, Cook, said the facility provided stickers to label food items. The label contained a space for the item name, the prep (preparation) date, the use by date, the employees initials, and the managers signature. Staff L said left over snacks needed to be discarded within 3 days of being prepared. Staff L opened a refrigerator and pulled out individually packaged clear circular containers with lids. In handwritten letters the lids showed "pureed 07/15" on them. Staff L said they did not know what was inside of the containers but noted it was a pureed substance that expired on 07/18/2024.

Hand Hygiene

In an interview on 07/17/2024 at 9:30 AM, Staff L, Cook, said they were required to perform hand hygiene when they entered the kitchen, before serving food, after they washed dirty dishes, and in between glove changes when moving from task to task.

In an observation on 07/17/2024 at 9:46 AM, Staff G, Medication Aide, came into the kitchen's side door from the hallway. Staff G grabbed a pair of disposable gloves and put them on their hands. Staff G grabbed the scoop that was on top of the ice machine and scooped ice out of the machine into a cup. Staff G then removed their disposable gloves and discarded into the trash. Staff G exited the kitchen out the same door they entered. During the entire observation Staff G did not wash their hands with soap and water at the kitchen sink.

In an observation on 07/17/2024 at 11:33 AM, Staff Y, Cook, was at the dishwashing area spraying soiled dishes off and placing them in the racks to be washed. Staff Y then grabbed clean rack of dishes out of the dishwashing machine. Staff Y was not observed to wash their hands before pulling out the clean rack of dishes after handling soiled dirty dishes. Staff Y grabbed the clean dishes and put them away on the shelves. Staff Y walked over to the desk by the door leading to the courtyard and grabbed a personal cup and took a drink. Staff Y put the cup down and walked out of the kitchen to go outside.

In an observation on 07/17/2024 at 11:43 AM, Staff Y exited the kitchen, reaching into their pant pocket, pulled out a bottled and then sprayed something from the bottle into their nose. Staff Y put the bottle back into the pants pocket and then sat down at a dining room table with the residents. Staff Y was not observed to wash their hands or

use hand sanitizer after touching their nose. At 11:49 AM, Staff Y entered the double doors of the kitchen. Staff Y went to the grill and began stirring the substance inside the pot on the grill. Staff Y was not observed to wash their hands upon re-entering the kitchen and before stirring food. At 11:51 AM, Staff Y exited the kitchen and still did not wash hands or use hand sanitizer.

In an interview on 07/19/2024 at 1:56 PM, Staff S, Dietary Manager, stated kitchen staff were to wash their hands before and after removing their gloves, as soon as they walk into the kitchen they were to wash with soap and water, if they grab a door handle, or any change in task. Staff S stated they were to put gloves on prior to using the scoop to get ice in the ice machine.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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:

(a) Orientation and safety;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review the facility to ensure staff completed their facility orientation training and completed their continued education for 1 of 1 facility reviewed. This failure placed all 73 of 73 residents at risk for being improperly cared for by untrained staff.

Findings included...

WAC 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f)

Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."

WAC 388-112A-0611 "Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed? (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (i) A certified home care aide; (iii) A certified nursing assistant; (b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC."

WAC 246-980-110 Continuing education. "(1) A home care aide must demonstrate completion of twelve hours of continuing education per year as required by RCW 74.39A.341. The required continuing education must be obtained during the period between renewals. Continuing education is subject to the provisions of chapter 246-12 WAC, Part 7. (2) Verification of completion of the continuing education requirement is due upon renewal. If the first renewal period is less than a full year from the date of certification, no continuing education will be due for the first renewal period."

Facility Orientation

Record review of the facility provided document titled, "employee HR [human resource] list", undated, showed Staff A, Administrator was hired at the facility on 11/14/2022.

Record review of Staff A's personnel file showed there was no facility orientation to review.

Record review of the facility provided document titled, "employee HR [human resource] list", undated, Staff H, Caregiver was hired at the facility on 04/18/2024.

Record review of Staff H's personnel file showed there was no facility orientation to review.

Record review of the facility provided document titled, "employee HR [human resource] list", undated, showed Staff I, Caregiver was hired at the facility on 04/19/2024 .

Record review of Staff I's personnel file showed there was no facility orientation to review.

Record review of the facility provided document titled, "employee HR [human resource] list", undated, showed Staff J, Cook was hired at the facility on 02/12/2024.

Findings included...

Record review of the facility provided untitled document, dated 07/14/2024 through 07/20/2024, showed it was a list of employees time cards that worked for review.

In an interview on 07/16/2024 at 3:17 PM, Staff A, Administrator, said the facility did not retain 12-weeks of staffing schedules that showed what shift the facility staff member were supposed to work compared to what the facility staff member actually worked. Staff A stated there was always so many changes to the schedule they only use the employee's time card for review.

There were no records to review that showed 12-weeks of worked and planned staff schedules for review.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete the Resident Service Agreement (facility's version of the Negotiated Service Agreement) within 30 days following admission to the facility for 2 of 3 sampled newly admitted residents (Resident 1 [R1] and Resident 8 [R8]). This failure placed R1 and R8 at risk of unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's policy titled, "Service Agreement Policy", undated, showed a service agreement would be developed thirty days following the resident's

Record review of Staff J's personnel file showed there was no facility orientation to review.

In an interview on 07/22/2024 at 9:10 AM, Staff A, Administrator said they thought the DSHS 5-hour facility orientation and the facility orientation fulfilled the same requirement. Staff K, Office Manager, said they thought having facility staff complete both orientations were redundant. Staff A said none of the sampled staff members had completed the required facility orientation for the facility.

Continued Education

Record review of Staff G's employee records that were provided to the Department for review, showed Staff G, Medication Aide, had only completed 8.10 hours of continued education credits.

In an interview on 07/17/2024 at 1:19 PM, Staff A, Administrator, said they did not have any more continued education credits to provide for Staff G.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to document and retain staff schedules for 1 of 1 facility reviewed. This failure placed all 73 of 73 residents and staff at risk of not having access to accurate documentation.

admission. The service agreement would include the date, services needed and to be provided, and resident requests and preferences. The Participants would sign the agreement and it would be kept in the resident's record.

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted] and [redacted].

Record review of R1's "Service Agreement", date effective 06/11/2024, showed R1's 30-day evaluation should have been on 05/25/2024.

Record review of R1's "14 and 30- Day Service Plan Reviews", undated, showed a single piece of paper that had a 30-day review section dated 05/25/2024 on it. Changes in service plan section showed in handwritten letters R1 could shower independently. Changes in resident ability/preferences section showed R1 could shower and complete activities of daily living without assistance. Staff C signed and did not date the document.

R8

Record review of R8's untitled and undated document that listed R8's demographics showed R8 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of an email sent to the Department on 07/18/2024 at 2:50 PM, showed R8's 30-day service agreement was completed late on 04/11/2024.

Record review of R8's Service Agreement 14/30 day evaluation, dated 04/29/2024, showed it was signed and dated by the guardian on 04/29/2024. The service agreement was completed 56 days past when it was required to be completed.

In an interview and observation on 07/19/2024 at 10:48 AM, Staff C said they had been responsible for completed service agreements. Staff C said they did not complete another resident service agreement at the 30-day mark. Staff C said for 30-day service agreement reviews they used a single piece of paper to show changes to resident's service agreements. Staff C showed the Department a blank "14 and 30-Day Service Plan Reviews" paper that they used.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 9/19/24 .

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Administrator (or Representative) — Date: 10/10/24

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the resident's service agreements (facility's version of the negotiated service agreement) was signed for 3 of 9 sampled residents (Resident 7 [R7], Resident 3 [R3], and Resident 6 [R6]). This failure placed R7, R3, and R6 at risk for unmet care and services.

Findings included...

Record review of the facility's document titled, "service plans", undated showed service plans (called service agreements) must be updated quarterly and upon any change of condition. Care conferences were to be held with residents and resident representatives, including powers of attorney, billing representatives, guardians, and other family to go over each update, sign the agreement, and discuss any issues and ensure good working relationships with family members and guardians.

Record review of the facility provided document titled, "Service Plan content/wording", showed 30-day service plans required care conferences and new signatures. Service plans were written in the facility's electronic record system every quarter and with change of conditions. Original service plan would be filed in the resident's chart, signed, and completed. All significant change service plan and quarterly service plans need new signatures.

R7

Record review of R7's untitled and undated document showed they moved into the facility on [redacted]/2023 with multiple medical diagnoses.

Record review of R7's Service Agreement, undated, showed it was signed, dated, and agreed upon on [redacted]/2023.

Record review of R7's Service agreement, undated, showed it was not signed, dated, and agreed upon. At the top of the service agreement in handwritten letters showed "waiting for conference."

R3

Review of R3's untiled and undated document that listed R3's demographics showed R3 moved into the facility on [redacted]/2024.

Record review of R3's Service Agreement/30 day Assessment, dated 07/05/2024, showed it was not signed, dated, or agreed upon.

R6

Record review of R6's untitled and undated document that showed R6's demographics, showed R6 moved into the facility on [redacted]/2021 with multiple medical diagnoses that included [redacted].

Record review of R6's Service Agreement, undated, showed it was not signed, dated, and or agreed upon. On the first page of the service agreement there was a handwritten note that showed, "waiting on care conference".

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, stated all resident service agreements were to be updated and signed every quarter.

In an interview on 07/22/2024 at 9:10 AM, Staff A, Administrator, stated all resident service agreements were to be completed and signed every 3 months.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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;

(i) Conducts an evaluation; and

(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 9 sampled residents (Resident 7[R7]) refused their medication. This failure placed R7 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 provided document that was untiled and undated, under the section titled, "when to notify the doctor (can be faxed 24 hours a day)", showed the doctor was to be notified when a resident refused their medication.

R7

Record review of R7's untitled and undated document showed they moved into the facility on [redacted]/2023 with multiple medical diagnoses.

Record review of R7's MAR (Medication Administration Record), dated 05/01/2024 – 05/31/2024, showed on 05/19/2024 R7 took most of their medication but spit a tiny bit of their Acetaminophen 1000 mg (milligrams), Divalproex sodium 125 mg, Melatonin 6mg, Risperdal 0.5 mg, and Trazodone out at facility staff.

Record review of an email sent to the Department on 07/18/2024 at 2:51 PM, showed that Staff A, Administrator, stated the facility did not notify R7's MD (medical doctor) that they refused their medications.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said if a resident refused their medication they would notify the residents MD after the second consecutive refusal.

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

Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify a residents physician for 1 of 7 sampled residents (Resident 5 [R5]) when an allegation of sexual abuse was reported. This resulted in R5's physician unaware of R5's increase in anxiety and emotional distress related to the incident and unable to provide medical guidance for R5.

Findings included...

Record review of the facility provided document that was untiled and undated, under the section titled, "when to notify the doctor (can be faxed 24 hours a day)", showed the doctor was to be notified when there was a change of condition with a resident.

Record review of the facility's policies and procedures titled, "Resident Incidents and Investigations", undated, showed prompt response to an incident is critical for protection of the residents, treatment of injury or adverse effects, and the collection of accurate data. Prompt reporting included the nurse, medical professional, emergency contact, and supervisor.

R5

Record review of R5's document that was a list of her demographics that was undated,

showed R5 moved into the facility on [redacted]/2023. R5 had multiple medical diagnoses that included [redacted] and [redacted].

Record review of R5's "resident alerts", dated 07/07/2024 at 10:02 PM, showed R5 had come to the dining room very panicked saying that a man tried to rape them and was in their room. R5 reported that Resident 15 (R15) was in their room. The medication technician documented that R15 was removed from R5's room. R5 continued to tell the medication technician that R15 tried to ripe their clothes off and rape them. The medication technician documented that one hour after R5 reported this incident, R15 had walked up close to R5, and R5 began to point at R15 and stated that was the man that tried to rape her.

In an interview and observation on 07/18/2024 at 4:13 PM, R5 reported to the Licensor that there was a male that attempted to rape her and threated to kill them in their room. R5 was noted to raise their voice, talked with their hands, and had exaggerated facial expression when they explained about the incident. R5 stated they kept their door locked from that incident.

Record review of an email sent to the Department on 07/18/2024 at 2:48 PM, showed Staff A documented that for the incident that occurred on 07/07/2024 with R5, R5's physician was not notified .

In an interview on 08/05/2024 at 1:22 PM, Staff A, Administrator, stated it would depend on the situation, if a resident's physician would be notified when an allegation of abuse and neglect was reported. Staff A stated typical the physician was notified within 24 hours of the allegation.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 10/10/24

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 ensure 2 of 9 sampled residents (Resident 8 [R8] and Resident 1 [R1]) medications were available to be administered. 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 facilities policies and procedures titled, "Medications: Refill Procedures", undated, showed the community would maintain at least 48 hours of prescribed medications, or more for residents with community assisted or provided medication services. If the prescribed medication is provided through the community used pharmacy, the prescribed medications will be auto filled by the pharmacy and arrive to the community within 48 hours of the last dose on hand. If the prescribed medication is provided by the family or filled by the family or resident through another pharmacy, the community will maintain a written backup plan of when reordering should be done and by whom. The community will reorder from the pharmacy directly if the on-hand stock of the medication gets below a calendar week of dosages. If the community contacts the pharmacy for a correction or reorder of a prescribed medication and does not receive response within 12 hours, the Resident Care Coordinator and Nurse will be notified and follow up with the pharmacy until the prescribed medication arrives at the community.

R8

Record review of R8's untitled and undated document that listed R8's demographics showed R8 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R8's Service Agreement, dated 06/13/2024, under the section titled "medical care management", showed staff were to administer all medications per physician orders to R8. Staff were to store, manage, and order refills of medications for R8. R8 received all medications through the facility's house pharmacy.

Record review of R8's Medication Administration Record (MAR) dated 05/01/2024 through 05/31/2025, showed R8 had an order for vitamin B-1 take daily. Review of the administrations showed on 05/13/2024 through 05/17/2024, R8's Vitamin B-1 was out not available for administration and medications was ordered from the pharmacy.

Review of the administrations for 05/19/2024 through 05/21/2024, showed R8 missed their vitamin B-1 as it was not available for administration and medication was ordered from the pharmacy.

Record review of an email sent to the department on 07/18/2024 at 2:50 PM, showed R8's physician was not notified about R8 not receiving their Vitamin B-1 for dates 05/13/2024 through 05/21/2024 for review.

R1

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted] and [redacted].

Record review of R1's "Service Agreement", dated 06/11/2024, showed R1 preferred staff assisted them and managed their medications. R1 used inhalers and could operate them when cued.

Record review of R1's June MAR, dated 06/01/2024 – 06/30/2024, showed that R1 had an order for fluticasone propionate and to inhale 2 puffs twice daily for their COPD. R1 missed 1 dosage of their medication on 06/21/2024. R1 missed 2 dosages of their medication on 06/22/2024 – 06/30/2024 due to the pharmacy needed a prescription from R1's MD (medical doctor).

Record review of R1's July MAR, dated 07/01/2024-07/14/2024, showed R1 had an order for fluticasone propionate and to inhale 2 puffs twice daily for their COPD. R1 missed 1 dosage of their medication on 07/01/2024 – 07/02/2024. R1 missed 2 dosages of their medication on 07/03/2024 – 07/05/2024. R1 missed 1 dosage of their medication on 07/06/2024. All dosages missed were due to the pharmacy needed a prescription from R1's MD.

Record review of R1's "Resident Progress Notes", dated 06/21/2024 – 07/06/2024, showed that the facility staff members only followed up 3 of 16 days related to R1's missed fluticasone propionate. On 06/21/2024 – 06/22/2024, there were no documented progress notes that facility staff had faxed or called R1's MD, pharmacy, or resident representative to try and obtain the prescription. On 06/24/2024 – 06/27/2024 there were no documented progress notes that facility staff had faxed or called R1's MD, pharmacy, or resident representative to try and obtain the prescription. On 06/30/2024 – 07/06/2024 there were no documented progress notes that the facility staff faxed or called R1's MD, pharmacy, Insurance, or Resident Representative in attempt to get prior authorization to try and obtain the prescription.

In an interview on 07/19/2024 at 11:36 AM, R1 said they had not had their fluticasone propionate inhaler for an extended period. R1 said the facility staff informed them to use their nebulizer instead of the inhaler. R1 expressed concern with using their nebulizer because in the past they had been hospitalized due to overdosing on too many nebulizer treatments. R1 said they wrote a letter to their MD to try and expedite the process.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said if a resident had missed their medication because it ran out, they would notify the MD daily. Staff C said if the MD would not respond to the facility staff members fax request to refill a medication, they encouraged residents or resident representatives to call the MD themselves. Staff C said R1 had other medications they used in place of their missed fluticasone propionate.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

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

(q) Regarding the management of pets in the assisted living facility, if permitted, consistent with WAC 388-78A-2620 ;

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to implement and follow the facility policy for smoking evaluations, fall risk evaluations, dementia management evaluations, grievances and complaints, and pets. The facility staff were uneducated on policies that effected residents receiving necessary care. This failure placed 73 of 73 residents at risk for not getting proper care by untrained staff.

Findings included...

Record review of Staff A, Administrator's personnel file showed Staff A completed their Department of Health Counselor Certified Certification and was active until 08/24/2024.

Record review of the facility's policy titled, "Health Assessment Procedure", undated, showed the nurse completed smoking assessments, fall risk assessments, and SLUMS (Saint Louis University Mental Examination) assessments if applicable to the resident.

Record review of the facility's policy titled, "Service Agreement Policy", undated, showed a service agreement would be developed thirty days following the resident's

admission, quarterly, and if a change of condition was noted. Prior to the admission the initial service agreement would be based on the resident evaluation performed prior to the move in date. The service agreement would include the date, services needed and to be provided, and resident requests and preferences. The Participants (resident, resident representative, administrator, director of nursing, and care manager if appropriate) would sign the agreement and it would be kept in the resident's record. The service agreement would be based on the quarterly evaluation.

Record review of the facility's document titled, "service plans", undated showed service plans (called service agreements) must be updated quarterly and upon any change of condition. For Washington new residents required 14-day and 30-day service plan updates. Care conferences were to be held with residents and resident representatives, including powers of attorney, billing representatives, guardians, and other family to go over each update, sign the agreement, and discuss any issues and ensure good working relationships with family members and guardians.

Record review of the facility provided document titled, "Service Plan content/wording", undated, showed "14-day assessment (WA [Washington] only) was handwritten on printed service plan and updates put in CC [CommuniCare facility's electronic record] updates put in CC and printed in 14 days". The 30-day service plans required care conferences and new signatures. Service plans were writing in facilities electronic record system every quarter and with change of conditions. Original service plan would be filed in the resident's chart, signed, and completed. All significant change service plan and quarterly service plans need new signatures.

Record review of the facility's policy titled, "Grievances and Complaints", undated, showed if a resident or their representative had a grievance or a complaint that they were encouraged to bring it to the attention of facility management whether it was through resident council or through facility staff. Facility staff would document the complaint on the appropriate form with the name of the person who received the information and the date. The form would be turned into Staff A, Administrator who would route it to the appropriate staff member to follow up. The facility management would investigate the complaint and findings would be documented. The resident or representative would be verbally informed of the results within 10 non-weekend days of the report being filed.

Record review of the facility's "Resident Council", dated 05/09/2024, showed handwritten notes showed male residents had been inappropriate in the dining room which effected other residents' participation. There was a note that facility staff needed to report concerns to Staff A, Administrator. There was a note that residents expressed there needed to be more handicap access on the facility sidewalks. There was a note that residents thought the dining room door to the outside should be electronic. There was a note that confrontation in activities needed to stop. There were no documented notes to review of how and when the facility staff followed up on the residents' concerns, they expressed.

Record review of the facility's "Resident Council", dated 07/04/2024, showed handwritten notes that residents were served too much pork and they wanted more variety of food. Residents wanted more fresh fruit accessible to them. Residents expressed concerns about the handwashing and hand sanitizers in the facility. There was a note that the vents in the laundry room needed to be cleaned. Residents expressed concern that Staff R, Maintenance Supervisor, does not follow up on tasks

that needed to be completed. Residents expressed concern that the facility windowsills were dirty. Residents expressed concerns that the activity room needed to be cleaned. There were no documented notes to review of how and when the facility staff followed up on the residents' concerns, they expressed.

WAC 388-78A-2620 Pets.
"If an assisted living facility allows pets to live on the premises, the assisted living facility must:
(1) Develop, implement and disclose to potential and current residents, policies regarding:
(a) The types of pets that are permitted in the assisted living facility; and
(2) Ensure animals living on the assisted living facility premises:
(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;
(b) Are certified by a veterinarian to be free of diseases transmittable to humans;
(c) Are restricted from central food preparation areas."

Record Review of the facility's policy titled "Resident Pets", undated, showed the policy did not include what type of pets were permitted on the premises. It did not include that pets were to have regular examinations and immunizations appropriate for their species by a veterinarian in Washington state, be free from diseases, and did not include information about the pet being restricted from food preparation areas.

Service Agreements and Evaluations

Record review of R1's "Resident Info [information] Sheet", undated, showed R1 moved into the facility on [redacted]/2024. R1 had multiple diagnoses which included [redacted] and [redacted]. Risk factors included R1 smoked/drank.

Record review of R1's "Smoking Evaluation", dated 04/21/2024, showed it was an initial evaluation. The cognitive concerns section was blank. The functional risk factors included a checked box that R1 had upper respiratory infections, illness, or used oxygen. The section did not include which risk factor was applicable to R1. The medications that can impair alertness, awareness, strength, and safety section was blank. The concerns based on history section was blank. R1 and Staff A, Administrator signed the document on [redacted]/2024.

In an observation and interview on 07/19/2024 at 11:36 AM, R1 had a carton of cigarettes and a lighter on their counter in their apartment. R1 said Staff E, Licensed Practical Nurse, had never completed a formal evaluation to determine if they were considered to be safe when they smoked.

Record review of R1's "Fall Risk Evaluation", dated 04/21/2024, showed it was an initial evaluation. The diagnoses, medications, incontinence, mobility boxes were checked as applicable to R1. A yes box had been checked off next to the statement R1 was considered a fall risk. R1 and Staff A, Administrator signed the document on 04/22/2024.

Record review of R1's "Dementia Management Evaluation", dated 04/21/2024, showed it was an initial evaluation. A no box had been checked off next to the statement that R1 did not need specialized dementia care. R1 and Staff A, Administrator signed the

document on [redacted]/2024.

In an interview on 07/19/2024 at 10:48 AM, Staff C, Resident Care Coordinator, said Staff E, Licensed Practical Nurse, completed health assessments and they completed service agreements for the residents. Staff C said they would go with Staff E when they completed the initial health assessment prior to the resident moving into the facility. Staff C said they were not aware Staff E was supposed to complete a 14-day health assessment. Staff C said they had a 14- and 30-day service plan review they completed for the resident service agreements, and they thought that was the same thing.

In an interview on 07/19/2024 at 1:23 PM, Staff E said they were responsible for completed assessments. Staff E said they completed health assessments initially before the resident moved in and the next assessment they completed would be at 30-days. Staff E said they did not complete 14-day assessments. Staff E said the facility updated resident service agreements every 3 months of when there was a change of condition. Staff E said they completed a health assessment every time a service agreement had been updated. Staff E said they were responsible for completed smoking evaluations. Staff E said they had visually assessed R1's ability to safely smoke.

In an interview on 07/24/2024 at 10:44 AM, Staff E said health assessments were on a different document then the resident service agreements. Staff E said they signed and dated health assessments whereas Staff A and Staff C would sign and date resident service agreements .

Record review of an email sent to the Department on 07/22/2024 at 3:50 PM, showed Staff A, Administrator, said "We have a completed evaluation within 14 days: all that information is in the service agreement and completes the full assessment topics... Our service agreement is our service agreement AND evaluation."

Grievances and Complaints

In an interview on 07/22/2024 at 9:10 AM, Staff A said they did not have any documented grievances they could provide to review. Staff A said they used resident council meeting minutes to follow up on resident grievances. Staff A said if a resident expressed a grievance, they would follow up with the department head the concern was about and the department head would follow up as needed. Staff A said they did not document their conversations with the department heads.

Pets

In an interview on 07/17/2024 at 3:19 PM, Staff K, Office Manager, said Resident 13 had a cat named [redacted] who lived in the facility. Staff K said the facility did not have any updated pet records to provide to review.

In an interview on 07/22/2024 at 12:35 PM, Staff N, Housekeeper, said there were dogs and cats that resided in the facility.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

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 and interview, the facility failed to maintain safe water temperatures on 1 of 2 buildings (Assisted Living building) reviewed. This failure placed residents, visitors, and staff at risk of injury from unsafe water temperatures and decreased quality of life.

Findings included...

Record review on 07/17/2024 at 9:31 AM, of the maintenance binder, with the facility maintenance documents showed, a document titled, "water temperature log temperature check (every two weeks)", dated May 8 (no year), was a list of the hot water temperatures that were checked in the PM that day. There were no other hot water temperature checks documented for review for dates 05/08/2024 through 07/16/2024 for review.

In an observation on 07/16/2024 at 12:59 PM, in the public bathroom across from the assisted living dining room, the hot water temperature was 123.7 degrees Fahrenheit (F). When the hot water was running, steam was observed to be rising from the running water.

In an observation on 07/16/2024 at 1:05 PM, inside the public bathroom across from the kitchen, the hot water temperature was 120.8 degrees F.

In an observation and interview on 07/16/2024 at 1:09 PM, the sink in the resident accessible laundry room, the hot water temperature was 124.1 degrees F. Staff K, Office Manager, stated there were four or five assisted living residents that used the laundry room to wash their clothes.

In an interview on 07/16/2024 at 1:12 PM, in the activity room public bathroom for the residents, the hot waters temperature was 100.3 degrees F.

In an observation on 07/17/2024 at 9:08 AM, in the public bathroom across from the assisted living dining room, the hot water temperature was 122.3 degrees F. The hot water was hot to touch and observed steam rising from the running hot water.

In an observation on 07/17/2024 at 9:11 AM, the sink in the resident accessible laundry room, the hot water temperature was 125.5 degrees F.

In an interview and observation on 07/17/2024 at 9:20 AM, Staff R, Maintenance Supervisor, stated they try to check the hot water temperatures for the facility once a month. Staff R stated hot water temperatures were to range from 105 degrees F to 120 degrees F. Staff R checked the hot water temperature in the public bathroom across from the assisted living dining room with a laser thermometer gun. When Staff R was checking the hot water, the red laser was noted to be at times pointed in the water, and then at times that was pointing to the metal faucet of the sink. Staff R's thermometer showed the hot water temperature to be 126.6. Staff R stated the hot water temperature fluctuates, when other sinks throughout the building use the hot water, when showers or laundry was being done. Staff R stated the most accurate hot water temperature was best gotten first thing in the morning.

In an observation on 07/17/2024 at 9:26 AM, in the activity room public bathroom, Staff R checked the sinks hot water with their laser thermometer that showed the hot water temperature was 93.9 degrees F. Staff R stated that was "way to low". Staff R stated, "I guess I will turn the hot water tank temperatures down", when Staff R was asked for a plan to prevent the resident's danger of getting burned form the hot water.

In an interview on 07/17/2024 at 12:58 PM, Staff A, Administrator, stated they would have Staff R check the hot water temperatures that afternoon to ensure the hot water temperature was within approved temperature range.

In an observation on 07/19/2024 at 11:45 AM, in the activity room in the resident used public bathroom the hot water in the sink was turned on at 11:39 AM. At 11:42 AM the hot water temperature was 100.6 degrees F.

In an observation on 07/22/2024 at 9:40 AM, in the activity room in the resident used public bathroom, the hot water in the sink's hot water temperature was 95.3 degrees F.

In an interview on 07/22/2024 at 9:57 AM, Staff R said they checked the water temperature in the facility and the numbers were in range. Staff R said the activities room water temperature was 104 degrees. Staff R said they had to adjust the hot water temperature dial up more.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 10/10/24

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to have a communication system available for 2 of 4 sampled memory care residents (Resident 7 [R7] and Resident 6 [R6]) in their common area of their apartment to call for staff if they required assistance. This failure resulted in two memory care residents not having a means to summon on-duty staff and placed the residents at risk for a delay of care and assistance, and unmet care needs.

Findings included...

In an observation on 07/16/2024 at 1:52 PM, the door to R7's room was open by a magnet on the wall. R7 was awake and sitting upright in bed. There was no observed call light or call light cord on the wall or in the common area around R7's bed available for use observed.

In an observation and interview on 07/18/2024 at 4:30 PM, in R6's room Staff V, Caregiver, was brushing R6's hair. When Staff V was asked how R6 would call for staff assistance if R6 was in bed, Staff V looked around the room and stated, "there is not call light in the room", that they were unsure how R6 would call for help if they wanted to. Staff V stated because there are not call lights in the rooms, the caregivers were told they had to constantly walk the hallways and check on the residents. Staff V stated some residents wear a call light pendant to use. Staff V stated that R5 and R6 did not have a call pendant.

In an interview and observation on 07/19/2024 at 12:17 PM, Staff D, Resident Care Coordinator, stated a handful of the memory care residents had call light pendants that they wore. Staff D stated all the staff that work in the memory care building walk the hallways and do frequent checks. Staff D stated that there were alert pads that are moveable located in the rooms. Staff D went to the sitting area across for their office and showed a small upright rectangle pad that had "ALERT" on it. The alert pad was on the wall that was fourth of the way up the wall from the ground. Staff D was unsure where the call light alert was located in R6's room. Staff D stated call pendant use would be in the residents service agreement.

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Administrator (or Representative)

10/10/24
Date