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

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

RE: Easthaven Villa License # 2144

Dear Administrator:

This letter addresses Compliance Determination(s) 25229 (Completion Date 06/12/2023) and 18200 (Completion Date 02/07/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/12/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610-1, WAC 388-78A-2610-2-d, WAC 388-78A-2450-1-a, WAC 388-78A-2120-3-b

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 (253)254-3190.

Sincerely,

Cory Cisneros

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 18200
Intake ID: 61372
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/05/2023 through 02/07/2023
Complainant Contact Date(s):

Allegation(s):
allegation 1) inadequate staffing to provide the care and services to the residents per the service agreement.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 6 Closed records sample size: 3
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Identified staff Nursing staff
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:
1) after interview and record review the facility failed to adequate staff to ensure the care and services were provided per the residents service agreement. Staff were unable to provide care as care planed.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 18200
Intake ID: 61855
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/05/2023 through 02/07/2023
Complainant Contact Date(s):

Allegation(s):
allegation 1) inadequate staffing to provide the care and services to the residents per the service agreement.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 6 Closed records sample size: 3
Observations:	Staff to resident interactions Resident rooms Resident care equipment Environmental Infection control and prevention Dining Residents Identified resident
Interviews:	Identified resident Identified staff Nursing staff Residents Housekeeping staff
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:
1) after interview and record review the facility failed adequately staff the facility to ensure the residents receive the care and services per the residents service agreement. failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 18200
Intake ID: 64957
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/05/2023 through 02/07/2023
Complainant Contact Date(s):

Allegation(s):
Concern that facility staff are not wearing a face mask within the facility.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 6 Closed records sample size: 3
Observations:	Staff to resident interactions
Interviews:	Identified staff Kitchen staff Laundry staff Business office manager Nursing staff
Record Reviews:	Facility policies

Investigation Summary:
Failed practice found. The facility will be cited for staff not wearing a face mask within 6 feet of a resident. The facility will be cited for not all staff having their N95 medical evaluation and annual N95 fit testing up to date.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 18200
Intake ID: 68491
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/05/2023 through 02/07/2023
Complainant Contact Date(s):

Allegation(s):
1) allegation- daughter is refusing to allow comfort measures to the resident.

Investigation Methods:

Sample:
Total residents: 72
Resident sample size: 6
Closed records sample size: 3

Observations:
Residents
Identified resident
Resident care equipment
Infection control and prevention environmental.
Resident rooms
Staff to resident interactions
Medication administration

Interviews:
Family members
Nursing staff
Identified resident
Hospice staff
Management staff

Record Reviews:
Medical records

Investigation Summary:
1) after interviews and record review the facility has protected the resident of any abuse conducted by the daughter. the staff have intervened and contacted hospice/MD to help resident with comfort measures. The facility did fail to monitor and document the residents change in condition, decline, and the daughters reactions and concerns towards the resident.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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

Statement of Deficiencies	License #: 2144	Compliance Determination # 18200
Plan of Correction	Easthaven Villa	Completion Date
Page 1 of 20	Licensee: Caring Places Management, LLC	02/07/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 01/05/2023, 02/02/2023 and 01/26/2023 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following complaint number(s): 44580, 52012, 57534, 58591, 58826, 61372, 61412, 61855, 64957, 68491

The following sample was selected for review during the unannounced on-site visit: 6 of 72 current residents and 3 former residents.

The department staff that investigated 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, Suite 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

02/21/2023
Date

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

Administrator (or Representative) 02/28/2023 Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure required infection control measures were being followed to prevent communicable diseases. Staff failed to wear a face mask as required. The facility also failed to ensure they documented and tracked fit testing and medical clearances for staff. These failures placed 72 of 72 residents and 37 staff at risk for being infected and spreading communicable diseases.

Findings included...

Record review of Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings, dated 10/31/2022, under the "Source Control for Healthcare Personnel" section showed, "One of the following should be worn by HCP [Healthcare Personnel] for source control while in the facility A NIOSH-approved N95 or equivalent or better respirator, OR ... A well-fitting facemask". "HCP should always wear well-fitting source control while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers".

Record review of United States Department of Labor Occupational Safety and Health Administration dated September 26, 2019, under 1910.134 (C) showed "Respiratory protection program. This paragraph requires the employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use. The program must be administered by a suitably trained program administrator. In addition, certain program elements may be required for voluntary use to prevent potential hazards associated with the use of the respirator." 1910.134(c)(1)(i) showed "Procedures for selecting respirators for use in the workplace." 1910.134(c)(1)(ii) showed "Medical evaluations of employees required to use respirators."

Record review of a facility policy, titled, "N-95 Respirator Medical Evaluation and Fit Testing", undated, showed, "All new CPM [Caring Places Management] employees will review the community's Respiratory Protection Presentation during their new employee orientation and will be required to complete an N-95 Respirator Medical Evaluation and Fit Testing, to ensure that staff are aware of how to use the masks appropriately, in the event that they are needed. Thereafter, CPM employees will complete annual fit testing."

Medical Clearance for N95 Fit Testing and Fit Testing Records

Record review of a Respirator Fit Test Record for Staff L, Dietary Aid, showed a fit test that expired on 05/19/2022.

Record review of a Medical Clearance For Respirator Use showed Staff L was evaluated on 01/07/2022 and was supposed to be recertified within one year. There was no documentation that showed Staff L was recertified.

Record review of a Respirator Fit Test Record for Staff F, Medication Aid, showed a fit test that expired on 05/18/2022. Record review of a Medical Clearance For Respirator Use showed Staff F was evaluated on 05/19/2021 and was supposed to be recertified within one year. There was no documentation that showed Staff F was recertified.

Record review of a Respirator Fit Test Record for Staff C, Resident Care Coordinator, showed a fit test that expired on 05/26/2022.

Record review of a Respirator Fit Test Record for Staff E, Medication Aid, showed a fit test that expired on 05/19/2022.

Record review of a Respirator Fit Test Record for Staff G, Caregiver, showed a fit test that expired on 05/18/2022.

Record review of a Respirator Fit Test Record for Staff H, Caregiver, showed a fit test that expired on 01/05/2023.

Record review of a Respirator Fit Test Record for Staff I, Housekeeping Manager, showed a fit test that expired on 01/05/2023.

Record review of a Respirator Fit Test Record for Staff J, Resident Care Coordinator, showed a fit test that expired on 05/18/2022.

Record review of a Respirator Fit Test Record for Staff K, Medication Aid, showed a fit test that expired on 01/10/2023.

Record review of a Respirator Fit Test Record for Staff N, Caregiver, showed a fit test that expired on 01/10/2023.

Record review of a Respirator Fit Test Record for Staff O, Life Enrichment Coordinator, showed a fit test that expired on 01/07/2023.

Record review of a Respirator Fit Test Record for Staff P, Caregiver, showed a fit test that expired on 08/22/2022.

Record review of a Respirator Fit Test Record for Staff Q, Caregiver, showed a fit test that expired on 05/26/2022.

Record review of a Respirator Fit Test Record for Staff R, Medication Aid, showed a fit test that expired on 05/26/2022.

Record review of a Respirator Fit Test Record for Staff S, Caregiver, showed a fit test that expired on 01/10/2023.

Record review of a Respirator Fit Test Record for Staff T, Medication Aid, showed there was not a fit test record to be reviewed.

In an interview on 01/05/2023 at 12:05 PM, Staff U, Housekeeper, stated they had received minimal training regarding wearing a face mask within the facility. Staff U stated they had not been N95 fit tested. Staff U stated they were unaware they were supposed to be fit tested before wearing an N95 respirator. Staff U stated Staff D, Office Manager, informed them they were allowed to opt into wearing an N95 respirator if they felt inclined, but it was not required due to the facility not being in COVID-19 (Corona Virus Disease 2019- a respiratory disease) outbreak mode.

In an interview on 01/05/2023 at 1:15 PM, Staff C, Resident Care Coordinator (RCC), stated facility staff were supposed to wear a face mask if they were within 6 ft (feet) of a resident. Staff C stated if the facility was in COVID19 outbreak that facility staff would be required to wear an N95 respirator. Staff C stated they were last fit tested in 2020.

In an interview on 01/13/2023 at 10:05 AM, Staff H, Caregiver, stated they must wear a face mask if they were within 6 ft (feet) of a resident. Staff H stated they received this guidance from the Medication Aids and the Administration. Staff H stated they could not remember the date they were fit tested.

In an interview on 01/13/2023 at 10:30 AM, Staff I, Housekeeping Manager, stated that

they must wear a face mask within the facility. Staff I stated they were N95 fit tested when they were hired on 01/04/2022.

In an interview on 01/13/2023 at 11:37 AM, Staff A, Administrator, stated the facility staff were N95 fit tested upon hire during facility orientation. Staff A stated that they received fit testing guidance from the Department of Health.

Face Mask

In an observation on 01/05/2023 at 2:02 PM, showed Staff B, Assistant Administrator (AA) was in the common hallway next to the reception desk. Staff B was not wearing a face mask. Staff B was within arm's reach of a resident as they were talking to the resident.

In an interview on 01/13/2023 at 11:14 AM with Staff B, Assistant Administrator stated the facility policy regarding face masks is that staff must wear a face mask when staff encounter a resident. Staff B stated face masks should be worn in all resident areas such as the dining room, hallways, next to the medication cart, and inside of the resident's rooms.

In an interview on 01/13/2023 at 11:37 AM with Staff A, Administrator, stated the facility policy regarding face masks is that staff must wear a face mask when they are in common areas of the facility.

In an observation on 01/13/2023 at 10:04 AM, showed Staff H, Caregiver, was sitting at the memory care dining room table with their face mask pulled down under their nose and mouth. There were multiple residents in the communal dining room. One resident was within arm's reach of Staff H as they were sitting across the table from Staff H.

This is a recurring deficiency previously cited on 06/02/2021.

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) 03/23/2023 .

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

Administrator (or Representative) — Date: 02/28/2023

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have sufficient staffing to provide care and services as agreed on in the resident's service agreements. This failure placed 4 of 5 residents (Resident 1, Resident 2, Resident 3, and Resident 6) at risk for injury, unmet care needs, and decreased quality of life.

Findings included...

Record review of the facility's staffing policy, undated, showed that the staff schedules were to be created in accordance with resident needs and acuity.

Record review of the facility's Resident Characteristic roster, dated 01/05/2023, showed the current census(number) of residents for the assisted living facility was 44.

Record review of the facility's move out list for the month of December 2022 showed for the dates 12/06/2022 – 12/21/2022 the facility had 44 residents. For the dates 12/21/2022 – 12/26/2022 showed they had 45 residents. 12/26/2022- 01/05/2023 showed they had 44 residents in the facility.

Record review of facility staffing schedule for November 2022, showed all shifts had 2 caregivers and 1 medication aide scheduled. The November 2022 census showed the facility had 44 residents. Review of December 2022 staffing schedule showed each shift was scheduled for 1 caregiver and 1 medication aide for day and evening shift. Review of the facility census for December 2022 showed they had 44 residents.

Resident 1
Record review of a face sheet for Resident 1 (R1) showed they moved into the facility on [redacted] 2019, with multiple medical diagnoses including [redacted] and [redacted].

Record review of the Service Agreement (SA)/assessment, dated 12/27/2022, showed R1 needed full assistance with ADL's (activities of daily living) and transfers. They required two-person assist with transfers. Under the section, "Communications", showed R1 was able to make their needs known. Under the section titled, "Dressing", showed R1 was very weak at standing and could only stand for a few seconds at a time. Under the

section, titled, "Strengths, preferences and limitations", showed R1 needed a transfer pole or grab bars to help them stand. Staff were to encourage and use two person SBA (stand by assistance) during transfers. Sometimes R1 would need a boost from two staff members. R1 was noted to be a two-person assist when transferring for safety. This was scheduled routinely for all shifts to follow. Under the section, titled, "transfers", showed R1 was unable to transfer themselves independently. They were not able to bear weight for more than a few seconds. They were weak and nervous with transfers. They were to have two people in the room to transfer for safety and reassurance. It was hard for R1 to pivot when standing and needed physical assistance from staff to complete pivot transfers. Under the section, titled, "bed mobility", showed R1 was unable to roll or change position when in bed alone. Staff were to roll R1 in bed to change their brief.

Record review of the SA/assessment, dated 03/24/2022, showed that R1 needed full assistance with ADL's and transfers. Under the section titled, "transfers" showed R1 was unable to transfer themselves independently. R1 got nervous with transfers and preferred two caregivers to be present to assist them. Under the section titled, "ambulation", showed R1 has a history of vertigo.

Record review of the document, titled, "Assessment details history significant change", dated 11/07/2022, showed under the section, titled, "bed mobility", R1 needed extensive assistance (resident was involved but required cueing/supervision or partial assistance at all times) two-person physical assist. Under the section, titled, "transfers", showed R1 needed extensive assistance, two-person physical assist. Under the section, titled, "toilet use", showed R1 needed total dependence (full performance by others) and two-person physical assist. R1 had all toileting needs completed while in bed as R1 was too weak to use the toilet. Under the section, titled, "dressing", showed R1 needed extensive assistance with two-person physical assist with dressing tasks.

In an interview on 01/05/2023 at 1:27 PM, Staff C, Resident Care Coordinator, stated that R1 required two-person assist with all their transfers.

In an interview on 01/13/2023 at 10:23 AM, Anonymous Staff 1, Medication Aide, stated that R1 needed two people to assist with transfers. They stated that even with two people it was difficult to transfer R1. R1 had a history of their legs buckling and falling.

In an interview on 01/13/2023 at 10:36 AM, R1 stated that two staff members typically helped them transfer to their wheelchair or their bed. R1 stated that they felt unsafe to transfer with just one caregiver. R1 stated that they were transferred recently with only one caregiver.

In an interview on 01/13/2023 at 10:53 AM, Anonymous Staff 1 stated that they had transferred R1 independently because they were the only caregiver on shift and the medication aide was busy administering medications.

Resident 6

Record review of the face sheet for Resident 6 (R6), a former resident of the facility, showed they moved into the facility on [redacted] 2022 with multiple medical diagnosis including [redacted], and [redacted].

Record review of the R6's SA/assessment dated 11/18/2022, showed R6 was on hospice services related to their respiratory failure. Under the section, titled, "sleep", showed that R6 was unable to transfer safely. R6 needed assistance to lift their legs up into their bed due to weakness. Under the section, titled, "toileting", showed R6 was incontinent of both urine and bowel. R6 easily became short of breath and was unable to properly clean themselves. R6 needed assistance with changing their soiled brief. Under the section, titled, "memory", showed R6 had low oxygen levels that caused her to have some short-term memory issues. R6 was able to recall their past and able to make their needs known to staff. Under the section, titled, "behaviors", showed R6 had the possibility of experiencing anxiety due to her health declining and breathing issues. R6 pulled their call light excessively. R6 had experienced some depression and hopelessness. Under the section titled, "medical care management" showed R6 was anxious due to breathing difficulties. R6 recently dislocated their right elbow during a fall. Under the section, titled, "skin and foot care" showed R6 had an open area to their coccyx (tailbone area of the back) that was covered with a bandage.

In an interview on 01/13/2023 at 10:23 AM, Anonymous Staff 2, Medication Aide, stated that R6 required two-person assist with transfers. They stated that R6 had declined but was able to communicate their needs. R6 had become weak and confined to their bed. R6 required two people to reposition them in bed.

In an interview on 01/05/2023 at 10:23 AM, Staff G, Caregiver, stated that R6 required two people for transfers and repositioning/turning when they were in bed.

In an interview on 01/04/2023 at 2:17 PM, Anonymous Staff 3, Caregiver, stated that they were unable to get to R6 cleaned up after a bowel movement. They stated that they were the only caregiver on the shift and was assisting another resident. They stated that R6 was crying and noticeably upset from being left lying in their own bowel. Anonymous Staff 3 stated that they didn't have help available and had to turn and clean R6 by themselves.

Resident 2
Record review of a face sheet for R2 showed they moved into the facility on [redacted] 2018 with multiple medical diagnoses including [redacted].

Record review of R2's SA/assessment, dated 06/17/2021, showed that R2 could speak clearly and was able to make their needs known for the most part. Under the section,

titled, "toileting", showed R2 was frequently incontinent of urine and bowel and was unable to recognize when their brief was soiled (dirty). R2 spent most of their time in their bed and needed to have their brief checked and changed three to four times per shift. Under the section, titled, "sleeping", showed R2 was too weak to get out of the bed. Under the section, titled, "skin and foot care", showed the caregivers were to turn and reposition R2 four to six times per shift. R2 had a red area to the tailbone area. The Medication aides were to change the padded dressing once a daily and when soiled. Under the section titled, "transfers", showed R2 was bed bound (confined to a bed) for the past year. R2 was unable to transfer as their legs were weak. Under the section titled, "ambulation", showed R2 was unable to walk and would need to be pushed in a manual wheelchair for all ambulation. R2 was unable to bear weight and was bed bound.

Record review of R2's SA/assessment, updated 11/07/2022, showed that R2 was bed bound and unable to tolerate transfers or sit up in a wheelchair. R2 depended on staff for all care needs. R2 was unable to reposition themselves in bed. R2 could speak and was able to make their needs known. Under the section titled, "sleeping", showed that R2 was too weak to get out of bed. R2 was not able to adjust their position in bed to relieve pressure and to maintain comfort. R2 was to be checked and changed three to four times per shift. Under the section titled, "toileting", showed R2 was frequently incontinent of urine and bowel. R2 was unable to recognize when their brief was soiled (dirty). R2 spent most of their time in their bed and needed to have their brief checked and changed three to four times per shift. Under the section titled, "skin and foot care", showed that the care staff were to reposition R2 while in bed frequently throughout the shift. R2 was incontinent of bowel and bladder and was unable to reposition self in bed to relieve pressure. Under the section titled, "transfers", showed R2 was bed bound and was not able to bear weight. R2 stayed in bed all the time. Under the section titled, "bed mobility", showed R2 was weak and needed staff to assist with all repositioning in bed and was unable to help.

Record review of the document titled, "Assessment details current significant change", dated 12/13/2022, showed under the section titled, "bed mobility", R2 was bedfast or chairfast, (confined to a bed or a chair) all or most of the time. R2 needed physical assist with positioning in bed. Staff were to reposition R2 at least every two hours. Under the section titled, "toileting", showed R2 was incontinent (unable to control bladder or bowels) and required one-person extensive assistance. R2 needed their pads changed at least every two hours.

In an interview on 01/04/2023 at 2:17 PM, Anonymous Staff 3, Caregiver, stated that R2 was not safe to transfer with only one caregiver.

In an interview on 01/13/2023 at 10:23 AM, Anonymous Staff 1, Medication Aide stated that R2 was bed bound. Anonymous Staff 1 stated that R2 was dead weight (heavy) and unable to sit up by themself. They stated that if R2 needed to be removed from the facility, they would need three caregivers to transfer them.

In an interview on 01/13/2023 at 10:48 AM Anonymous Staff 3, Caregiver, stated that they only had time to check and changed R2 twice on their shift when there was only one caregiver.

In an interview on 01/13/2023 at 10:53 AM, Anonymous Staff 2, Caregiver, stated that R2 needed two-person assist with all transfers. They stated that R2 didn't get up out of bed. They stated they were only able to check and change R2 twice a shift.

Resident 3
Record review of the face sheet for Resident 3 (R3) showed they moved into the facility on [redacted]2022 with multiple medical diagnosis including [redacted].

Record review of R3's SA/assessment, dated 11/05/2022, showed under the section titled, "bathing", R3 needed assistance with their showers. They needed assistance with transfers in and out of the shower, gathering their supplies for the shower, and assistance with washing during the shower. R1 was to have a shower twice a week. Under the section titled, "memory", showed that R3's memory was declining. R3 wrote everything down to help them from forgetting things. R3 was alert and oriented and able to make her needs and desires known. Under the section titled, "behaviors", showed that R3 becomes tearful, shaky, and ask many questions when they are feeling anxious.

Record review of the document titled, "Temporary shower schedule", undated, showed R3 was scheduled to have a shower on 01/08/2023 and 01/11/2023. Documentation for the shower dated 01/08/2023 showed nothing had been documented if the shower was completed. The shower scheduled on 01/11/2023, there was "done" handwritten for that date. The document showed that, "medication aides were to observe that the shower is being completed. Caregiver must call for the medication aide while resident is in the shower. Medication administration record documentation must be accurate with completed shower and refusals."

Record review of the document titled, "temporary shower schedule" date range 01/07/2023 – 01/13/2023 showed on 01/08/2023, there was no documentation if R3 received their shower.

Record review of an email, dated 01/13/2023, showed un-named staff reported that R3 never refused a shower and would often track a staff member down on their shower day to get their shower.

In an observation and interview on 01/05/2023 at 12:04 PM, there was a white board on the wall in R3's room. The white board showed R3's showers were scheduled on Wednesday and Sunday evenings.

In an interview on 01/05/2023 at 12:05 PM, R3 stated that there was a lack of staff at the facility. They stated that "I have gone without my showers." R3 stated that staff tell them that there was just one caregiver working for the facility. R3 stated that the caregiver told R3 they didn't have time to give R3 their shower. R3 stated that it had been three separate times since they moved in that they hadn't gotten their shower, because there wasn't

enough staff. R3 stated that they just hope they have time to get their shower on Sunday when their family was coming to visit. R3 stated that they are anxious when their shower day approaches whether or not they will get their shower. They stated that they enjoy their showers and felt dirty when they didn't get them.

In an interview on 01/13/2023 at 10:23 AM, Anonymous Staff 2, Medication Aide, stated they were told there wasn't enough residents in the facility to keep two caregivers and one medication aide to work an eight-hour shift. They stated that the facility was reduced to one caregiver and one medication aide for each eight-hour shift. They stated that they passed medications to 45 residents during their eight-hour shift. They stated that they did not visually check that the resident's showers were completed. The caregivers wrote either "done or refused" on the shower log.

In an interview on 01/13/2023 at 11:27 AM, Anonymous Staff 2, stated that the blank spot for when a shower was to be given, indicated that it wasn't recorded or was not given.

In an interview on 01/13/2023 at 12:30 PM, Anonymous Staff 1, stated that they were the only caregiver scheduled for the evening shift on 01/08/2023. They stated they did not have the time on their shift to give R3 a shower.

In an interview on 01/13/2023 at 12:40 PM, Staff C, Resident Care Coordinator, stated that there wasn't any documentation that showed when R3 received their shower since they admitted to the facility. There were no medication administration records with R3's documented showers provided.

In an interview on 01/05/2023 at 1:27 PM, Staff C stated that the facility's census (number of residents in the facility) was low. They had to reduce the number of caregivers from two down to one and with one medication aide for every eight-hour shift.

In an interview on 01/13/2023 at 12:27 PM, Staff C stated that the number of residents for the assisted living side of the facility was never below 44 residents. Staff C stated that the facility wasn't allowed to use agency staff (company that sends staff in to help care for the residents).

In an interview on 01/13/2023 at 10:23 AM, Anonymous Staff 2, stated that 44 residents was a lot for one caregiver to take care of.

In an interview on 01/13/2023 at 11:55 AM, Staff A, Executive Director, stated that the facility typically staffs two caregivers and one medication aide for the assisted living side of the facility. Staff A stated that for a month and a half the census (number of residents in the facility) had decreased to about 20 residents. They had to reduce the number of caregivers down to one with one medication aide for each eight-hour shift.

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) 03/23/2023

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

Administrator (or Representative) — Date: 02/28/23

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:

(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 observation, interview, and record review, the facility failed to monitor the residents' well-being with medication changes, after a fall, a change in residents' condition, and after admission to the facility for 5 of 8 residents (Resident 1, Resident 2, Resident 4, Resident 6 and Resident 5). This failure placed residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy, titled, "Alert Charting Procedures and Protocol", revised date of 05/22/2015, showed "Medication Technician (MT) on shift when the Alert Protocol is triggered will create the Medical Alert in Communicare beginning the Alert Charting Process...documentation of the observed status of the resident, to be done once daily unless otherwise specified in the Protocol."

Record review of a document titled, "Resident alert protocol", undated, showed resident alerts would be initiated according to the following protocol, based on the alert sub-type:
"Admit: Record observations every shift for 3-5 days post-admit. Take vital signs and weight on day of admit (if abnormal, refer to nurse instruction.) Record observations of resident's orientation to facility, meal attendance, appetite, attitude & ability to make needs known.

Change in ADL: Record observations until resident returns to baseline or becomes new baseline. Record details of change, resident's thoughts on the change, if any, objective findings, staff response/interventions to promote independence.

Change of Condition: Record observations until resident returns to baseline or becomes new baseline. Record details of change, resident's thoughts on the change, if any, objective findings, staff response/interventions to promote independence.

Nausea/Vomiting: Record observations every shift until resolved. Take vital signs every shift (if abnormal, refer to nurse Instruction.) Record how many times the resident vomited and observations of dry heaving, dizziness, pain, color of vomit, fever, ability to swallow, and fluid intake. Encourage clear fluids.

Pain: Record observations every shift until pain management is in place. Take vital signs once daily (if abnormal, refer to nurse instruction.) Record observations of resident's level of pain - mild, moderate, severe - and any non-verbal symptoms of pain. Record response to pain medication and benefit of nondrug interventions.

Med/Procedure: Record observations every shift for 3 days. Record observations specific to side effects of that medication, and outcome, per nurse/MD instruction.

Readmit: Record observations every shift for 3 days regarding reasons they were in hospital/ER/SNF. Take vital signs once daily, weight only on day of return (if abnormal vitals, refer to nurse instruction.)

Fall: injury: Record observations every shift for 3 days. Record observations of resident's ability to ambulate, transfer, injury, skin tear, discoloration of skin, headache, dizziness, sleepiness or confusion. Watch for common contributors to falls, such as constipation, pain, need to void, etc.

Fall: Non-injury: Record observations every shift for 24 hours, vital signs on day of fall (if abnormal, refer to nurse instruction.) If unstable then continue for an additional 48 hours and record observations of resident's ability to ambulate, transfer, injury, skin tear, discoloration of skin, headache, dizziness, sleepiness or confusion. Watch for common contributors to falls, such as constipation, pain, need to void, etc."

Record review of a document, titled, "Medication aide handbook for Caring Places Management Medication Aides", updated August 2018, showed under the section titled "Progress note content and recommendations":
"alert charting must begin with why on alert in progress note. When removed from alert must say so in progress note. Progress notes must include action you took regarding whatever you are charting about. Such as complaints of pain in back, medicated with Tylenol for pain, some relief reported from Tylenol. Etc. All progress notes must

include only what you see, hear, feel or smell. Do not write what you think. Objective information only. Read you progress note after writing and ensure what you are saying makes sense, tells a story. Write a progress note on anything that happens to resident . . . Anything that happens or is seen with resident should be documented but not every issue requires alert charting." Under the section titled, "what to do when resident falls", step 10, showed "place resident on alert per protocol." Step 15 showed, "write progress note of incident and any first aid provided. Place resident on alert."

Resident 6
Record review of the face sheet for Resident 6 (R6), a former resident of the facility, showed they moved into the facility on [redacted] 2022 with multiple medical diagnoses including [redacted], and [redacted].

Record review of R6 Service Agreement (SA)/assessment, dated 11/18/2022, showed R6 was on hospice services related to their respiratory failure. Under the section titled, "sleep", showed that R6 was unable to transfer safely. R6 needed assistance to lift their legs up into their bed due to weakness. Under the section titled, "toileting", showed R6 was incontinent of both urine and bowel. R6 easily became short of breath and was unable to properly clean themselves. R6 needed assistance with changing their soiled brief. Under the section titled, "memory", showed R6 had low oxygen levels that caused some short-term memory issues. R6 was able to recall their past and able to make their needs known to staff. Under the section titled, "behaviors", showed R6 had the possibility of experiencing anxiety (feeling of being overwhelmed, worry, anxious) due to their health declining and breathing issues. R6 pulled their call light excessively. R6 had experienced some depression and hopelessness. Under the section titled, "medical care management", showed R6 was anxious due to breathing difficulties. R6 recently dislocated their right elbow during a fall. Under the section titled, "skin and foot care", showed R6 had an open area to their coccyx (tailbone area of the back) that was covered with a bandage.

Record review of R6 resident progress note, dated [redacted] 2022, showed that R6 moved into the facility on hospice services. There was no other documentation on R6's adjustment to admitting to the facility.

Record review of R6's resident progress, note dated 11/18/2022, showed that R6 had a change in condition. They needed full assistance with their activities of daily living, transfers, and medications. R6 was noted to have an open wound on their coccyx covered by a bandage. R6 had pain to their dislocated elbow from a recent fall. Oxycodone (pain medication) was ordered to be given three times daily and as needed every two hours to help manage R6's pain. R6's level of care had increased. There was no other documentation that showed how R6 adjusted to the new medication, and no documentation of how R6's pain level was or if the medication was helping R6's pain. There was no further documentation about R6's open wound to the coccyx. There was no further documentation about R6's overall change in condition and health needs.

Record review of R6's resident progress note, dated 12/10/2022, showed an order for R6 to be given their anxiety medication once in the morning and once in the evening to help with R6's desire to drink and restlessness. There was no further documentation that showed if the anxiety medication was effective in reducing the residents desire to drink or their restlessness.

Record review of the document titled, "Hospice nurse visit", dated 12/20/2022, showed that the hospice provider had been called about R6 was having increased confusion and disorientation and a possible urinary tract infection. The Hospice nurse wrote that R6 had increased confusion and a change in condition was progression of R6's disease. The Hospice nurse implemented R6's Haldol (antipsychotic medication to help reduce the confusion and disorientation) order two times daily and as needed.

Record review of R6's resident progress note, dated 12/20/2022, showed R6 was very confused that morning. Hospice was notified and they were to make a visit that afternoon. There was not further documentation about R6's confusion or any new orders that hospice provided during the visit.

Record review of R6's resident progress note, dated 12/23/2022, showed R6 started a new medication, Haldol (antipsychotic medications to help reduce anxious, confusion). R6 was to take the medication every eight hours to assist with R6's increased confusion and shortness of breath. There was no further documentation on how the resident was adjusting to the new medication, if any improvement in confusion or shortness of breath, or any possible side effects of the medication.

In an interview on 01/13/2023 at 12:45 PM, Staff C, Resident Care Coordinator, stated that R6 didn't have any alert charting from the time they admitted to the facility on [redacted]2022 until they passed away on [redacted]2022.

Resident 4
Record review of the face sheet for Resident 4 (R4) showed they moved into the facility on [redacted]2022 with multiple medical diagnoses including [redacted].

Record review of the document titled, "pre-admission evaluation", dated 10/26/2022, showed R4 lived at home with their wife. They had eloped (wandered away) looking for their wife when they had gone to the hospital. Under the section titled, "sleeping", showed R4 may wander at night. R4 was to be observed for issues with sleep and alert the registered nurse. Under the section titled, "life enrichment" showed R4 liked to spend most days with their wife at home watching television.

Record review of R4's SA/assessment, dated 12/07/2022, showed R4 was able to communicate their needs. R4 had some memory issues. Under the section titled, "sleeping" showed R4 did not sleep well through the night. They had the occasional episode of

wandering during the night. Under the section titled, "behaviors", showed R4 wandered around looking for their wife forgetting their wife was in the hospital.

Record review of R4's resident progress note, dated [redacted]2022, showed that R4 moved into the memory care community at the facility. R4 was placed on alert charting to monitor for overall acclimation to the community.

Record review of R4's resident alert charting and progress notes, dated [redacted]2022 through 11/02/2022, showed for R4 there was no documentation for R4 being newly admitted to the facility, adjustment to the facility, and any behaviors related to the recent move into the facility. There was no documentation if R4 was sleeping at night.

Resident 2
Record review of a face sheet for Resident 2 (R2) showed they moved into the facility on [redacted]2018 with multiple medical diagnoses including [redacted], [redacted], and [redacted] and [redacted].

Record review of R2's SA/assessment, dated 06/17/2021, showed R2 was able to speak clearly and able to make their needs known for the most part. Under the section titled "toileting", showed R2 was frequently incontinent of urine and bowel and was unable to recognize when their brief was soiled (dirty). R2 spent most of the time in bed and needed to have their brief checked and changed three to four times per shift. Under the section titled "sleeping", showed R2 was too weak to get out of the bed. Under the section, "skin and foot care", showed the caregiver was to turn and reposition R2 four to six times per shift. R2 had a red area to the tailbone area. Medication aide was to change the padded dressing once a daily and when soiled. Under the section titled "transfers", showed R2 was bed bound (confined to a bed) for the past year. R2 was unable to transfer- legs weak. Under the section "ambulation", showed R2 was unable to walk and would need to be pushed in a manual wheelchair for all ambulation. R2 was unable to bear weight and was bed bound.

Record review of R2's SA/assessment, updated 11/07/2022, showed that R2 was bed bound and unable to tolerate transfers or sitting in a wheelchair. R2 depended on staff for all care. R2 was unable to reposition self in bed. R2 could speak and was able to make their needs known. Under the section "sleeping", showed that R2 was too weak to get out of bed. R2 was not able to adjust their position in bed to relieve pressure and to maintain comfort. R2 was to be checked and changed three to four times per shift. Under the section titled "toileting", showed R2 was frequently incontinent of urine and bowel and was unable to recognize when their brief was soiled (dirty). R2 spends most of his time in his bed and needed to have their brief checked and changed three to four times per shift. Under the section titled "skin and foot care", showed that the care staff were to reposition R2 while in bed frequently throughout the shift. R2 was incontinent of bowel and bladder and was unable to reposition self in bed to relieve pressure. Under the section titled, "transfers", showed R2 was bed bound and was not able to bear weight. R2 stayed in bed at all times. Under the section titled "bed mobility", showed R2 was weak and needed staff to assist with all repositioning in bed and was unable to help.

Record review of R2' resident change of condition progress note, dated 11/03/2022, showed that R2 had stools (bowel movement) that were "black in color and tarry in appearance."

Record review of R2's resident progress note, dated 11/05/2022, showed R2 had black stool that evening.

Record review of the resident progress and alert notes for R2, showed there was no documentation about the black stools for 11/04/2022 or 11/06/2022 through 11/16/2022.

Record review of the resident alert notes for R2, dated 11/03/2022 through 11/16/2022, showed there was no documentation that staff were observing the resident for any further black stools.

Resident 1
Record review of a face sheet for Resident 1 (R1) showed they moved into the facility on [redacted] 2019, with multiple medical diagnoses including [redacted] and [redacted], and [redacted].

Record review of R1's SA/assessment, dated 03/24/2022, showed that R1 needed full assistance with ADL's and transfers. Under the section titled, "transfers" showed R1 was unable to transfer herself independently. R1 got nervous with transfers and preferred two caregivers to be present to assist her. Under the section titled, "ambulation", showed R1 has a history of vertigo. Under the section titled, "eating", showed R1 had trouble clearing food at times in their throat and swallowing causing her to cough.

Record review of the document titled, "Assessment details history significant change", dated 11/07/2022, showed under the section titled "bed mobility", R1 needed extensive assistance (resident was involved but required cueing/supervision or partial assistance at all times) two-person physical assist. Under the section titled, "transfers" showed R1 needed extensive assistance, two-person physical assist. Under the section titled, "toilet use" showed R1 needed total dependence (full performance by others) and two-person physical assist. R1 had all toileting needs completed while in bed as R1 was too weak to use the toilet. Under the section titled, "dressing" showed R1 needed extensive assistance with two-person physical assist with dressing tasks.

Record review of R1's progress note, dated 10/21/2022, showed that R1 had a small choking issue with a cubed potato. They were able to clear the potato on their own, but they had a coughing fit that lasted 3 minutes. R1 was short of breath and wheezing afterwards so she was given their as needed albuterol (inhalant medication to help open the lungs).

Record review of R1's progress notes for R1, dated 10/22/2022 through 10/31/2022, showed there was not further alert charting related to the resident's choking episodes, physician notification, or any changes to the resident.

Record review of R1's alert charting, dated 10/21/2022 through 10/31/2022, showed there was no documentation on how R1 was after the choking episode on 10/21/2022.

Record review of R1's resident progress note, dated 12/03/2022, showed R1 had a controlled fall to the ground. Care staff tried to transfer resident. R1 had become extremely weak in the legs and was unable to help bear their own weight. Care staff called for medication aide for assistance. They were unable to get R1 up safely and was assisted to the floor. Medication aide called the medication aide from the memory care unit to assist care staff and assisted living medication aide to stand the resident up and transfer R1 back to their bed with the one care staff and two medication technicians assistance. There was no documentation that showed R1 was monitored for any changes or latent injuries had occurred after the incident on 12/03/2022.

Resident 5
Record review of the face sheet for Resident 5 (R5) showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted] and [redacted].

Record review of the SA/assessment for R5, dated 02/03/2023, showed that R5 had a decline and was on hospice services. R5 was bed bound and no longer able to bear weight. Under the section titled, "toileting" showed that R5 needed complete care with toileting needs. R5 required to be cleaned and changed while in bed. Under the section titled, "medical Care Management, showed that R5 was admitted to hospice services on 01/23/2023, R5 had difficulty swallowing medications. Under the section titled, "transfers", showed that R5 was unable to walk. Under the section titled, "bed mobility" showed that R5 was unable to reposition self and needed repositioned three to four times per shift.

Record review of the document titled, "Client coordination note report", dated 01/26/2023, showed that R5 had an audible gurgle (irregular breathing with bubbling noise) when they were sleeping in bed. Representative for R5 declined the use of pain medication. R5's blood thinning medication was discontinued and R5 started new antibiotic for suspected urinary tract infection (urine infection). It showed that the R5's Representative was giving R5 supplements, essential oils, fed R5, and was getting R5 out of bed and into the w/c. There was no documentation after 01/26/2023 that showed R5 was monitored for any changes and irregular breathing that had occurred.

Record review of the document titled, "Client coordination note report", dated 01/31/2023, showed that R5 replied "yes" when the Hospice nurse had asked R5 if they

were in pain. R5 frowned when the hospice nurse touched their body. R5 was rated a 5 for pain level as they were in a fetal position and wouldn't move. The facility had collected a urine sample and sent out to the lab for testing per R5's Representative's request. There was no documentation after 01/31/2023 that showed R5 was monitored for any changes or pain that had occurred.

In an interview on 02/02/2023 at 12:40 PM, Staff V, Medication Aide, stated that R5 wasn't able to sit up by themselves. They stated that R5 has been refusing their medications, or if they accept the medication, R5 would hold the medication in between their cheek and gums. They stated that a lot of the times the medication would fall out of R5's mouth. Staff V stated that they had asked R5 if they were in pain and R5 would say "yes". Staff V stated that R5 will yell out in pain if they tried to get her up out of bed or even just turning and repositioning them.

In an interview on 02/02/2023 at 1:35 PM, Staff C, Resident Care Coordinator, stated that R5 was observed sitting up in the wheelchair. R5 was wincing, had facial grimacing, and moaning when they were up in the wheelchair. R5's Representative's friend was the one to transfer R5 in the wheelchair. They were told by the medication aide R5 was in pain and they refused to allow the facility to medicate the resident for their pain they were experiencing. Staff C stated that R5 was observed to be given a fruit smoothie by their Representative. There were times that R5 would cough when given the smoothie.

In an observation on 02/02/2023 at 2:12 PM with Staff W, Licensed Practical Nurse, R5 was observed while lying in bed. R5 was in a fetal position. Staff W lightly touched R5's outer calf. R5 immediately pulled their leg to their body, facial grimaced, and moaned lightly. R5's feet were mottling (red or purple marbled coloring that can indicate one is near end of life). Staff W stated R5's skin was cool to the touch.

Record review of R5's resident alert charting, dated 01/20/2023 through 02/02/2023, showed there was no documentation about R5's inability or difficulty with eating, drinking, or swallowing their medications. There was no documentation of R5 screaming, yelling, moaning, or grimacing in pain when the staff turned, touched, and repositioned R5. There was no documentation that R5 was unable to get up out of bed due to being weak. There was no documentation that R5 was incontinent of bowel and bladder and needed staff to complete total care for them. There was no documentation about communication with R5's Representative about the need to start pain medication and the Representative refusing to allow the facility to medicate R5 for pain. There was no documentation that the urine sample was collected or that the hospice team was notified of the request. There was no documentation that hospice had been notified about all of the changes and concerns with R5 since they had returned back from the hospital on 01/20/2023.

In an interview on 01/13/2023 at 1:29 PM, Staff V, stated that they placed residents on alert charting for new medications, new admit to the facility, any falls, any injuries, new wounds, change in behavior, or any new changes at all. They were to chart on the residents each shift, until they were taken off alert charting.

In an interview on 01/13/2023 at 2:10 PM, Staff J, Resident Care Coordinator, stated that new alert charting was completed for all residents that have new medications for three days. If a resident was a new or a readmission to the facility, they would be on alert charting for 14 days. Staff J stated that all medication technicians were to chart on the resident every shift for any changes.

This is a recurring deficiency previously cited on 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) 03/23/2023

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

Administrator (or Representative) — Date 02/28/23

Easthaven Villa
Assisted Living & Memory Care Community
311 Cullens Street NW
Yelm, WA 98597

Plan of Correction

Statement of Deficiencies Report Dated February 7, 2023

Deficiency	Actions	Responsible Person(s)	Due Date	Completed Date
WAC 388-78A-2610 (1) (2) (d) Infection Control	(1) Staff will be retrained on infection control precautions, and Infection control protocol This training is part of our new hire onboarding and will be retrained no less than once quarterly.	Admin, Business Office (Onboarding), [redacted] LPN	3/28/23	
	(2) (D) All staff are trained during onboarding, and will be retrained no less than quarterly regarding proper PPE usage. N95 fit testing and med evals will be completed during new hire orientation, and retrained no less than each year prior to the expiration date.	Business Office (Onboarding), Admin, RCC's	3/28/23	

WAC 388-78A-2120(3)(b) Monitoring residents' well-being	Education with Med Aides to review Alert Charting Protocol, importance of placing on alert when appropriate.	[redacted]LPN[redacted]RCC, [redacted]RCC	3/28/23
	Post reporting requirements for change of condition, who to call, when to call.	LPN, RCCs	3/28/23
	RCC to review Alerts each day to add specific info applying to resident and extend alert out to tell whole story.	[redacted]RCC[redacted]RCC Lead Med Aide	3/28/23
	RCC training to identify priority daily tasks	[redacted]RN	3/28/23
	Nurse to assess and document wound /skin assessments weekly during healing process of wound	[redacted]LPN	3/28/23
	New admissions to be placed on alert monitoring for 14 days. RCC to double check all new admissions are placed on alert for required time frame.	[redacted]RCC[redacted]RCC, Lead Med aide	3/28/23
	Mandatory Reporting education with med aides and caregivers, training on completing online reports, phone reporting.	Admin,[redacted]RCC, [redacted]RCC	3/28/23

	RCC to end each alert with note telling why Resident was on alert, what actions taken and why alert no longer needed.	[redacted]RCC/[redacted]RCC	3/28/23
	Daily Staff huddles at designated times to discuss issues with Residents.	Lead Med Aide, Caregivers, Activities Director, RCC	3/28/23
	Develop and Implement Lead Med Aide Position to assist with daily task completion and supervision. Assist RCC in management of care concerns, change of conditions, referrals, appointments etc.	[redacted]RCC/[redacted]RCC Administrator, Lead Med Aide	3/28/23
WAC 388-78A-2450 Staff	(1) (a)Staffing was corrected to and extra care giver added to schedule in AL on 1/21/23. Going forward, the community will ensure they have sufficient trained staff based off of the acuity level of residents needs in community. The community will utilize agency staff as needed to fill in gaps in this staffing model.	RCC's, Admin	3/28/23