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

CHP Auburn WA Tenant Corp
Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

RE: Prestige Senior Living Auburn Meadows License # 2239

Dear Administrator:

This letter addresses Compliance Determination(s) 29454 (Completion Date 10/03/2023) and 25025 (Completion Date 07/13/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/03/2023 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-2483-1, WAC 388-78A-2483-2, WAC 388-78A-2483, WAC 388-78A-2474-2-c, WAC 388-112A-0400-4-b, WAC 388-112A-0400-4-c, WAC 388-78A-2464-1, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2100-1, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b, WAC 388-78A-2484-1, WAC 388-78A-2040-1, WAC 388-110-140-1-a, WAC 388-110-140-1-b, WAC 388-110-140-1, WAC 388-110-140-2-b, WAC 388-110-140-2-c, WAC 388-110-140-2-d-i, WAC 388-110-140-2-d-ii

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager

Region 2, Unit D
Residential Care Services

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

Statement of Deficiencies	License # 2239	Compliance Determination # 25025
Plan of Correction	Prestige Senior Living Auburn Meadows	Completion Date
Page 1 of 14	Licensee: CHP Auburn WA Tenant Corp	07/13/2023

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 on 06/12/2023, 07/13/2023 and 06/15/2023 of:
Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

The following sample was selected for review during the unannounced on-site visit: 9 of 89 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

RECEIVED
JUL 27 2023
DSHS/ALTSA/RCS

Laurie Anderson
Residential Care Services

07/20/2023
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.

Ashley Ziegelbauer
Administrator (or Representative)

7/25/2023
Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to complete a one-step Tuberculosis (TB) skin test 1 of 6 sampled staff (Staff C, Life Enrichment Director [LED]) who had a documented negative TB test result. This failure placed all the residents at risk of contracting Tuberculosis (TB), a communicable disease.

Findings included...

Review of the facility's document titled "Employee Summary", dated 06/12/2023, showed that the facility hired Staff C, Life Enrichment Director, on 12/06/2016.

Review of Staff C's personnel record showed documentation that Staff C completed a TB two-step skin test on 03/03/2016 and 03/10/2016 that showed negative results for TB. The record showed that Staff C completed a one TB skin test on 04/14/2016 that showed negative result for TB. There was no documentation that showed the facility completed a one-step TB test for Staff C when the facility hired Staff C.

During an interview on 06/13/2023 at 1:10 PM, Staff A, Executive Director, stated that when the facility reviewed the personnel files for staff, the records showed Staff C previously completed a TB test with negative results. Staff A stated that they were unaware Staff C required another one-step TB skin test when 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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 8/25/2023.

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

Ashley Ziegelbauer - 7/25/2023
Administrator (or Representative) Date

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

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

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

(c) Mental health specialty training as described in WAC 388-112A-0450 .

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 5 sampled care staff (Staff D, Personal Care Attendant [PCA]) completed the required specialty trainings for dementia and mental health. This failure placed all the residents at risk of unmet care needs and decreased quality of life from untrained caregivers.

Findings included...

Review of the facility's document titled "Employee Summary", dated 06/12/2023, showed that the facility hired Staff D, on 06/09/2020. Review of Staff D's personnel record showed no documentation that Staff D completed the dementia and the mental health specialty training as required.

During an interview on 06/13/2023 at 1:10 PM, Staff A, Executive Director, stated the facility had a system in place that ensured staff received all the required trainings, which included the specialty trainings. Staff A stated that the facility hired an approved trainer who offered trainings to staff in-house every month. Staff A stated that the trainer resigned last month and no longer worked for the facility. Staff A stated that Staff D worked in the Expression Unit (memory care unit) on the night shifts. Staff A stated that they were unaware Staff D had not completed the required dementia and mental health specialty training.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 8/25/2023

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

Ashley Ziegelbauer — Administrator (or Representative)

7/25/2023 — Date

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

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

This requirement was not met as evidenced by:

Based on interviews and record review, the assisted living facility (ALF) failed to complete a Department of Social and Health Services (DSHS) background inquiry (BGI) for 1 of 1 staff (Collateral Contact 1, contracted Registered Nurse Delegator). This failure place all residents at risk for potential abuse and neglect from contracted staff with unknown background check results.

Findings included...

During an interview on 06/14/2023 at 3:00 PM, Staff A, Executive Director stated that they were unable to recall if CC1 submitted a BGI to the facility. Staff A stated that they were unaware that the facility was responsible to complete a BGI through DSHS background check central unit for contracted staff.

During an interview on 06/15/2023 at 9:30 AM, CC1 stated that there was a contracted Nurse Delegation agreement between CC1 and the ALF. The delegation services included resident assessments. After the initial delegation, CC1 re-assessed residents every 90 days for continuation of delegation services.

Review of Staff A's email titled "Background Check for Contractor", dated 06/22/2023, confirmed CC1's first delegation visit was on 09/15/2022. The email included CC1's initial BGI, completed on 06/21/2023. The BGI results showed no disqualifying results. The BGI was completed, 279 days from the date of CC1's first delegation services visit.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 6\21\2023.

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

Ashley Ziegelbauer — Administrator (or Representative)

7\25\2023 — 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:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in the Negotiated Service Agreements (NSA) the care needs and interventions for 4 of 4 sampled residents (Resident 3, Resident 4, Resident 7, and Resident 9). This failure placed the residents at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

Resident 3
Review of Resident 3's April 2023, May 2023, and June 2023 eMAR (electronic medication record) showed Resident 3 received 81 milligrams (mg) Aspirin Enteric Coated [EC ASA, (coating around the tablet to allows the medication to pass through the stomach to the small intestine before dissolving) daily, by mouth for ventricular tachycardia (abnormal heart rhythm).

Review of facility document titled, "Service Plan Evaluation," dated 06/12/2023, showed Resident 3 was diagnosed with [redacted]. There was no documentation that showed Resident 3 received enteric coated aspirin. There was no documentation that provided the care staff with guidance about the possible side effects from EC aspirin administration, such as increased risk for bleeding. There were no instructions for staff about what actions were needed for such side effects.

Resident 4
Review of Resident 4's April 2023, May 2023, and June 2023 eMAR showed Resident 4 received 2.5 mg Apixaban (blood thinner) oral tablet twice a day, by mouth to thin the blood.

Review of facility document titled, "Service Plan Evaluation," dated 06/12/2023, showed Resident 4 was diagnosed with [redacted] and [redacted] There was no documentation that showed Resident 4 received Apixaban. There was no documentation that provided the care staff with guidance about the possible side effects from Apixaban administration, such as the risk for increased bleeding. There were no instructions for staff about what actions were needed for such side effects.

Resident 7
Review of Resident 7's April 2023, May 2023, and June 2023 eMAR showed Resident 7 received 15 mg Xarelto tablet daily, by mouth for atrial fibrillation (irregular, rapid heart rate that caused poor blood flow).

Review of facility document titled, "Service Plan Evaluation," dated 04/18/2023, showed Resident 7 was diagnosed with [redacted] There was no documentation that Resident 7 received Xarelto. There was no documentation that provided the care staff with guidance about possible side effects from Xarelto administration, such as increased risk of bleeding. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 06/14/2023 at 1:04 PM, Staff E, Licensed Practical Nurse, Assistant Health Services Director, confirmed that Resident's 7 service plan did not have a safety plan for taking a blood thinner medicine.

Resident 9
Review of Resident 9's April 2023, May 2023, and June 2023 eMAR showed Resident 9 received 20 mg Xarelto tablet daily, by mouth with an indicated use for stroke (loss of blood flow to part of the brain caused by blood clots and broken blood vessels).

Review of facility document titled, "Service Plan Evaluation," dated 04/11/2023, showed Resident 9 had a history of stroke and atrial fibrillation. The Service Plan also showed Resident 9 had a recorded history of three falls in 30 days. There was no documentation that Resident 9 received Xarelto. There was no documentation that provided the care staff guidance about the possible side effects from Xarelto administration, such as increased risk of bleeding. There were no instructions for staff about what actions were needed for such side effects.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 8/25/2023

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

Ashley Ziegelbauer — Administrator (or Representative)

7/25/2023 — Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(2) Complete an assessment specifically focused on a resident's identified problems and related issues

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the safety of a medical device for 7 of 7 residents (Resident 1, Resident 3, Resident 4, Resident 10, Resident 11, Resident 12, and Resident 13). The facility also failed to complete an assessment to evaluate the residents' abilities to correctly use the medical device. These failures placed the residents at risk for potential injury

Findings included...

BED CANE
Review of the Department of Health and Social Services (DSHS) document titled "Dear Assisted Living Facility Administrator", dated 05/15/2013, showed Assisted Living Facility Providers were issued a letter related to the safety risks associated with the use of all medical devices. The letter listed some examples of medical devices with known safety risks when used. The list included transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangulation, suffocation, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted.

FACILITY POLICY AND PROCEDURE
Review of the facility's policy and procedure titled "Bedrail use", dated November 2015, showed that bedrails were not permitted unless they were grandfathered in prior to September 30, 2015. The policy showed that only half rails would be allowed with the

approval of the Regional Nurse Consultant. The policy also showed that before bedrails could be applied, an evaluation and a bed rail assessment must be completed. The Procedure showed that the resident's Service Plan was to be revised to include the use of bed rails. The procedure also showed that the resident's ability to safely use the bed rails would be evaluated with each re-assessment/evaluation, service plan update and as needed with any changes in condition.

Review of the facility undated document titled "Resident Characteristic Roster" showed the facility admitted Resident 1 in [redacted] 2014, Resident 3 in [redacted] 2021, Resident 4 in [redacted] of 2022, Resident 10 in [redacted] 2021, Resident 11 in [redacted] 2023, Resident 12 in [redacted] 2021, and Resident 13 in [redacted] 2021.

RESIDENT 1
Observation on 06/13/2023 at 2:25 PM, showed a bed cane attached to the head of Resident 1's bed. The bed cane measured 11 inches wide and 14 inches long, which posed a potential hazard and possible entrapment

Review of Resident 1's Service Plan, dated 06/06/2023, showed Resident 1 was diagnosed with [redacted] The Service Plan documented that Resident 1 used the bed cane to assist with transfers in and out of bed. The Service Plan also documented that bed canes posed a risk for entrapment if not secured correctly. The Service Plan documented that quarterly, the Licensed Nurse would re-evaluate Resident 1's need for the bed cane. Further review of Resident 1's records found no bed rail evaluation or assessment for the bed cane.

RESIDENT 3
Observation on 06/14/2023 at 1:37 PM, showed a bed cane attached to the head of Resident 3's bed. The bed cane measured 11 inches wide by 4 inches long. The bed cane was unsecured. The bed cane had to prongs that slid in-between the mattress and bed frame. With minimal effort, the device pulled out away from the bed which created a gap greater than five inches. The bed cane posed a potential hazard and possible entrapment.

Review of Resident 3's undated Service Plan documented that Resident 3 required assistance with transfers. The Service Plan documented that the caregivers used the assistive device with Resident 3 during transfers, as directed by the Health Services Director and Resident Services Director. The Service Plan also showed that Resident 3 was a fall risk due to their comorbidities (the presence of two or more diseases/medical conditions simultaneously). Further review of Resident 3's records found no evaluation or assessment for the bed cane. Review of Resident 3's updated assessment dated 06/15/2023, documented that the bed cane enabled Resident 3 to move from side to side while in bed. There was no documentation that showed the facility completed any evaluation or assessment for the bed cane.

RESIDENT 10
Observation on 06/15/2023 at 12:20 PM, showed a bed cane attached to the head of Resident 10's bed. The bed cane measured four- and one-half inches wide and 17.5 inches

long. The bed cane posed a potential hazard and possible entrapment.

Review of Resident 10's Service Plan, dated 08/25/2023, documented that Resident 10 used the bed cane to assist with transfers in and out of the bed. The Service Plan documented that bed canes posed a risk for entrapment if not secured properly. The Service Plan also documented that quarterly, a Licensed Nurse would re-evaluate Resident 10's need for the bed cane, to "ensure" the device was the least restrictive and met the "minimum safe passage zones". Further review of Resident 10's records found no bed rail evaluations or assessments.

RESIDENT 11

Observation on 06/15/2023 at 12:20 PM and 1:00 PM, showed a bed cane attached to the head of Resident 11's bed. The bed cane measured 28 inches wide and eight inches long. The bed cane posed a potential hazard and possible entrapment.

Review of Resident 11's undated Service Plan documented that Resident 11 was a fall risk. The Service Plan did not show Resident 11 used a bed cane. Further review of Resident 11's records found no bed rail evaluations or assessments.

RESIDENT 12
Observation on 06/15/2023 between 12:20 PM and 1:00 PM, showed two bed canes attached to the head of Resident 12's bed. Each bed cane measured four inches wide and 16 inches long. The bed canes each posed a potential hazard and possible entrapment.

Review of Resident 12's undated Service Plan documented that Resident 12 used two bed canes to assist with transfers in and out of bed. The Service Plan documented that bed canes posed a risk for entrapment if not secured properly. The Service Plan also documented that on a regular basis, a Licensed Nurse would re-evaluate Resident 12's need for the bed cane, to ensure the bed cane was the least restrictive and that the bed cane met the minimum safe passage zones. Further review of Resident 12's records found no bed cane evaluations or assessments.

RESIDENT 13
Observation on 06/15/2023 between 12:20 PM and 1:00 PM, showed two bed canes attached to the head of Resident 13's bed. Each bed cane measured 10.5 inches wide and 8 inches long. The bed canes each posed a potential hazard and possible entrapment.

Review of Resident 13's Service Plan, dated 06/09/2023, documented that Resident 13 was a high risk for falls and required caregiver assistance for ambulation. The Service Plan did not show Resident 13 used two bed canes. Review of Resident 13's records found no bed cane evaluations or assessments.

During an interview on 06/14/2023 at 3:49 PM, Staff J, Regional Support Nurse, stated that there were no evaluations or assessments for Resident 1, Resident 3, Resident 10, Resident 11, Resident 12, and Resident 13. Review of an email dated 06/15/2023 at 1:12 PM, Staff J confirmed that no assistive device evaluation was done before "today".

RESIDENT 4: OVERLAY AIR MATTRESS AND HOSPITAL BED

Observation on 06/13/2023 at 8:00 AM, showed Resident 4 lying in a hospital low bed (bed that can be lowed close to the floor) with a fall mat placed next to the bed. Observation showed an alternating pressure relieving air mattress overlay (a mattress designed with rows of air cells, which can be inflated or deflated to alternate the pressure within the lying surface of the mattress. A pump automatically inflates or deflates the cells automatically) on top of the hospital bed mattress. The air pump used to control the inflation of the air mattress was attached to the foot of the bed.

Observation on 06/13/2023 at 10:25 AM, showed Staff K, Personal Care Attendant, and Staff J, Medication Technician (unlicensed staff who dispenses medications) assisted Resident 4 with dressing, provided incontinence care, and used a gait belt (an assistive device used to help safely transfer a person from a bed to a wheelchair or assist with sitting and standing) to transfer Resident 4 from the bed to a tilt in space wheelchair.

Review of Resident 4's Service Plan, dated 05/09/2023, showed no documentation that Resident 4 required an alternating pressure relieving air mattress overlay. There were no instructions in the service plan that provided the staff with instructions for how to use the air mattress. Further review of the plan showed no documentation that Resident 4 used a hospital low bed. There was no documentation in the service plan that informed staff to place a fall mat next to Resident 4's bed. There was no documentation in the service plan that explained the fall mat was used to limit the potential of injury if Resident 4 rollout of bed or attempted to get out of bed without assistance.

During an interview on 06/13/2023 at 10:25 AM, Staff K and Staff J stated that Resident 4 required staff assistance to stand and transfer to a wheelchair.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 8/25/2023.

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

Ashley Zegelbauer
Administrator (or Representative)

7/25/2023
Date

RECEIVED
JUL 27 2023
DSHS/ALTSA/RCS

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

(1) An initial skin test within three days of employment, and

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete an initial Tuberculosis (TB) skin test within three days of hire for 3 of 6 sampled staff (Staff A, Executive Director, Staff B, Medication Technician [unlicensed staff who dispense and administer medications], and Staff D, Personal Care Attendant [PCA]). This failure placed all the residents at risk of contracting Tuberculosis (TB), a communicable disease.

Findings included...

Review of a Department of Social and Health Services (DSHS) "Dear Administrator/Provider" letter, dated 05/17/2022, showed that Washington state experienced a significant increase in the number of TB cases. The letter stated that to reduce the risk of illness to the vulnerable people served, TB testing was reinstated on July 1, 2022. The previous suspension of the tuberculosis testing requirements expired on 07/01/2022

Review of the facility's document titled "Employee Summary", dated 06/12/2023, showed that the facility hired Staff A on 09/14/2022; Staff B on 12/10/2021; and Staff D on 06/09/2020.

STAFF A
Review of Staff A's personnel record showed that on 02/15/2023, Staff A completed the first step of a two-step TB skin test. Staff A completed the initial TB test 108 days after the date of employment.

STAFF B
Review of Staff B's personnel record showed that on 01/23/2023, Staff B completed the first step of a two-step TB skin test. Staff B completed the initial TB test 207 days after DSHS reinstated the TB testing requirements.

STAFF D
Review of Staff D's personnel record showed that on 02/15/2023, Staff D completed the first step of a two-step TB skin test. Staff D completed the initial TB test 229 days after DSHS reinstated the TB testing requirements.

During an interview on 06/13/2023 at 1:10 PM, Staff A, Executive Director, stated that they were unaware that DSHS reinstated the TB testing requirements in July 2022. Staff A stated

that the facility hired them as the Executive Director in September 2022. Staff A stated that, at that time, the facility did not have a system in place to complete TB testing for staff. Staff A stated that when they were hired, they reviewed the staff personnel files. Staff A stated that they discovered several staff who had not completed TB testing. Staff A stated that the facility completed TB testing for those identified staff with missing TB test results. Staff A also stated that they recognized the facility did not complete Staff D's TB testing in the required time frames.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 8/1/2023

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

Ashley Zeigelbauer — 7/25/2023

Administrator or Representative) — Date

WAC 388-110-140 Assisted living services facility physical requirements.

(1) Licensed assisted living facilities with an assisted living services contract are required to:

(a) Meet the physical requirements that were in effect at the time of initial contracting; or

(b) If there is a break in contract, meet the requirements in effect at the time of the new contract.

(2) The contractor must ensure each resident has a private apartment-like unit. Each unit must have at least the following:

(b) A private bathroom. The private bathroom must be equipped with a sink, a toilet, and a shower or bathtub. At least one wheelchair accessible bathroom with a roll-in shower that is at least forty-eight inches by thirty-six inches must be provided for every two residents whose care is partially or fully funded through the assisted living contract.

(c) A lockable entry door;

(d) A kitchen area. The kitchen area must be equipped with:

(i) A refrigerator.

(ii) A microwave oven, range or cooktop;

WAC 388-78A-2040 Other requirements.

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 10 of 10 residents (Resident 7, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, and Resident 22), who received [redacted] services and resided in the facility's secured memory care unit, had apartments that met the Assisted Living contract requirements. This failure violated the residents' rights and placed residents a risk of a diminished quality of life.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Facilities Management System (FMS)" showed the Assisted Living Facility (ALF) held an Assisted Living Facility contract, effective 02/01/2022 through 01/31/2026. The system showed that in 2019, the facility reported 18 apartments in the Expression Unit (memory care unit). The system showed that the apartments in the Expression Unit were not approved for an Assisted Living (AL) contract.

Review of the facility's document titled "DSHS Client Service Contract Assisted Living Services", dated 02/24/2022, showed that the facility "shall comply with all requirements of chapter 18.20 RCW [Revised Code of Washington], Assisted Living Facility and chapter 388-78A WAC [Washington Administrative Code], Assisted Living Facility. The Contractor shall provide services as required in chapter 388-110 WAC to each client placed in the Contractor's AL as specified in the client's 'Negotiated Service Agreement (NSA)' and authorized by DSHS and/or DSHS's designee. The NSA for any client placed by DSHS in the Contractor's AL is incorporated in this Contract by reference. All work performed under this Contract and any NSA shall be performed in accordance with chapter 70.129 RCW and chapter 388-110 WAC."

Review of the facility's document titled "Assisted Living Facility Resident Characteristic Roster", dated 06/12/2023, showed 10 State-paid residents resided in the Expression Unit. The roster showed the facility identified two types of rooms for the 10 residents on [redacted] services: five residents resided in single-room apartments and five residents resided in semi-private double-room apartments.

Review of a DSHS document titled "Client Service Contract, Assisted Living Services (AL)" showed that the facility (identified as the contractor) "shall provide services as required in chapter 388-110 WAC to each client placed in the Contractor's AL". Review of WAC 388-110 showed the contractor must ensure each resident has a private apartment-like unit and have at least the following: a private bathroom equipped with a sink, a shower or bathtub, at least one wheelchair accessible bathroom with a roll-in shower must be provided for every two residents who are partially or fully funded through the assisted living contract; a lockable entry door; a kitchen area which must be equipped with a refrigerator, a microwave oven, range, or cooktop".

Observations on 06/14/2023 at 1:45 PM and 06/15/2023 2:00 PM showed apartments for

the 10 residents on [redacted] contained no lockable doors. Further observation showed nine of the identified apartments contained no microwave oven, range, refrigerator, or cooktop. Additional observation on 6/12/2023 at 11:51 AM, showed that there were two common bathrooms in the secured Expression Memory Care unit. Each common bathroom contained two roll-in showers, for a total of four roll-in showers.

During an interview on 06/15/2023 at 3:00 PM, Staff J, Regional Support Nurse, stated that the facility was previously told by the Department Licensor(s) that they were allowed to use the Assisted Living (unsecured area of the facility roll in showers to meet the requirement for the Memory Care [redacted] residents. Additionally, Staff J stated that they were aware no microwave and refrigerator in the Expression Memory Care apartments. Staff J stated they were concerned that having a microwave in the memory care apartments was unsafe to the residents Staff J stated that the facility used the microwave and refrigerator in the secured Memory Care unit's kitchen to meet the ALF contract requirement for a microwave and refrigerator in each [redacted] residents' room. Staff J also stated that each Memory Care Resident Assessment and Service Plan showed language that an entry door lock would be provided upon request. In an email dated 7/10/2023 at 12:04 PM, Staff J stated that the language written in the [redacted] residents service plan for door locks met the ALF contract requirements.

Review of Resident 7's Service Plan dated 04/18/2023 documented "Family/POA is aware a lock on the resident's door is available and they decline a lock at this time. Family/POA to notify the community if their desire changes."

During an interview on 06/21/2023 at 1:34 PM, Collateral Contact (CC2, Resident 7's Representative) stated they were aware that Resident 7's room did not have a lockable door. CC2 was unaware there were specific room requirements needed in each room to fulfill the contract held by the facility. CC2 stated that they believed Resident 7 was safe in the facility. CC2 stated that the Expression unit was a secured unit, so they were not concerned about the unlockable door to Resident 7's room.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 8/25/2023.

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

Ashley Zigelbauer
Administrator (or Representative)

7/25/2023
Date

RECEIVED
JUL 27 2023
DSHS/ALTSA/RCS

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

07/20/2023

CHP Auburn WA Tenant Corp
Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

RE: Prestige Senior Living Auburn Meadows # 2239

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 07/13/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately.
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD).
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement'.
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

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

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

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

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

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

The facility failed to ensure the Medicaid disclosure form was printed in the required font size. Additionally, the facility failed to keep the signed and dated Medicaid disclosure form in the resident record for 1 of 9 sampled residents. During the licensing inspection, the facility changed the Medicaid disclosure form template to font sized fourteen. The facility obtained a new Medicaid disclosure form signed and dated by the resident.

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

The facility failed to remove two expired, as needed medications from the medication cart. Furthermore, the facility failed to separate a topical cream from an oral medication. During the full inspection, the facility discarded the expired medications. The topical cream was separated to a different compartment to prevent cross contamination. Additionally, the facility's Regional Support Nurse trained the medication technician staff the proper process for management of expired medications and proper storage of medications. The facility also implemented improved guidelines for storage of medications in a safe and proper manner that followed manufacturer or pharmacy recommendations and in accordance with federal and state regulations.

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

The facility failed to publicly post the assisted living facility license in a common area of the facility The facility also failed to place the copy of the last licensing report in a common area of the facility. During the inspection, the facility Executive Director posted the renewed license and the previous full inspection report, as required.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

The facility failed to maintain adequate air flow to two common bathrooms in the Expression's memory care unit, one laundry room on the second floor, one common bathroom on the second floor, and one common bathroom on the first floor. The facility scheduled repairs for the five air outflow vents. The professional service maintenance company arrived onsite. All five vents were repaired and worked properly prior to completion of the licensing inspection.

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;

(ii) Approved by a dietitian, and

(iii) Reviewed and updated as necessary or at least every five years.

The facility failed to ensure the dietary staff provided with a diet manual, approved by a Registered Dietician. Staff G, Dining Services Director, stated that the facility obtained a monthly menu from an online dietary service. Staff G printed a weekly menu for the month of June, which was signed by an online Registered Dietitian. During the inspection, Staff G printed a diet manual for staff use, as required.

WAC 388-78A-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all

planned construction regarding an assisted living facility prior to beginning work on any of the following:

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(vii) Kitchen or laundry equipment.

The facility failed to notify construction review service (CRS) when one section of the kitchen floor was removed due to plumbing issues. Staff H, Maintenance Director, stated that there was a leaky sink faucet in the kitchen. The floor near the sink was temporarily covered by a thin layer of concrete over the plywood floor. Staff A, Executive Director, stated that residents were not allowed in the kitchen. Staff A also stated that the facility rented a mobile kitchen trailer during this time to accommodate staff safety and work conditions. During the inspection, the facility notified CRS to review the planned kitchen renovation that were scheduled within the next two months.

WAC 388-78A-2610 Infection control.

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

The facility failed to implement the required Respiratory Protection Program, for an initial and an annual fit test, for all staff. Facility staff were last tested in March 2022. During the inspection, the facility completed the initial fit test for all new staff and completed the annual test for all other staff.

You Are Not:

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

You May:

• Contact me for clarification of the deficiency or deficiencies found

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

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

Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

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

Sincerely,

Laurie Anderson

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

Enclosure