STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Sunrise Senior Living Management Inc
SUNRISE OF BELLEVUE
15928 NE 8TH ST
BELLEVUE, WA 98008

RE: SUNRISE OF BELLEVUE License # 2163

Dear Administrator:

This letter addresses Compliance Determination(s) 35279 (Completion Date 01/17/2024) and 32129 (Completion Date 11/29/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/17/2024 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-2380-3, WAC 388-78A-2620-2-b, WAC 388-78A-2620-2-a, WAC 388-78A-3090-1-d, WAC 388-78A-3090-2-c-iv, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2466-1, WAC 388-78A-2371-1, WAC 388-78A-2371-2

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: SUNRISE OF BELLEVUE **Provider Type:** Assisted Living Facility
License/Cert.#: 2163
Compliance Determination #: 32129 **Intake ID:** 104269
Investigator: Thomas Forkgen **Region/Unit #:** RCS Region 2 / Unit D
Investigation Date(s): 11/06/2023 through 11/29/2023
Complainant Contact Date(s):

Allegation(s):
Resident to resident altercation. Named Resident 2 knocked down Named Resident 1 which resulted in Named Resident 1 requiring outside treatment in the emergency department.

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 9 Closed records sample size: 1
Observations:	Observed resident in the secured memory care. Observed Alleged perpetrator and Alleged Victim. Observed staff interaction with residents and the monitoring of residents.
Interviews:	Interviewed administrative staff, care staff, licensed nurses and Alleged perpetrator, Alleged victim's representatives. Interviewed additional Alleged victims representatives.
Record Reviews:	Reviewed facility policies, Alleged perpetrator's medical records and Alleged victim's and other Alleged victims medical records. reviewed incident reports and documentation of Alleged perpetrator's behaviors and the service plan.

Investigation Summary:
Facility failed to investigate one incident that occurred between the Named Resident 2 and Named Resident 1. Facility staff witnessed Named Resident 2 physically attack Named Resident 1 who was wheelchair bound. The facility staff who witnessed the incident provided a written statement. The facility administrative staff failed to investigate the incident, protect the memory care residents from further incidents from Named Resident 2 and assess and monitor the wellbeing of the Named Resident 1. Citation issued.

Conclusion / Action:

- [x] 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
20425 72nd Avenue S, Suite 400, Kent, WA 98032

12/13/2023

Sunrise Senior Living Management Inc
SUNRISE OF BELLEVUE
15928 NE 8TH ST
BELLEVUE, WA 98008

RE: SUNRISE OF BELLEVUE # 2163

Dear Administrator:

This document references the following complaint numbers 104269.

The Department completed a full inspection of your Assisted Living Facility on 11/29/2023 and found that your facility does not meet the Assisted Living Facility requirements.

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

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

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

Laurie Anderson, Field Manager
Residential Care Services

Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

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

WAC 388-78A-2680 Electronic monitoring equipment Audio monitoring and video monitoring.

(2) The assisted living facility may video monitor and video record activities in the facility or on the premises, without an audio component, only in the following areas:

(a) Entrances, exits, and elevators as long as the cameras are:

(i) Focused only on the entrance or exit doorways; and

(ii) Not focused on areas where residents gather.

The facility's entrance camera captured a common area with rocking chairs where residents may gather. During the full inspection the facility moved the rocking chairs until they could take measures to obscure the view.

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

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

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

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services

PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 11/06/2023, 11/06/2023, 11/09/2023 and 11/09/2023 of:

SUNRISE OF BELLEVUE
15928 NE 8TH ST
BELLEVUE, WA 98008

This document references the following complaint numbers: 104269.

The following sample was selected for review during the unannounced on-site visit: 9 of 60 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor
Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Laurie Anderson — Residential Care Services

12/13/2023 — 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)

12/18/23 — Date

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to inform visitors how to exit from the secured memory care unit. This failure placed visitors with insufficient information to leave the secured unit without assistance.

Findings included...

Observations of the memory care unit during the full inspection between 11/06/2023 and 11/09/2023 from 9:25 AM – 12:01 PM, showed the unit had 4 exits with 2 elevators and 2 staircases. Each exit used a coded box for access from the unit. Observation showed that none of the exits provided instructions about how to exit the unit.

During an interview on 11/06/2023, Staff Q, Maintenance Coordinator, stated that there was no system to inform visitors how to exit. Staff Q stated that visitors asked the staff for assistance to exit.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 11/9/23.

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

Administrator (or Representative) — Date: 12/18/23

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 resident and facility pets received regular examinations and were veterinarian certified to be free of diseases transmittable to humans. This failure placed all residents at risk of contracting illnesses from animals of unknown health status.

Findings included...

Record review of the facility's policy titled, "Pets", revised on 05/20/2021, showed that pets within the facility needed regular examinations and immunizations by a veterinarian licensed in Washington state. The policy showed the pet records needed to include documentation by a veterinarian certifying the pets were free of diseases transmittable to humans. The documentation showed that the pet records were maintained at the facility.

Observations on 11/07/2023 at 8:00 AM, 11/08/2023 at 11:10 AM, showed a pets within the common areas of the facility. Observation on 11/09/2023 at 10:40 AM, showed there were pets that resided in resident apartments.

Record review of facility's pet records showed that 4 of 6 sampled pets (Pet 1, Pet 2, Pet 3, & Pet 4) had incomplete veterinarian records.

PET 1
Review of Pet 1's veterinary records, dated 10/31/2023, showed there was no documentation that Pet 1 was certified by a veterinarian to be free of diseases transmittable to humans. There was no documentation of a completed regular veterinarian examination.

PET 2
Review of Pet 2's veterinary records, dated 11/06/2023, showed there was no

documentation that Pet 2 was certified by a veterinarian to be free of diseases transmittable to humans. There was no documentation of a completed regular veterinarian examination.

PET 3
Record review of Pet 3's veterinary records, dated 07/22/2023, showed there was no documentation that Pet 3 was certified by a veterinarian to be free of diseases transmittable to humans. There was no documentation of a completed regular veterinarian examination.

PET 4
Record review of Pet 4's veterinary records, dated 05/30/2023, showed there was no documentation that Pet 4 was certified by a veterinarian to be free of diseases transmittable to humans. There was no documentation of a completed regular veterinarian examination.

During an interview on 11/06/2023 at 1:30 PM, Staff O, Activities and Volunteer Coordinator, acknowledged that they were responsible for ensuring all pets met the requirements to be in the facility. Staff O further stated that they were not aware pets within the facility had to complete regular examinations. During an interview on 11/07/2023 at 1:00 PM, Staff O stated that they were unaware that the facility had a pet policy.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 11/2/23 .

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

Administrator (or Representative) — Date: 12/18/23

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the air exchange vents within resident laundry rooms and wet mop closets functioned. This failure placed the residents at risk of breathing poor or unsafe air quality, which could trigger respiratory issues and health problems.

Findings included...

Observations on 11/06/2023 between 9:25 AM and 12:20 PM during the environmental tour, showed the following air exchange vents were not functioning: third floor resident laundry room, second floor resident laundry room, and second floor janitor closet with wet mop sink.

During interviews on 11/06/2023 between 9:25 AM and 12:20 PM, Staff O stated that they were aware some fans needed to be replaced. Staff O stated that they routinely checked the fans. Staff O stated that they did not log the air exchange vent checks. Staff O stated that the three fans observed were not properly functioning to provide adequate ventilation.

Review of the facility's service call record from a heating, ventilation, and air conditioning (HVAC) company service call, dated 11/10/2023, documented the second-floor resident laundry room, second floor janitor closet, and third floor resident laundry room air exchange vents did not function.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 12/14/23 .

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

Administrator (or Representative) — Date: 12/18/23

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State name and date of birth background check (BGI) for every two years for 1 of 9 sampled staff (Staff A) every two years. This failure placed all residents at risk of abuse, neglect, or exploitation from caregivers with unknown backgrounds.

Findings included...

Review of the facility's employee roster showed the facility hired Staff A on 10/15/2021. Review of the records showed that Staff A's initial Washington state name and date of birth BGI expired on 10/14/2023. The records showed that on 11/06/2023, the facility completed a new BGI, 22 days after the initial BGI expired.

During an interview on 11/07/2023 at 3:12 PM, Staff R, Business Office Coordinator, stated that they were responsible for conducting the background checks and fingerprint checks for all employees. Staff R stated that they were aware Staff A's initial BGI expired and was due for renewal. Staff A stated when they realized Staff A's BGI expired, they immediately processed a new BGI.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 11/9/23 .

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

Administrator (or Representative) — Date: 12/18/23

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to investigate resident to resident altercation between 2 of 2 residents (Resident 7 and Resident 10). This failure placed the other 19 memory care unit residents at risk for additional harm and potential abuse and neglect.

Findings included...

Review of the facility undated policy titled "Incident and Event Reporting" showed that it was the facility's policy to ensure all team members promptly and accurately report and documented incidents to promote early intervention, improve quality of care for residents, and improve the safety for the residents. The policy showed that the Executive Director was responsible for ensuring events were documented. The policy showed that the resident(s) physician/health care provider and resident(s) responsible party would be notified of event/incident, and state/federal/provincial would be notified. The Resident Care Director or designee was responsible to review the report for accuracy, clarity, and completeness. The Resident Care Director or designee was responsible to verify that the responsible party and health care provider was notified. The policy showed that it was the responsibility of the Resident Care Director/Executive Director/designee to investigate the cause and facts of the incident.

Review of the facility's Resident Characteristic Roster showed that 21 residents resided in the facility's secured Memory Care Unit (Reminiscence unit).

RESIDENT 7
Review of Resident 7's facility notes, from August 2023 through November 07, 2023, showed a pattern of aggressive physical behavior towards residents and staff. On 08/04/2023 at 1:30 PM, Staff S, Care Manager, and former employee, heard Resident 10 yelling. Staff S observed Resident 7 violently pushing Resident 10's wheelchair into an office while hitting Resident 10 on the head with their hand. When Staff S attempted to remove Resident 7, Resident 7 started hitting Staff S. Staff S called for other staff to assist.

Review of the facility records found no records of an investigation for the 08/04/2023 incident. There was no documentation in Resident 10's records that showed staff evaluated Resident 10 for injuries and psychological harm from the incident. Review of the records showed the facility did not monitor Resident 10 after the incident.

Review of a summary report written by Staff Y, Resident Care Director, Registered Nurse, showed that an unidentified nurse documented a late entry of a written statement by an unidentified staff member who witnessed the incident. The report showed that the nurse who documented the incident in Resident 7's record did not verify the staff member's written statement. The summary showed that the staff member was no longer employed by the facility. The summary showed that the nurse who documented the incident did not contact the physician or notify the responsible parties of Resident 7 and Resident 10 about the incident.

Review of Resident 10's records showed no evidence that the facility assessed Resident 10 for injuries and monitored Resident 10 for potential psychological trauma from the incident. Review of Resident 10's records showed no documentation that Resident 10's family or responsible party were notified and made aware of the incident.

The Department Licensor was unable to observe or interview Resident 10. Resident 10 passed away in the hospital in [redacted] of 2023.

During an interview on 11/08/2023 at 3:35 PM, Staff Y stated that they were unable to substantiate abuse or neglect regarding the 08/04/2023 incident. Staff Y stated that since the staff member who wrote the witness statement was no longer employed by the facility, Staff Y was unable to obtain clarity of the incident. Staff Y stated that Resident 7 had a history of aggressive behavior. Staff Y stated that the facility worked with the family to relocate Resident 7 to an environment that would better meet their needs.

During an interview on 11/17/2023 at 2:14 PM, Staff V, Registered Nurse, Wellness Nurse, stated that they worked the morning of 08/04/2023. Staff V stated they were unaware of the incident that occurred between Resident 7 and Resident 10. Staff V stated that no one reported to them that a resident-to-resident altercation took place. Staff V stated that an investigation was not completed since they had no knowledge of the incident.

During an interview on 11/15/2023 at 3:35 PM, Staff W, Registered Nurse, Wellness Nurse, stated they worked in the Assisted Living side (non-memory care) the evening of 08/04/2023. Staff W stated they did not know anything about the incident. Staff W stated the incident was not reported to them. Staff W stated that an investigation was not completed since they were not provided knowledge of the incident.

During an interview on 11/15/2023 10:02 AM, Staff T, Wellness Nurse, stated that they were not on duty and did not work on 08/04/2023. Staff T stated that 08/06/2023 was their first day back to work. Staff T stated that when they returned to work, they discovered the witness statement written by Staff S. Staff T stated that they spoke with Staff Z, Reminiscence Coordinator, about the statement and then documented the statement in Resident 7's records. Staff Z stated they faxed Resident 7's physician about the incident. Staff T stated they did not verify the witness statement with Staff S because they worked opposite shifts. Staff T stated that they did not speak with Staff Y about the incident.

During an interview on 11/15/2023 at 9:02 AM, Staff S, stated that they were in the activity room when they heard yelling. Staff S stated they rushed to the activity room and witnessed Resident 7 "violently pushing" Resident 10's wheelchair with Resident 10 in it. Staff S stated that as Resident 7 pushed the wheelchair around, Resident 7 was hitting Resident 10 on the head. Staff S stated that Resident 10 was yelling. Staff S stated that when they tried to intervene, Resident 7 started hitting them as well. Staff S stated they called out for help and two other staff members responded. Staff moved Resident 7 away from Resident 10. Staff S stated that Staff Y never asked them about the incident. Staff S confirmed that their last day of employment at the facility was on 09/25/2023, 53 days after the incident occurred.

During an interview on 11/29/2023 at 3:57 PM, Collateral Contact (CC 2), Resident 10's representative, stated that the facility never informed them of the incident that occurred on 08/04/2023 between Resident 10 and Resident 7.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 12/14/23 .

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

Administrator (or Representative) — Date: 12/18/23