



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**1200 Alder Street, Union Gap, WA 98903**

Highgate Wenatchee LP  
HIGHGATE SENIOR LIVING  
1320 S MILLER ST  
WENATCHEE, WA 98801

RE: HIGHGATE SENIOR LIVING License # 2225

Dear Administrator:

This letter addresses Compliance Determination(s) 29473 (Completion Date 09/18/2023) and 26803 (Completion Date 07/21/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/18/2023 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-2480-1

The Department staff who did the off-site verification:  
Robin Rainville, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

*Gwin Kaercher*

Gwin Kaercher, Field Manager  
Region 1, Unit G  
Residential Care Services



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
1200 Alder Street, Union Gap, WA 98903

|                           |                                 |                                  |
|---------------------------|---------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2225                 | Compliance Determination # 26803 |
| Plan of Correction        | HIGHGATE SENIOR LIVING          | Completion Date                  |
| Page 1 of 3               | Licensee: Highgate Wenatchee LP | 07/21/2023                       |

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 follow-up on 07/19/2023 and 07/20/2023 of:

HIGHGATE SENIOR LIVING  
1320 S MILLER ST  
WENATCHEE, WA 98801

This document references the following SOD dated: 07/21/2023

The following sample was selected for review during the unannounced on-site visit: 5 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor  
Elaine Lopez, Licensor  
Robin Rainville, Assisted Living Facility Licensor

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 1, Unit G  
1200 Alder Street  
Union Gap, WA 98903

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.

*Twinn Kaercher*  
Residential Care Services

08/01/2023  
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.



|                           |                                 |                                  |
|---------------------------|---------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2225                 | Compliance Determination # 26803 |
| Plan of Correction        | HIGHGATE SENIOR LIVING          | Completion Date                  |
| Page 2 of 3               | Licensee: Highgate Wenatchee LP | 07/21/2023                       |

  
Administrator (or Representative)

8/8/23  
Date

**WAC 388-78A-2480 Tuberculosis Testing Required.**

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure screening for tuberculosis (TB) was completed within three days of hire for 2 of 2 Staff (C, E) who were hired since the last full inspection. This failure placed residents at risk of potential exposure to a communicable disease.

**Findings included...**

Review of a written plan of correction to the last full inspection, signed by Staff A, Administrator, on 05/31/2023 showed that Staff I, Community Resource Manager would check the staff records tracking matrix system weekly for compliance with TB test requirements.

Staff records were reviewed with Staff I on 07/19/2023 at 12:10 PM. Staff A stated that they were responsible for tracking employee hiring and training requirements. Staff I also stated that they had added TB testing to their staff records tracking matrix after the last full inspection.

- Staff C, Clinical Assistant, was hired 06/21/2023. Staff C's file showed a TB first step test was completed on 06/26/2023, 5 days after they were hired.
- Staff E, Resident Care Coordinator, was hired on 07/06/2023. Staff E's file showed a TB first step completed on 07/10/2023, 4 days after they were hired.

On 07/19/2023 at 12:54 PM, Staff I stated that they did not know why the TB tests were done late for Staff C and E other than staff noncompliance.

This is a recurring deficiency previously cited on 05/10/2023.

**Plan/Attestation Statement**

|                           |                                 |                                  |
|---------------------------|---------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2225                 | Compliance Determination # 26803 |
| Plan of Correction        | HIGHGATE SENIOR LIVING          | Completion Date                  |
| Page 3 of 3               | Licensee: Highgate Wenatchee LP | 07/21/2023                       |

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 8/21/23.

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

  
Administrator (or Representative)

8/8/23  
Date



## Residential Care Services Investigation Summary Report

**Provider/Facility:** HIGHGATE SENIOR LIVING

**License/Cert.#:** 2225

**Compliance Determination #:** 23588

**Investigator:** Robin Rainville

**Investigation Date(s):** 05/01/2023 through 05/10/2023

**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 79354

**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

A named resident exhibited behavior changes and refused care after a named staff member began providing personal care to them.

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### Investigation Methods:

|                        |                                                                                                                                                                                                                        |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 52<br>Resident sample size: 7<br>Closed records sample size: 0                                                                                                                                        |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident rooms<br>Staff to resident interactions                                                                                                           |
| <b>Interviews:</b>     | Identified resident<br>Residents<br>Nursing staff<br>Family members<br>Administrative Staff<br>Former staff                                                                                                            |
| <b>Record Reviews:</b> | Facility resident characteristic roster<br>Medical records (care plans, progress notes, assessments etc)<br>Incident investigation<br>Facility policies<br>Personnel files<br>Staff training records<br>Staff patterns |

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### Investigation Summary:

Interview and record review showed that the named resident began refusing personal care including toileting, and covered their genital area and said no repeatedly. The resident became more withdrawn, sleeping more and eating less, The behaviors were noted to be new and started when the named staff member was assigned to the named

resident's floor to provide care on the night shift. The Assisted Living Facility (ALF) investigated the incident and suspended the named staff member. The ALF assessed and monitored the named resident. The named resident's behaviors improved and they went back to their baseline. The ALF failed to immediately report to the department and local law enforcement when suspected sexual abuse was alleged. Failed practice identified under WAC 388-78A- 2630 (1a,b) on the Statement of Deficiencies dated 05/10/2023.

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**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  
**1200 Alder Street, Union Gap, WA 98903**

05/23/2023

**CERTIFIED MAIL**

7022 0410 001 0687 4592

Highgate Wenatchee LP  
HIGHGATE SENIOR LIVING  
1320 S MILLER ST  
WENATCHEE, WA 98801

RE: HIGHGATE SENIOR LIVING # 2225

Dear Administrator:

This document references the following complaint numbers 79354.

The Department completed a full inspection of your Assisted Living Facility on 05/10/2023 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:

Gwin Kaercher, Field Manager  
Residential Care Services

Region 1, Unit G  
1200 Alder Street  
Union Gap, WA 98903

- 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 388-112A-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.

The Assisted Living Facility failed to provide documentation of facility orientation training before staff had routine interactions with residents.

**WAC 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities? Adult family homes.**

(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training.

The Assisted Living Facility failed to provide dementia and mental health specialty trainings for staff within one hundred and twenty days of hire as required .

**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:**

HIGHGATE SENIOR LIVING # 2225

05/10/2023

Page 3 of 3

- 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 (509)208-5231.

Sincerely,



Gwin Kaercher, Field Manager  
Region 1, Unit G  
Residential Care Services

Enclosure



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
1200 Alder Street, Union Gap, WA 98903



|                           |                                 |                                  |
|---------------------------|---------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2225                 | Compliance Determination # 23588 |
| Plan of Correction        | HIGHGATE SENIOR LIVING          | Completion Date                  |
| Page 4 of 33              | Licensee: Highgate Wenatchee LP | 05/10/2023                       |

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 the unannounced on-site full inspection and complaint investigation on 05/01/2023, 05/02/2023, 05/03/2023, 05/04/2023 and 05/05/2023 of:

HIGHGATE SENIOR LIVING  
1320 S MILLER ST  
WENATCHEE, WA 98801

This document references the following complaint numbers: 79354.

The following sample was selected for review during the unannounced on-site visit: 7 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Robin Rainville, Assisted Living Facility Licensors  
Tracy Ramirez, Assisted Living Facility Licensors  
Elaine Lopez, Licensors  
Anna Cairns, ALF Long Term Care Surveyor

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 1, Unit G  
1200 Alder Street  
Union Gap, WA 98903

*Take w/ AED  
Briete 6/6/2023  
850 am. OK to  
change BLC date to 06/24/23  
They made an error in  
calculating dates  
Mainline  
6/6/23*

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.

*Gwin Kaercher*  
Residential Care Services

05/23/2023

Date

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



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)

5/31/23  
Date

**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;
  - (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:
    - (a) History of substance abuse;
    - (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.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete assessments of the ability to leave the facility for 7 of 7 Residents (1, 2, 3, 4, 5, 6, 7), ability to safely understand and use a medical device for 2 of 2 Residents (1, 5), ability to perform their self-medication for 1 of 1 Resident (7), failed to include resident's diagnosis for 1 of 7 Residents (3), and failed to complete an assessment within 14 days of move-in for 1 of 1 Resident (1). This failed practice placed the residents at risk of unassessed needs and potential harm.

Findings included...

Assessment of the ability to leave the facility:

Record review of residents' assessments showed that for Residents 1, 2, 3, 4, 5, 6, and 7 the facility had not assessed their individual ability to leave the facility unsupervised.

On 05/02/2023 at 10:50 AM, Staff H, Assistant Executive Director, stated that the facility did not have assessments for Resident 1, 2, 3, 4, 5, 6, and 7's ability to leave the facility unsupervised.

Assessment for a medical device:

#### Resident 1

On 05/02/2023 at 10:21 AM, Resident 1 was observed in their apartment, being assisted out of bed by a caregiver. A floor to ceiling transfer pole (used to provide support during a transfer in and out of bed) was observed next to the resident's bed.

Record review of Resident 1's 03/23/2023 facility assessment showed that the resident had a transfer pole. Resident 1's record did not include an assessment for their ability to safely use the transfer pole.

On 05/02/2023 at 4:05 PM, Staff H stated that there was not an assessment completed for Resident 1's use of the transfer pole.

#### Resident 3

Record review of Resident 3's demographic page dated 07/01/2021 showed they had diagnoses which included [REDACTED] and [REDACTED].

Record review of Resident 3's assessment did not include the resident's diagnoses.

In an interview on 05/10/2023 at 11:01 AM, Staff H stated that diagnoses were included in assessments. Staff H stated that the ALF had a high turnover with nurses; they had also been completing assessments on their own, and it was a learning curve.

#### Resident 5

Observation on 05/03/2023 at 9:12 AM, showed Resident 5's bed to have a bedrail attached to the side.

Record review of the facility's assessment dated 01/15/2023 showed that Resident 5 had a side rail on their bed.



On 05/04/2023 at 8:23 AM, Staff H stated that there was not an assessment completed for Resident 5's ability to safely use the bedrail.

Assessment for self-medication:

Resident 7

On 05/02/2023 at 2:30 PM, Resident 7 stated that they were independent with their medication.

Record review showed Resident 7's record did not have a self-medication assessment.

On 05/04/2023 at 11:05 AM, Staff H, stated that Resident 7's self-medication assessment had not been completed.

Assessment within 14 days of move-in:

Resident 1

Review of the characteristic roster provided by Staff A, Executive Director, showed that Resident 1 moved into the ALF on [REDACTED]/2022.

Resident 1's record included a pre-admission assessment dated 11/16/2022. Resident 1's record showed that another assessment was not completed for the resident until 03/23/2023.

Record review for Resident 1 showed the facility did not complete a full assessment that included all of the required topics within 14 days of moving into the ALF.

On 05/02/2023 at 4:05 PM, Staff H stated that a 14-day full assessment was not completed on Resident 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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23  
6/24/23

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

Jan A. [Signature]  
Administrator (or Representative)

5/31/23

Date

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

- (1) The care and services necessary to meet the resident's needs, including:
  - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
    - (ii) The resident's full assessments;
    - (iii) On-going assessments of the resident;
  - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
  - (a) Exclusively for the individual resident; or
- (5) Appropriate behavioral interventions, if needed;

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 7 Residents (1, 3, 5) Negotiated Service Agreements (NSA) contained necessary content to meet residents' needs. This failed practice placed residents at risk of not receiving appropriate care and services.

Findings included...

#### Resident 1

Resident 1's 03/23/2023 full assessment showed that the resident was on Hospice (end of life comfort care provided by an outside agency), had a cardiac pacemaker (an implanted device that regulates the heart and requires monitoring), and had a transfer pole (used to provide support during a transfer in and out of bed) at their bedside.

Review of 03/04/2023- 04/24/2023, progress notes in Resident 1's record, written by Staff L, Registered Nurse (RN) and former Healthcare Director, showed that the resident was on Hospice. The progress notes showed that Hospice was treating an ongoing skin concern and wound to the resident's buttocks. The notes indicated that care staff were to turn and reposition the resident every two hours.

Resident 1 was observed in their apartment on 05/02/2023 at 9:52 AM, being transferred from their bed to the wheelchair by a caregiver without the use of the transfer pole. The caregiver confirmed that Resident 1 had a wound on their buttocks that was getting better.

Resident 1's 03/23/2023 NSA showed that they had Hospice services, however the NSA did not identify what role Hospice had in Resident 1's care. The NSA did not include any information about Resident 1's pacemaker, how it was monitored, or who was responsible to manage it. The NSA did not identify that Resident 1 had or used a transfer pole at the bedside.

Additionally, Resident 1's NSA did not include information or direction for the staff regarding the resident's wound, including what to monitor for and report, who was to treat the wound, and that the resident required repositioning assistance every two hours.

#### Resident 3

Record review of Resident 3's full assessment dated 12/28/2022 showed the resident had physical, sexual, and verbal behaviors that were assessed.

Record review of Resident 3's NSA dated 12/28/2022 did not include any behaviors and/or



interventions for behaviors from their assessment.

On 05/10/2023 at 11:01 AM, Staff H, Assistant Executive Director, stated that they had been completing NSAs on their own, and it was a "learning curve."

#### Resident 5

Record review of Resident 5's assessment dated 01/15/2023 showed the resident had socially inappropriate/disruptive behaviors assessed.

Record review of Resident 5's NSA dated 01/15/2023 did not include any behaviors and/or interventions for behaviors from their assessment.

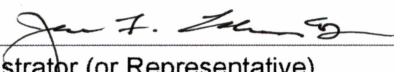
On 05/04/2023 at 8:45 AM, Staff H stated that they did not have an updated NSA with Resident 5's behaviors and/or interventions for staff to follow.

#### 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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23

6/24/2023

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

  
Administrator (or Representative)

5/31/23  
Date

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

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:



(i) Available to and used by staff persons responsible for food preparation;

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 1 dietary manual was approved by a registered dietitian within the last five years and was available for staff responsible for food preparation to follow and use. The ALF also failed to ensure 2 of 2 Residents (1, 5), received their prescribed diets. This failed practice placed residents at risk for not having their prescribed diets and nutritional needs met.

**Findings included...**

**Kitchen Observation:**

On 05/02/2023 at 10:19 AM, during the food service observation, there was no dietary manual available on-site for staff to use and follow. Observation of the kitchen board that posted the dietary needs for staff to follow, did not show updated prescribed diets for Resident 1 and 5.

On 05/02/2023 at 11:24 AM, Staff A, Executive Director, confirmed that there was no dietary manual, signed by a dietitian within the last five years, on-site.

**Resident 1**

Resident 1's 03/23/2023 Negotiated Service Agreement (NSA) showed that the resident required mechanical soft diet and nectar thickened liquids.

Observation of the kitchen showed they did not have directive or instructions for staff on how to prepare mechanical soft diets and thicken liquids.

On 05/04/2023 at 1:52 PM interview with Staff L, Dining Services Supervisor, stated that for prescribed diets that required thickened liquids, their staff did not have directions to follow to thicken all liquids consistently. Staff L stated there was no dietary manual that was used by staff to follow prescribed diets.

**Resident 5**

Record review of Resident 5's NSA dated 01/15/2023 showed that they had a diet order for no concentrated sweets.

Record review of Resident 5's progress note dated 03/15/2023, written by Staff L, Registered Nurse (RN), former Health Care Director, showed an order of a 2,000 milligram (mg) sodium diet when Resident 5 returned from the hospital.

During the food service observation in the kitchen on 05/02/2023 at 10:19 AM, Resident 5's special diet card did not include a no concentrated sweets and/or a 2,000 mg sodium diet.

On 05/04/2023 at 1:58 PM, Staff H, Assistant Executive Director, stated that Resident 5's prescribed diets were not provided to the kitchen.

**Plan/Attestation Statement**

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23

6/24/2023

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

Jan F. [Signature]  
Administrator (or Representative)

5/31/23  
Date

**WAC 246-215-04555 Equipment Mechanical warewashing equipment, hot water sanitization temperatures (FDA Food Code 4-501.112).**

(1) Except as specified in subsection (2) of this section, in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 194 F (90 C) or less than:

(b) For all other machines, 180 F (82 C).

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the concentration of the dishwasher's sanitizing solution was accurate for 2 of 3 dishwashers in the facility. This failed practice placed residents at risk of exposure to food borne illnesses.

**Findings included...**

On 05/02/2023 at 11:55 AM, Staff K, Caregiver, stated that they did not know how to monitor sanitization for the Memory Care Unit (MCU) dishwasher. Staff K stated that they would check that the soap was in good supply.

During observations on 05/04/2023 at 1:36 PM Staff L, Dining Services Supervisor, was requested to run the dishwasher in the main activity room in the Assisted Living (AL) facility. Staff L stated that the dishwashers used high temperature for sanitization. The observation showed that the dishwasher temperature was 109 degrees Fahrenheit, and the dishwasher showed a low temperature warning. Staff L used a test strip that fell off the dishware in the dishwasher. Chemical or temperature sanitization could not be determined using either method.

Staff L acknowledged the facility had not been using a monitoring system for chemical concentrations or temperatures for sanitizing resident dishware.

On 5/04/2023 at 1:42 PM Staff L was requested by the licenser to run the dishwasher in the MCU. Staff L was observed to run the dishwasher using a test strip. The observation showed that the temperature gauge window was broken and not showing a temperature. Chemical or temperature sanitization could not be determined using either method. Staff L stated they did not have a tracking system for the MCU.

On 05/04/2023 at 2:22 PM, the licensors notified Staff A, Executive Director was informed, that two of the three dishwashers in the facility were not meeting the required sanitization concentration or temperature to prevent food borne illnesses to residents. Staff A stated that they would direct staff to stop using both dishwashers, and that the main kitchen dishwasher would be used to wash and sanitize all dishware. Staff A also stated that an outside vendor would be called for repair, and signs would be placed on both dishwashers, to not be used.

On 05/04/2023 at 1:27 PM, Staff H, Assistant Executive Director, stated there was no dishwasher log or process for monitoring proper sanitization of the AL's and MCU's activity room dishwasher.

#### 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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23

6/24/2023

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

  
Administrator (or Representative)

5/31/23  
Date



**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 interview and record review, the Assisted Living Facility (ALF) failed to ensure a valid Washington State name and date of birth background check was submitted every two years for 3 of 3 Staff (A, E, F) who had worked in the ALF for more than two years. This failure placed residents at risk of being cared for by disqualified staff.

Findings included...

Staff records were reviewed with Staff I, Community Resource Manager (CRM), on 05/03/2022 at 11:02 AM.

- The file for Staff A, Executive Director, showed that they had been hired on 04/06/2018. Their file included a Washington State name and date of birth background check result dated 02/07/2020. Their file included a subsequent background check result dated 04/15/2022, two years and 68 days later. Staff A's file did not show that a Washington State name and date of birth background check result was maintained every two years as required.
- The file for Staff E, Caregiver, showed that they had been hired on 10/14/2014. Their file included a Washington State name and date of birth background check result dated 01/28/2019. Their file included a subsequent background check result dated 07/24/2021, two years and 176 days later. Staff E's file did not show that a Washington State name and date of birth background check result was maintained every two years as required.
- The file for Staff F, Caregiver, showed that they had been hired on 09/01/2016. Their file included a Washington State name and date of birth background check result dated 09/16/2020. Their file included a subsequent background check result dated 01/23/2023, two years and 127 days later. Staff F's file did not show that a Washington State name and date of birth background check result was maintained every two years as required.



At 12:50 PM, Staff I stated that a new background check request had not been submitted for Staff A, E, and F before they expired. Staff I stated that they were responsible for monitoring and submitting all background checks and would send each staff an update when they are due, but that the prior CRM didn't keep track of two-year due dates.

#### 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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

6/24/2023

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

Jan T. [Signature]  
Administrator (or Representative)

5/31/23

Date

**WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:**

(2) The results of the national fingerprint background check are pending.

#### This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a fingerprint background result was pending for 3 of 3 provisionally hired current Staff (B, C, D), and 1 of 1 provisionally hired former Staff (M), who had unsupervised access to the residents in the home. This failure placed residents at risk of being cared for by disqualified staff members.

#### Findings included...

Staff records were reviewed with Staff I, Community Resource Manager, on 05/03/2023 at 11:02 AM. Staff I stated that they were responsible for tracking and submitting background and fingerprint checks.

-Staff B, Caregiver, was hired on 01/03/2023. Their file showed a Washington state name and date of birth background check result dated 01/03/2023. Staff B's file did not include a national fingerprint background result.

Review of staff schedules for February 2023 through April 2023 showed that Staff B typically worked unsupervised as the day shift caregiver assigned to the 2nd floor of the main building but often filled in on other shifts and other areas.

-Staff C, Caregiver, was hired on 12/13/2022. Their file showed a Washington state name and date of birth background check result dated 12/15/2022. Staff C's file did not include a national fingerprint background result.

Review of staff schedules for February 2023 through April 2023 showed that Staff C typically worked unsupervised as the day shift caregiver assigned to float and helped on both floors of the main building.

-Staff D, Maintenance Manager, was hired on 04/04/2023. Their file showed a Washington state name and date of birth background check result dated 04/05/2023, which indicated a review was required. Staff D's file did not include a national fingerprint background result.

On 05/01/2023 at 4:07 PM, Staff M was observed to go into a resident's apartment unsupervised to attend to a request for maintenance.

-Staff M, former Caregiver, was hired on 02/10/2023 and employment ended on 04/17/2023. Their file showed a Washington state name and date of birth background check result dated 02/10/2023. Staff M's file did not include a national fingerprint background result.

Review of staff schedules for February 2023 through April 2023 showed that Staff M had worked unsupervised in the memory care unit and on the second floor of the main building.

On 05/03/2023 at 11:15 AM, Staff I stated that the fingerprint background check results for Staff B, C, D and M were not pending as an appointment to have fingerprints completed had not been scheduled. Staff I stated that they gave new staff the fingerprint scheduling information during orientation, but that they did not have a system to ensure new staff made the fingerprint appointments.

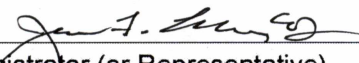
#### Plan/Attestation Statement

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6/24/2023

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



  
Administrator (or Representative)

5/31/23

Date

**WAC 246-980-030 Can a nonexempt long-term care worker work before obtaining certification as a home care aide?**

(1) A nonexempt long-term care worker may provide care before receiving certification as a home care aide if all the following conditions are met:

(b) The long-term care worker must submit an application for home care aide certification to the department within fourteen calendar days of hire. An application is considered to be submitted on the date it is post-marked or, for applications submitted in person or online, the date it is accepted by the department.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a Home Care Aide (HCA) application was sent to the department within 14 days of hire for 2 of 2 current Staff (B, C), and for 1 of 1 former Staff (M) who were not certified and had provided care to the residents in the home. This failure placed residents at risk of being cared for by unqualified staff and disallowed the department from the ability to track and monitor home care aide applicants.

**Findings included...**

Staff records were reviewed with Staff I, Community Resource Manager, and Staff H, Assistant Executive Director, on 05/03/2023 at 11:02 AM.

Review of staff records showed that Staff B, Caregiver, was hired on 01/03/2023. Staff B's file did not include documentation of their qualification as a long-term care worker, which included an HCA application.

Review of staff records showed that Staff C, Caregiver, was hired on 12/13/2022. Staff C's file did not include documentation of their qualification as a long-term care worker, which included an HCA application.

Review of staff records showed that Staff M, former Caregiver, was hired on 02/10/2023 and employment ended on 04/17/2023. Staff M's file did not include documentation of their qualification as a long-term care worker, which included an HCA application.

Record review of a training enrollment list provided by Staff H showed that the ALF had five

additional current staff members for whom the HCA application had not been submitted.

On 05/03/2023 at 11:25 AM, Staff H stated that they were responsible for ensuring staff's HCA applications were submitted and that training was completed as required. Staff H stated that they did not know the HCA application had to be done within 14 days of hire; they did not submit them until the staff completed all the training requirements. Staff H stated that HCA applications had not been submitted for Staff B, C, or M, or for other current HCA students.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

06/24/2023

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

  
Administrator (or Representative)

5/31/23

Date

**WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040 , that is the resident's primary special need.**

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that 4 of 4 Staff (A, B, E, F) completed the specialty training for developmental disabilities, when a resident with disabilities lived in the home. This failure placed the resident at risk of care from untrained staff.

**Findings included...**

During the entrance conference with Staff A, Executive Director, on 05/01/2023 at 11:40 AM, they stated that the ALF had one resident, Resident 8, who had developmental disabilities and lived in the home. Staff A stated that none of the facility staff had the developmental disability specialty training certificate because the resident did not need help from the staff.

Review of Resident 8's 04/08/2022 doctor's orders for their admission to the ALF showed



that the resident had a diagnosis of [REDACTED].

Resident 8 was observed in their apartment on 05/04/2023 at 10:20 AM. The resident was able to answer only yes and no questions due to their disability. A caregiver was observed to come into the room to make the residents bed and take out their garbage.

Staff records were reviewed with Staff I, Community Resource Manager, and Staff H, Assistant Executive Director, on 05/03/2023 at 11:02 AM.

- Staff A's file showed that they were hired on 04/06/2018 as the Executive Director. Staff A's file did not include documentation that they had completed the development disabilities specialty training.
- Staff B's file showed that they were hired on 01/03/2023 as a Caregiver. Staff B's file did not include documentation that they had completed the developmental disabilities specialty training.
- Staff E's file showed that they were hired on 10/14/2014 as a Caregiver. Staff E's file did not include documentation that they had completed the developmental disabilities specialty training.
- Staff F's file showed that they were hired on 09/01/2016 as a Caregiver. Staff F's file did not include documentation that they had completed the developmental disabilities specialty training.

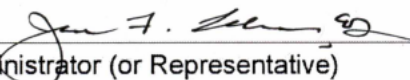
On 05/03/2023 at 11:26 AM, Staff H stated the ALF did not have a qualified trainer to provide the developmental disabilities training for all staff.

#### 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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

6/24/2023

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

  
Administrator (or Representative)

5/31/23  
Date

**WAC 388-112A-0720 What are the CPR and first-aid training requirements?**

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 2 Long Term Care Workers (LTCW) maintained their first aid and Cardiopulmonary Resuscitation (CPR) card. This failed practice placed residents at risk of not receiving emergency care if needed.

**Findings included...**

On 05/03/2023 at 11:03 AM staff record review was completed with Staff I, Community Resource Manager.

-Staff B's business file documented they were hired at the ALF on 01/03/2023 as a Caregiver. Staff B's file did not include a first aid and CPR card.

-Staff C's business file documented she was hired at the ALF on 12/13/2022 as a Caregiver. Staff C's file did not include a first aid and CPR card.

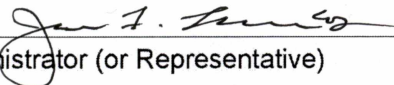
During staff record review Staff I stated that the previous Community Resource Manager had not kept records up to date. Staff I stated that they had completed a staff record audit in August of 2022.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

6/24/2023

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

  
Administrator (or Representative)

5/31/23  
Date

**WAC 388-78A-2480 Tuberculosis Testing Required.**

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure screening for Tuberculosis (TB) was completed within three days of hire for 3 of 3 Staff (B, C, D), who were hired since the last full inspection. This failure placed residents at risk of potential exposure to a communicable disease.

**Findings included...**

Staff records were reviewed with Staff I, Community Resource Manager (CRM), on 05/03/2022 at 11:02 AM. Staff I stated that they were responsible for tracking employee hiring and training requirements.

- Staff B, Caregiver, was hired 01/03/2023. Staff B's file showed a TB first step test was completed on 01/31/2023, 28 days after they were hired.
- Staff C, Caregiver, was hired on 12/13/2022. Staff C's file showed a TB first step completed on 01/28/2023, 46 days after they were hired.
- Staff D, Maintenance Manager, was hired on 04/04/2023. Staff D's file did not include documentation that they had been screened or tested for TB since they were hired.

On 05/03/2023 at 12:11 PM, Staff I stated that TB tests were done late for Staff B and C because the previous facility nurse had not completed the tests. Staff I stated that the new nurse had started to get caught up on the tests during staff meetings in January and February 2023.

On 05/03/2023 at 12:14 PM, Staff A, Executive Director, stated that they did not know why Staff D had not been screened for TB since they were hired.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

6/24/2023

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

Jan T. L...  
Administrator (or Representative)

5/3/23  
Date

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



**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 5 Residents (4) who required assistance with their medication received their prescribed medications in a correct and timely manner. This failed practice placed residents at risk of exacerbation of their chronic health conditions.

**Findings included...**

Record review of Resident 4's Negotiated Service Agreement (NSA) dated 04/11/2023 showed the resident had only as needed medications, not routine.

Record review of Medication Administration Record (MAR) showed:

- February 2023, Resident 4 received their prescribed sleeping medication for nine days. Staff documented the medication was not available to give to the resident for a total of 13 days. There was a total of six days of the month staff documented the resident refused the medication due to ineffectiveness.

-March through May of 2023, the MAR documented the medication was not given and was awaiting a discontinue order from the physician.

Record review of Resident 4's progress notes, showed that an attempt was made on 03/27/2023 to contact a physician to receive a discontinue order for the prescribed medication. As of 05/05/2023 the prescribed medication remained on the MAR.

On 05/04/2023 at 10:20 AM during an interview with Staff H, Assistant Executive Director, they confirmed there had not been a discontinue order completed.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23

6/24/2023

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

  
Administrator (or Representative)

5/31/23

Date

**RCW 70.129.030 Notice of rights and services -- Admission of individuals.**

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to inform each resident at least every 24 months in writing of the service items, activities available in the facility, and the rules of the facility's operation for 2 of 2 Residents (2, 9), who lived in the facility for more than 24 months. This failed practice did not allow residents to make informed decisions regarding living choices.

**Findings included...**

24 month notification record review occurred on 05/04/2023 at 10:30 AM with Staff A, Executive Director. Staff A stated that they were typically the one responsible for updating rental agreements every 24 months, and that they kept a list of due dates.

-The ALF's May 2023 resident characteristic roster showed that Resident 4 was admitted on [REDACTED]/2019. Resident 2's most current resident rental agreement was signed and dated on 02/28/2019.

Resident 2's file did not show that the ALF had informed the resident every twenty-four-months of the ALF's rules, service items and activities.

Staff A stated that Resident 2's rental agreement, "Must have been missed."

-The ALF's resident characteristic roster showed that Resident 9 was admitted on [REDACTED]/2020. Resident 9's most current resident rental agreement was signed and dated on 11/30/2020.



Resident 9's file did not show that the ALF had informed the resident every 24 months of the ALF's rules, service items and activities.

Staff A stated that the updated rental agreement had been sent electronically to Resident 9's representative on 02/27/2023 but it had not been signed and returned yet.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23

6/24/2023

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

Don F. [Signature]  
Administrator (or Representative)

5/31/23  
Date

**WAC 388-78A-2990 Heating-cooling Temperature. The assisted living facility must:**

(2) Equip each resident-occupied building with a mechanical air cooling system or equivalent capable of maintaining a temperature of 75 F in communities where the design dry bulb temperature exceeds 85 F two percent of the year per the ASHRAE standards;

(4) Prohibit the use of portable space heaters unless approved in writing by the Washington state director of fire protection;

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure their cooling and heating system was maintained and properly working for 2 of 2 common areas (first and second floors). This failed practice placed 52 residents at risk of discomfort and decreased quality of life.

**Findings included...**

Record review showed a letter dated 07/07/2022 to the facility from a service and construction contractor with a proposal for work on the ALF's Heating, Ventilation, Air Conditioning (HVAC) system. The proposal outlined four separate options for repair, treatment, and installation that the ALF could select.

During an interview on 05/02/2023 at 4:15 PM Staff A, Executive Director, was asked about their plan as the second- floor temperature was above 78 degrees Fahrenheit due to the Air Conditioners (AC) on the second floor not working. Staff A was also notified that there were two portable cooling and heating units in apartment 211, and apartment 211's



current temperature, according to the licensor's thermometer, read at 78 degrees Fahrenheit.

Staff A was also informed that through an interview with Resident 7 the licensor was informed that Resident 11 and spouse left the ALF to stay at their home that was located nearby due to not having functioning air conditioning to cool their apartment.

Staff A stated they were unaware that the second-floor AC units were not on or that the resident apartments AC units were not operating properly. Staff A stated that they had two companies that had given them bids to flush the ALF's HVAC system. Staff A stated after the bids were received by the ALF, the ALF researched the information on how to flush the system, and Staff J, Corporate Maintenance Trainer flushed the system.

On 05/02/2023 at 4:15 PM Staff H, Assistant Executive Director, stated that the HVAC system was 25 years old, the south side worked, north side did not work, and the AC units in the four corners on the second floor worked intermittently. Staff H stated that it had to do with flushing the filter system.

Interview on 05/03/2023 at 10:36 AM, Staff H stated that the AC units have had issues with maintaining hot and cold temperatures for the last four years.

On 05/03/2023 at 11:00 AM Staff J, stated that they had "blown out" the HVAC system two weeks ago. Staff J stated that there should have been glycol (anti-freeze coolant) in the line but there wasn't. Staff J also stated that the ALF changed the filters in the units every three months.

#### Resident 7

Resident 7 attended the Resident Group meeting held on 05/02/2023 at 11:00 AM and stated that it was 85 degrees Fahrenheit in their apartment last week. Resident 7 said, "Heating and AC is terrible." Resident 7 also stated that their apartment windows had black out curtains and blinds to help with the heat. Resident 7 stated that they had talked with Staff A and was told that someone from Montana had come to the facility to fix the HVAC.

Observations on 05/02/2023 at 2:30 PM, showed Resident 7 was in their apartment that was on the west side of the ALF. A small portable heater was observed plugged into the wall in the living room area and a portable AC unit was plugged in and sitting in the living room with the exhaust hose attached to the west facing window.

On 05/02/2023 at 2:30 PM, Resident 7 stated that last week their apartment had reached 85 degrees Fahrenheit and the ALF's AC had not been working in their apartment. Resident 7 also stated that previously, Staff J, had told them the ALF's plan was to shut down the AC for two days and sand blast the system. Resident 7 stated that they confirmed the plan

with Staff A. Resident 7 then stated that when Staff J arrived at the ALF, Staff J had told Resident 7 that the money for the ALF's HVAC system went to another facility in Seattle. Resident 7 stated that there were 4-5 apartments with portable AC units.

#### Resident 11

Telephone interview with Resident 11 on 05/03/2023 at 10:16 AM showed that Resident 11 and their spouse had not attended the resident group meeting because they had been staying at their private home due to not having air conditioning in their apartment at the ALF. Resident 11 stated they came back to the ALF for evening meals and depending on the temperature of their apartment, would determine if they will stay the night at the ALF.

On 05/03/2023 at 3:30 PM, Resident 11 and their spouse were interviewed and observed in their apartment in the ALF. Observation showed Resident 11's apartment to be facing the west side of the ALF with a 3 ½ foot tall swamp cooler unit that was sitting in their west side bedroom.

Resident 11 stated the AC unit was not working and it was 80 degrees Fahrenheit in the apartment, and the weather was only going to get hotter. Resident 11 stated a caregiver had brought them a swamp cooler unit, but it did not bring the temperature down in the apartment. Resident 11 also stated that they had mentioned to Staff I, Community Resource Manager, and caregivers, that the ALF's AC had not been working in their apartment. Resident 11 stated that Staff A had never approached them about the AC not working. Resident 11 stated that they pay a high amount to live at the ALF and expected working AC.

On 05/03/2023 at 3:50 PM observation of the ALF's thermostat in Resident 11's apartment showed the AC was set at 61 degrees Fahrenheit and the thermostat read as 83 degrees Fahrenheit in their apartment. The licensor's thermometer showed 84.1 degrees Fahrenheit.

Resident 11 stated that they had moved in December 2022 and there was no problem with uncomfortable temperatures in their apartment at that time. Resident 11 stated that the ALF's dining room was cold in the winter, residents wore their coats to the dining room when going for their meals, and the ALF placed space heaters throughout the dining room for heat.

On 05/03/2023 at 3:50 PM, Staff C, Caregiver, was asked if the second floor got hot. Staff C said, "I know, it's hot." Staff C stated that Resident 11 and spouse had been going to their private home because it's been too hot in their apartment.

During the interview on 05/03/2023 at 4:14 PM, with Staff A and Staff H they were asked about Resident 11's higher temperature reading of 84.1 degree Fahrenheit in their apartment. Staff A and H were also informed that residents expressed that during the



winter, residents wore their coats down to the dining room, and space heaters were placed throughout the dining room for heat. Staff A stated that the HVAC repair company had come the previous week and did not find any issues with the HVAC system and would be coming back later today.

On 05/04/2023 at 10:45 AM, Staff J, Corporate Maintenance Trainer, stated that he was changing filters in the air conditioning units in resident apartments, and that it should have been done every 3 months but that was not happening. Staff J, said, "The filters were disgusting." The licensor asked Staff J if that could be part of the issue with the HVAC system. Staff J stated, "Possibly."

**Plan/Attestation Statement**

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6/24/2023

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

Jan F. King  
Administrator (or Representative)

5/31/23

Date

**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 record review and interview, the Assisted Living Facility (ALF) failed to immediately report to the Department's Complaint Resolution Unit (CRU) hotline and failed to report to local law enforcement (LLE) when staff had reasonable cause to believe suspected sexual or physical abuse had occurred for 1 of 1 Resident (1). This failed practice resulted in a delayed investigation by the department, no notification to the LLE, and placed the residents at risk of abuse.

Findings included...



Review of the Department of Social and Health Services "Assisted Living Facility Guidebook" dated February 2018, showed that the department established ALF guidelines which require facility staff to immediately report, investigate and protect residents when the facility has reasonable cause to believe abuse had occurred.

Record review of the facility's policy titled, "Reporting Abuse, Neglect and Exploitation," revised July 2014, showed direction for facility staff to follow including reporting within 24 hours all abuse, or suspected abuse, to the abuse hotline and if necessary, to LLE.

Review of Resident 1's assessment and care plan, both dated 03/23/2023, showed that the resident needed total hands-on assistance from the staff for bathing, dressing, grooming, and toileting which included changing soiled briefs and cleaning the resident after incontinence (loss of bladder or bowel control).

A facility communication note written by a caregiver on 04/14/2023 showed that Resident 1 was, "Very cranky" that night and did not want to be changed. The note also showed Resident 1 did not want to go to dinner and was very sleepy.

Record review of a facility investigation completed by Staff A, Executive Director, showed that on 04/13/2023 a caregiver reported to Staff H, Assistant Executive Director, that Resident 1 was displaying behavior changes. The behaviors included refusals of personal care, covering their genital area with their hands, and saying, "No, no, no" when staff attempted to provide toileting assistance. The caregiver reported that these behavior changes started when Staff M, former Caregiver, began working with Resident 1 on the night shift.

The investigation showed that Staff L, Registered Nurse (RN), the former Healthcare Director, was notified of the concern and assessed the resident on 04/13/2023. When Staff A was notified of the concern on 04/14/2023, they placed Staff M on administrative leave pending further investigation. Staff M was later terminated on 04/17/2023 by Staff A who stated they, "Were not a good fit" at the facility.

In an interview with Staff L, RN, on 05/03/2023 at 9:15 AM, they stated that they were told that Staff A or Staff H would make the report to the CRU. Staff L also stated they were told by a corporate director that the incident was not reportable. Staff L, RN, stated that they had reported the concern to Resident 1's responsible party on 04/20/2023, as no one had notified them of the allegation by that point. Staff L, RN, stated that they made the report to the CRU on 04/20/2023, of the suspected abuse that had been reported to them seven days earlier on 04/13/2023, because they felt the allegation was reportable and no one else had made a report.

On 05/03/2023 at 10:33 AM, Staff H stated that they had started to conduct an investigation and interview staff, along with Staff L, RN. Staff H stated that caregivers had reported that after Staff M started to work with Resident 1, the resident began to refuse

care, became withdrawn, and was eating less and sleeping more, all of which was unusual for them. Staff H stated that after Staff M was terminated Resident 1 no longer displayed these behaviors. Staff H also stated that they thought the CRU report would have been made by Staff A.

On 05/03/2023 at 4:06 PM, Staff A stated that they did not think the incident was reportable as suspected abuse per their investigation. Staff A stated that they did not know what to report to the department or LLE.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23  
6/24/2023

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

  
Administrator (or Representative)

5/31/23  
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;

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to maintain and keep in good repair 1 of 4 (west) exterior roof lines of the Assisted Living (AL) facility. The ALF also failed to maintain and keep in good repair 1 of 2 first-floor walls in the AL facility stairwell and 1 of 1 laundry room located in the Memory Care Unit (MCU). This failed practice placed all residents at risk of decreased quality of life and harm.

**Findings included...**

The AL and MCU's exterior and interior environmental tour occurred on 05/01/2023 at 2:17 PM with Staff D, Maintenance Manager, and Staff J, Corporate Maintenance Trainer.

**AL Exterior:**



At 2:23 PM, on the exterior southeast side of the facility the soffit was observed to be hanging off the fascia, 5 feet in length.

The rain gutter at the southeast corner of the facility was observed to be full of pigeon feces and the rain gutter was pulled off the fascia.

AL Interior:

At 2:30 PM, the AL's interior southwest first-floor stairwell wall had an area the size of 5-inch x 3-inches with 5 darkened spots black to purple in color above the floor molding. The area also had a small refrigerator, that was not plugged in, pulled away from the discolored wall.

Staff D and Staff J stated they were unsure what the discolored wall area was and how long it had been there.

MCU Interior:

On 05/01/2023 at 2:58 PM observations of the MCU's laundry room showed that behind the length of the two washing machines, the sheet rock was missing from the floor up 6-8 inches, with water damage to the existing sheet rock.

On 05/01/2023 at 4:15 PM, during the debrief, Staff A, Executive Director, was informed of the exterior and interior environmental findings. Staff A acknowledged the findings.

On 05/05/2023 at 9:30 AM, Staff A stated that they had cleaned the black area although the dark area was still there and they would be checking for mold.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

6/24/2023

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

  
Administrator (or Representative)

5/31/23  
Date



**WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and**

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

**This requirement was not met as evidenced by:**

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide and maintain intact sixteen mesh screens on operable windows in resident apartments in 5 of 5 areas (east, north, west, south, and the Assisted Living (AL) courtyard) of the facility. This failed practice placed residents at risk of having pests and bugs enter their apartments.

The AL's exterior environmental tour occurred on 05/01/2023 at 2:17 PM with Staff D, Maintenance Manager, and Staff J, Corporate Maintenance Trainer.

The exterior environmental tour of the facility showed:

- East side: 2 windows on the second floor without window screens;
- North side: 2 windows on the second floor without window screens;
- West side: 4 windows on the second floor without window screens;
- South side: 3 windows on the second floor without window screens;
- Manor courtyard: 7 windows without window screens.

At 2:32 PM, Staff D stated that they noticed window screens were missing and did not know what happened to them.

On 05/01/2023 at 4:15 PM during the interview with Staff A, Executive Director, they stated that they were unaware of how many screens were missing from the windows.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23.

6/24/2023

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

  
Administrator (or Representative)

5/31/23  
Date

**WAC 246-980-050 How long does a nonexempt long-term care worker have to complete the home care aide training and certification requirements?****(1) Training:**

(a) A long-term care worker must successfully complete all training required by RCW 74.39A.074 (1) within one hundred twenty calendar days of the date of hire as a long-term care worker.

(b) A long-term care worker who has not completed the training within one hundred twenty calendar days is no longer eligible to provide care until certification as a home care aide has been granted.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 1 Staff (B) hired as a long-term care worker completed training within 120 days of hire as required. This failure placed residents at risk of being cared for by untrained staff.

**Findings included...**

Review of RCW 74.39A.074 showed that long term care workers must complete 70 hours of basic training related to core competencies.

Staff training records were reviewed with Staff I, Community Resource Manager (CRM), and Staff H, Assistant Executive Director, on 05/03/2022 at 11:02 AM.

The file for Staff B, Caregiver, showed that they were hired on 01/03/2023. Staff B's file did not show documentation that they had completed the 70 hours basic training for long term care workers within 120 days of hire. Staff H stated that Staff B still worked in the ALF as a caregiver.

At 11:26 AM, Staff H stated that Staff B was not enrolled in the training program for long term care workers upon hire. Staff H thought they had 120 days from the date the staff was enrolled in the program, to complete the trainings.

**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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 7/5/23

6/24/2023

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

Statement of Deficiencies

License #: 2225

Compliance Determination # 23588

Plan of Correction

HIGHGATE SENIOR LIVING

Completion Date

Page 33 of 33

Licensee: Highgate Wenatchee LP

05/10/2023

Jan T. L...  
Administrator (or Representative)

5/31/23  
Date



## Plan of Correction

Highgate Senior Living

SOD Date: 7/21/23

### WAC 388-78A-2480 Tuberculosis Testing Requirement

- a. Formal written counseling and training was completed with Community Resource Manager on 7/20/23. The CRM is responsible for ensuring all new hire hires completing the Step I and Step II TB shots within the required time frame. The TB testing information will be updated in the Training Matrix by the CRM and the tracking form will be placed in the team member file.
- b. Team members C and E completed TB shot series and are in full compliance.
- c. The CRM will require all new hires get their Step 1 TB before day one of orientation. Shot records will be recorded on the Tuberculosis Skin Testing Record.
- d. The new team member will receive a reminder from the CRM the day before the second TB shot is scheduled. The second TB shot will be recorded on the Tuberculosis Skin Testing Record with both test results attached to the form.
- e. The CRM will review the new hire TB dates with ED on a weekly basis to verify TB shots are given within required time periods.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

1) WAC 388-78A-2090 Full Assessment

- a. Assistant Executive Director completed an audit of all current residents and added information regarding resident diagnoses, resident ability to leave the community, use of medical devices, self-medication assessment, and verify the 14 day assessment is completed following each resident move in.
- b. Assessments for residents 1-7 have been reviewed and Service Plans updated.
- c. Newly moved in residents will be added to the scheduling calendar so the 14 day assessment is completed within the required time period.
- d. Highgate AED and/or RCC will complete a quarterly audit of resident Service Plans to verify they identify resident diagnoses, capabilities, needs, and preferences.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

1) WAC 388-78A-2140 Negotiated Service Agreement Content

- a. The Assistant Executive Director will complete an audit of all current residents to verify that any residents with special services (Hospice, Therapy, etc.) have information directing Highgate team members regarding their role in that residents care. Any residents who have physical, sexual, or verbal behaviors will have Service Plans identifying specific behaviors and recommended interventions.
- b. Resident 1,3, and 5 Service Plans will be update by 6/2/2023 to reflect their current needs.
- c. The Assistant Executive Director and/or Resident Care Coordinator will complete a monthly audit of all residents with Negotiated Service Plans or who have exhibited new physical, sexual, or verbal behaviors. The AED and/or RCC will be responsible for informing ED of results and develop a plan to update the resident Service Plans if needed.



## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

### WAC 388-78A-2300 Food and Nutrition Services

- a. Kahlid Iraqui, Director of Culinary for Highgate sent the Sysco IMPAC binder for the Chef and Cooks to reference when preparing and servicing residents on specialized diets.
- b. Resident #1 and #5 meal cards have been updated and adjustments have been made in food preparation to follow specialty diet orders.
- c. All resident meal cards have been audited to verify that special dietary orders are listed correctly.
- d. Chef Raul will hold a meeting with the Cooks to review how the IMPAC binder is used and the importance of checking resident meal cards for specialty diets so that adjustments can be made to food preparation and service based on dietary orders (Example: low sodium, diabetic, and mechanical soft diets).
- e. Highgate will re-educate Medication Aides to update resident meal cards whenever new physician orders are received for a specialty diet.
- f. A random monthly audit of current residents will be completed by HD and/or designated Medication Aide to verify that specialty diet orders and resident meal cards continue to match.

## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 246-215-04555 Equipment – Mechanical ware washing equipment, hot water sanitization temperatures.
  - a. On 5/6/2023 an Ecolab representative completed a check of the Cottage and Manor Lounge dishwashing machines. The Cottage dishwasher gauge was replaced and checked to verify it was working properly. The Manor Lounge dishwasher was also checked by EcoLab and both the gauge and solution were working correctly. EcoLab representative provided additional education that both the Cottage and Manor Lounge dishwashers are low temperature machines which means Highgate will not be seeing any high temperature readings. These dishwashing machines will alert the team members when a chemical is low so that a new bottle can be installed.
  - b. Temperature tracking forms were started for both the Cottage and Manor Lounge dishwashing machines. Care Partners and Life Enhancement team members were educated regarding the requirement to complete the temperature checks daily. A reminder sign was also posted in the Team Member Breakroom.
  - c. Chef Raul will complete a weekly check of all dishwasher temperature logs and follow-up with the appropriate supervisor if a team member is not completing the temperature check logs correctly.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-78A-2466 Background checks
  - a. The Highgate Policy on Background Checks was reviewed with the Community Resource Manager on 5/25/2023 with the Director of Operations.
  - b. The Community Resource Manager went through all of the Team Member files to audit for background checks.
  - c. The CRM also updated the Training Matrix to track any new hires, to verify dates of employment, and to identify team members who need to complete their two year background check.



Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-78A-24681 Background checks Employment Provisional Hire-pending results of national fingerprint background check.
  - a. A system was created with the Community Resource Manager to ensure new team members have scheduled fingerprint appointments after hire.
  - b. On the day of orientation, the CRM will sit down with the new team member to schedule a fingerprint appointment.
  - c. The CRM will contact the team member the day after the scheduled appointment and collect the paperwork/receipt from the appointment.
  - d. The CRM will check the online website to print off the information and file.
  - e. The CRM will update the Training Matrix that the fingerprinting was completed.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 246-980-030 Nonexempt HCA Application within 14 days of hire
  - a. The AED completed an audit of all current care partners to verify that they have submitted an HCA application. For any care partners that have not completed this step the AED will assist them in submitting the HCA application as soon as possible.
  - b. Team members I, B, C, M, and H have completed HCA Application.
  - c. All new hire care partners will complete and submit their HCA application with 14 days of hire. The AED will be responsible for tracking care partner hire dates and verifying that the HCA application has been submitted within the 14 day time period.
  - d. The CRM has added to the Training Matrix HCA application to the training matrix and will check in with AED to verify completion.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-78A-2490 Specialized training for developmental disabilities.
  - a. Team Member A the Executive Director signed up for the specialty training for developmental disabilities June 13-15, 2023.
  - b. Team Member B is signed up for the specialty training for developmental disabilities June 13-15, 2023.
  - c. Team Member E and F are signed-up to attend specialty training for developmental disabilities on June 13-15<sup>th</sup>.
  - d. Post training, the Executive Director will provide the specialty training for the team members.
  - e. The specialty training for developmental disabilities will be added to the Community Resource Manager's Training spreadsheet for tracking on a monthly basis.



Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-112A-0720 What are the CPR and First Aid training requirements?
  - a. Training requirements were reviewed with the Community Resource Manager with the Executive Director. New hires must have the CPR/First Aid Training in the first 30 days of hire and then every two years.
  - b. A copy of the CPR/ First Aid documentation is to be filed in the team member file as soon as the team member completes the courses.
  - c. Highgate Wenatchee held a CPR/First Aid training on May 22, 2023 with 12 team members attending. Team Member B and C attended this training.
  - d. CRM will be responsible for scheduling a monthly CPR/First Aid Training and notifying team members who are required to attend.
  - e. The CRM will record on the Training Matrix completion of the CPR/First Aid Training to ensure quality compliance. The ED and CRM will review the list of team members needing CPR/First Aid on a monthly basis.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

1) WAC 388-78A-2480 Tuberculosis Testing Required

- a. The Highgate Policy on Tuberculosis Skin Testing was reviewed with the Community Resource Manager on 5/25/2023 with the Director of Operations.
- b. Team members B, C, and D will complete the required TB testing as soon as possible.
- c. The Community Resource Manager updated the Training Matrix to show the TB testing. This Training Matrix will be reviewed with the Executive Director on a weekly basis to ensure timely and accurate testing of new hires.
- d. New hires will be asked by CRM to get their first shot on the day of orientation which will be recorded on the Tuberculosis Skin Testing Record.
- e. The new team member will receive a reminder from the CRM the day before the second TB shot is scheduled. The second TB shot will be recorded on the Tuberculosis Skin Testing Record with both test results attached to the form.

## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

### 1) WAC 388-78A-2240 Non Available Medications

- a. Highgate completed an audit of all current resident medications to verify resident medications are available for immediate use. Audit results did not find any other residents with unavailable medications.
- b. Highgate requested and received orders from the physician to discontinue resident #4 sleeping medication as the resident refused to take any more medications.
- c. The Health Care Director or designated Medication Aide will not enter new medication orders in to Q-Mar until the medication has been received. If a medication is not received by Highgate in timely manner, then the Medication Aide will follow-up with the pharmacy, physician, and family to get the issue resolved.
- d. If Highgate Health Care Director or designated Medication Aide are unsuccessful in receiving ordered medications, then the ED and/or AED will be notified to help remove barriers and get the medication delivered as soon as possible.
- e. The Health Care Director or designated Medication Aide will complete a monthly audit of all current resident medications to verify medications are available for immediate use.



Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) RCW 70.129.030 Notice of rights and services—Admission of individuals
  - a. Director of Operations did a full audit of Resident files to review date of move in and set up spreadsheet on 5/22/2023. Executive Director will be able to clearly update on a monthly basis to set up a good system for tracking.
  - b. On the statement of deficiencies, it stated on the resident characteristic roster that Resident 4 was admitted on [REDACTED]/2019. Director of Operations reviewed the resident characteristic roster which stated the move in date as [REDACTED]/22. This resident is not out of state compliance as it has not been two years since the move in date.
  - c. Resident 9-new rental agreement signed on 5/6/2023.
  - d. Resident 2-new rental agreement signed 5/15/2023.
  - e. Executive Director has added reminders to the monthly calendar so that all Residency Agreements are reviewed and signed within the required two year time period.

## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

### 1) WAC 388-78A-2990 Heating-cooling

- a. On 5/2/23 Salcido Connection checked Resident #7 and #11 HVAC units. Repairs were made and both HVAC units were back up and operational the same day. Apartment temperatures were checked and found to be back in to an acceptable range.
- b. Any HVAC units that are not operating properly will be checked by maintenance and a plan developed to make repairs (Example: back flushing the HVAC line, flushing out the full heating/cooling loop, replacing filters, cleaning coils, ordering parts, replacing fan blades, etc.)
- c. Since 5/15/2023 Dave Tamez Special Projects Coordinator was assigned to Highgate Wenatchee and has been working to resolve Manor 1<sup>st</sup> and 2<sup>nd</sup> floor HVAC issues. Work completed by Dave includes the following: Manor 1<sup>st</sup> floor – NW corner HVAC blower replaced, lounge HVAC back flushed lines, SE HVAC coils cleaned. Manor 2<sup>nd</sup> floor – NW corner replaced thermostat, NE corner repaired electrical problem, Activity room unit on the left fan motor being replaced (HVAC unit on right is working properly). Dave has also started to add clean-out valves to allow easy access to back flush the line if needed in the future.
- d. Dan Striden VP of Construction and Dave Tamez Special Project Coordinator will also be completing further preventative maintenance in June of 2023 with the installation of a filtration system for the heating/cooling system.

Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-78A-2630 Reporting abuse and neglect
  - a. On 5/17/2023 at the monthly All Team Meeting, the Executive Director did a training on reporting abuse, neglect and any incident of suspected sexual abuse.
  - b. The Highgate policy on Reporting Abuse, Neglect and Exploitation was passed out to each team member.
  - c. Team members not at the meeting were followed up with coaching and received the handout.
  - d. Training included mandatory reporting to the Aging and Disability Services Administration Complaint Resolution Unit hotline and immediate reporting to the appropriate law enforcement agency.
  - e. Once the mandatory reporter makes a call to the State Hotline the Executive Director, Highgate Director of Resident Services and CEO need to be notified of any allegation of potential abuse or neglect immediately.



## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-78A-3090 Maintenance & Housekeeping
  - a. Highgate Maintenance Director completed the following work: repaired the soffit hanging down from exterior south east side of facility, removed the pigeon feces in rain gutter, reattached the gutter to the fascia, removed the small refrigerator from the southwest first floor stairwell, I cleaned the wall behind and repainted, and repaired Cottage laundry room wall behind the washing machines and installed new sheet rock.
  - b. Highgate Maintenance Manager will complete a monthly walk through of the interior and exterior of the Manor and Cottage identifying any maintenance or housekeeping concerns. The results of the monthly walk thru will be reviewed with ED and a plan put in place for the Maintenance Director to correct any identified issues.
  - c. All Team Members will be re-educated to use the Maintenance Log to write down non-emergent maintenance requests. If there is an urgent need for assistance a phone call will need to be made directly to the Maintenance Manager.

## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 388-78A-3000 Ventilation
  - a. Highgate has a list of all the window screens identified in the survey.
  - b. On 5/31/2023 the AED called several local businesses to get the window screen estimates. One estimate will be selected and that business will make and deliver the window screens.
  - c. Maintenance Manager will install replacement window screens.
  - d. Maintenance Manager will check for missing window screens during weekly exterior walks around the community with ED.

## Plan of Correction

Highgate Senior Living

Date of Survey Conclusion: 5/10/23

- 1) WAC 246-980-050 Nonexempt HCA completed within 120 days of hire
  - a. The AED completed an audit of all current care partners to verify that they have completed their HCA course within 120 days of hire.
  - b. All care partners are expected to complete the HCA courses within 120 days of hire or they will be removed from the work schedule until it has been completed.
  - c. Team member B was removed from the floor until the certification was completed. The HCA certification was completed by Staff B on May 23, 2023.
  - d. The AED and/or RCC will be responsible for ensuring all newly hired care partners are signed up as soon as possible for HCA courses to allow time for HCA course work to be completed.
  - e. The CRM has updated the Training Matrix to track that the HCA course is completed by new hire care partners within the required 120 day.
  - f. The AED and/or RCC will complete a monthly audit of newly hired care partners to verify that they are signed up for HCA courses and making progress with the learning modules. The ED will be informed of any concerns related to lack of progress so that a follow-up meeting can be set-up with the care partner to discuss any barriers and set goals for completion.