



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

Park View Villas, LLC
Park View Villas
2020 A St Se Ste 101
Auburn, WA 98002

RE: Park View Villas License # 2332

Dear Administrator:

This letter addresses Compliance Determination(s) 63768 (Completion Date 08/07/2025) and 61139 (Completion Date 06/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/07/2025 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-2260-1, WAC 388-78A-2260-2-b, WAC 388-78A-2260-2-d, WAC 388-78A-2090

The Department staff who did the on-site verification:
Anissa Bearden, Licensors

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Allied Health Field Manager
Region 3, Unit E
Residential Care Services

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



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

Statement of Deficiencies	License #: 2332	Compliance Determination # 61139
Plan of Correction	Park View Villas	Completion Date
Page 1 of 6	Licensee: Park View Villas, LLC	06/18/2025

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 06/16/2025 and 06/18/2025 of:

Park View Villas
1430 Park View Lane
Port Angeles, WA 98363

This document references the following SOD dated: 06/18/2025

The following sample was selected for review during the unannounced on-site visit: 5 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Megan Zerby, Community ALF/AFH Licenser
Emily Boniface, Community Program Nurse Licenser

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

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

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.

Clinton Fridley
Residential Care Services

07/02/2025

Date

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

Administrator (or Representative)

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

- (1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.
- (2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:
 - (b) Together for each resident and physically separated from other residents' medications;
 - (d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications for 4 of 7 sampled residents (Resident 2 [R2], Resident 4 [R4], Resident 13 [R13] and Resident 15 [R15]) who were unable to safely secure their own medications, were securely stored. This failure placed affected residents at risk for receiving the wrong medication.

Findings included...

<Resident 2>

Record review of the facility's resident characteristic roster, dated 06/16/2025, showed R2 moved into the facility on [REDACTED]/2024 and had a diagnosis of [REDACTED] ([REDACTED]). R2 shared the room with their spouse (Resident 16) who according to the same document also had a diagnosis of [REDACTED].

On 06/16/2024 at 2:53 PM, R2's room was observed, and a 1 oz tube of Neosporin (antibiotic ointment) was seen on the shelf above the toilet in their bathroom.

On 16/16/2025 at 3:44 PM, Staff U, Marketing Director, stated that they assume that Staff B, Interim Executive Director and Resident Care Director, oversaw making sure medications are not in residents' rooms. They called Staff B and confirmed that they were responsible for making sure medications are not in residents' rooms and that the caregivers help them keep an eye on it.

<Resident 4>

Record review of the facility's characteristic roster, dated 06/16/2025, showed R4 moved into the facility on [REDACTED]/2024, and had a diagnosis of [REDACTED] ([REDACTED]).

Record review of R4's Negotiated Service Agreement (NSA) showed that staff are to administer all R4's medications, including over the counter medications that will need a doctor's order.

On 06/16/2025 at 3:14 PM, R4's room was observed, and a package of Imodium (used to treat diarrhea) tablets were seen inside the bathroom medicine cabinet.

<Resident 13>

Record review of the facility's characteristic roster, dated 06/16/2025, showed R13 moved the facility on [REDACTED]/2025.

Record review of R13's NSA showed that staff are to order, store and administer R13's medications.

On 06/16/2025 at 3:08 PM, R13's room was observed, and a 3.75-ounce tube of 2% Miconazole derma fungal was seen inside the bathroom medicine cabinet.

<Resident 15>

Record review of the undated resident characteristic roster showed R15 ,moved into the facility on [REDACTED]/2025.

Record review of R15's NSA showed that staff are to order, store and deliver R15's

medications to them twice daily. The document also stated that the staff should hand pills to R15 one at a time.

On 06/16/2025 at 3:14 PM, R15's room was observed, and a 16 fluid ounce (fl oz) bottle of Pepto Bismal (used to treat indigestion) were seen inside the kitchen cabinet. A bottle of calcium antacid 50 tablets (used to treat heartburn) and a 12 fl oz bottle of Philip's Milk of Magnesia were seen inside the bathroom cabinet.

This is an uncorrected deficiency previously cited on 02/25/2025.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

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:

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 4 residents (Resident 12 [R12], Resident 13 [R13], and Resident 15 [R15]) received a full assessment within 14 days of their move-in date. This failure placed residents at risk for unmet care needs.

Findings included...

On 06/16/2025 the department entered the facility for an unannounced follow-up visit. A characteristic roster, staff list, and resident records, including 14-day assessments for R12, R13, R14, and R15 were requested.

<Resident 13>

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

Record review of the facility characteristic roster, dated 06/16/2025, showed R13 moved into the facility on [REDACTED]/2025.

Record review of R13's undated resident assessment showed the first review date as 05/14/2025 indicating the date of the resident's pre-admission assessment. The second review date showed 06/06/2025, and the third review date showed 06/10/2025.

<Resident 12>

Record review of the facility resident characteristic roster, dated 06/16/2025, showed R12 moved in on [REDACTED]/2025.

Record review of R12's undated resident assessment showed the first review date as 05/19/2025. There was no other review date on the form indicating R12 was assessed after 05/19/2025.

In an interview on 06/17/2025 at 5:17 PM, Staff P, Corporate Director of Wellness and covering Administrator, was asked to confirm that R12 and R15 had not been reassessed after their move into the facility. Staff L indicated they would investigate and send the department the information found.

On 06/18/2025 at 2:15 PM, Staff P sent the Department an email and included an updated assessment for R12, completed on 06/17/2025, and resident notes that showed a note confirming the date the 14-day assessment was completed.

Record review R12's "Resident Notes," dated 05/01/2025 through 06/18/2025, showed R12 physically moved into the facility on [REDACTED]/2025. The notes showed that on 06/17/2025, Staff T, Registered Nurse, wrote "14-day assessment completed..."

<Resident 15>

Record review of the facility resident characteristic roster, dated 06/16/2025, showed R15 moved in on [REDACTED]/2025.

Record review of R15's undated resident assessment showed 04/11/2025 as the first review date. There were no other review dates on the form indicating R15 was assessed after 04/11/2025.

In an interview on 06/17/2025 at 5:17 PM, Staff P, Corporate Director of Wellness and

covering Administrator, was asked to confirm that R12 and R15 had not been reassessed after their move into the facility. Staff L indicated they would investigate and send the department the information found.

On 06/18/2025 at 2:15 PM, Staff P sent the Department an email and included an updated assessment for R15 and showed it was completed on 05/09/2025.

In an interview on 06/18/2025 at 4:18 PM Staff B, Executive Director, stated that Staff B and Staff T were responsible for completing resident assessments. Staff B stated that they complete the preadmission assessments and sometimes the full 14-day assessments. Staff B stated that they were responsible for ensuring the 14-day assessments were completed. Staff B stated that Staff T took over completing the 14-day resident assessments approximately one month ago but that they were still responsible for ensuring the assessments were conducted within the required timeframes.

In an interview on 06/18/2025 at 4:25 PM, Staff P, Corporate Director of Wellness, acknowledged the facility's deficiency due to not completing 14-day assessments within the required timeframe.

This is an uncorrected deficiency previously cited on 02/25/2025.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

03.07.2025 10:29:16

State of Washington

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

Statement of Deficiencies	License #: 2332	Compliance Determination #54155
Plan of Correction	Park View Villas	Completion Date
Page 1 of 49	Licensee: Park View Villas, LLC	02/25/2025

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 02/05/2025, 02/06/2025 and 02/07/2025 of:
Park View Villas
1480 Park View Lane
Port Angeles, WA 98363

The following sample was selected for review during the unannounced on-site visit: 7 of 33 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Emily Boniface, Community Program Nurse Licenser
Megan Zetty, Community ALF/AFH Licenser

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

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Statement of Deficiencies	License #: 2332	Compliance Determination # 54155
Plan of Correction	Park View Villas	Completion Date
Page 1 of 49	Licensee: Park View Villas, LLC	02/25/2025

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 02/05/2025, 02/06/2025 and 02/07/2025 of:

Park View Villas
1430 Park View Lane
Port Angeles, WA 98363

The following sample was selected for review during the unannounced on-site visit: 7 of 33 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Emily Boniface, Community Program Nurse Licenser
Megan Zerby, Community ALF/AFH Licenser

From:
DSHS, Aging and Long-Term Support Administration
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State of Washington

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Statement of Deficiencies	License #: 2332	Compliance Determination # 54155
Plan of Correction	Park View Villas	Completion Date
Page 2 of 49	Licensee: Park View Villas, LLC	02/25/2025

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.

Jody Just
Residential Care Services

03/07/2025
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.

Pauline Sitten
Administrator (or Representative)

3/10/2025
Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

- (1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.
- (2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:
 - (b) Together for each resident and physically separated from other residents' medications;
 - (d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications for 4 of 7 residents (Resident 1 [R1], Resident 2 [R2], Resident 4 [R4] and Resident [6]) were securely stored. The failure to secure medications placed 4 of 33 residents at risk of access and potential ingestion of potentially harmful substances and presented risk for tampering or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed eight of the 33 assisted living residents had a diagnosis of [REDACTED] ([REDACTED]) or [REDACTED] ([REDACTED]).

<Resident 1>

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

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.

Residential Care Services

Date

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

Administrator (or Representative)

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

- (1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.
- (2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:
 - (b) Together for each resident and physically separated from other residents' medications;
 - (d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications for 4 of 7 residents (Resident 1 [R1], Resident 2 [R2], Resident 4 [R4] and Resident [6]) were securely stored. The failure to secure medications placed 4 of 33 residents at risk of access and potential ingestion of potentially harmful substances and presented risk for tampering or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed eight of the 33 assisted living residents had a diagnosis of [REDACTED] ([REDACTED]) or [REDACTED] ([REDACTED]).

<Resident 1>

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State of Washington

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Statement of Deficiencies	License #: 2332	Compliance Determination #54155
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Record review of "Washington Resident Characteristic (Licensed Resident)", dated 02/05/2025, showed R1 moved-into the facility on [REDACTED]/2024 with a diagnosis of [REDACTED].

Record review of R1's Negotiated Service Agreement (NSA), dated 11/12/2024, showed that staff were to assist with administering and ordering all of R1's medications. Staff assisted with one to five medications twice per day.

In an observation on 02/07/2025 at 2:47 PM, a 0.33 oz (ounces) tube of oral pain relief gel, 1 Fl (fluid) oz bottle of equate nasal mist, 1 Fl oz bottle of top care nasal mist, 0.5 Fl oz bottle of soothe xp eye drops, two bottles of 4 Fl oz eyewash, a box with 24 tabs of AZO urinary tract defense supplement, a bottle with 100 caplets of 650 mg acetaminophen (a pain relief medication) and a box of 30 125 mg simethicone (gas relief medication) soft gel tablets were present in R1's unlocked bathroom cabinet.

In an observation On 02/07/2025 at 2:49 PM, a package of 36 tabs with Equate Antacid and Pain Relief (contains 325mg of aspirin), an 11 Fl oz bottle of Kaopectate Bismuth Subsalicylate (treats upset stomach), and bottle of 3% hydrogen peroxide solution (topical antiseptic) was observed in R1's unlocked kitchen cabinet.

In an interview on 02/07/2025 at 2:56 PM, Staff H, Caregiver, stated that medications didn't belong in a resident's room if they required assistance with medications.

<Resident 2>

Record review of "Washington Resident Characteristic (Licensed Residents)", dated 02/05/2025, showed that R2 moved-into the facility on [REDACTED]/2024, was diagnosed with [REDACTED], required medication administration, and received nurse delegation.

Record review of R2's NSA, dated 01/10/2024, showed R2 required nurse delegation once per day and received medication services from staff three times per day for 6 to 10 medications.

In an observation on 02/06/2025 at 6:05 PM, a tube of Fluticasone (nasal spray to treat congestion) and a bottle of 3 percent hydrogen peroxide were seen in R2's unlocked bathroom mirror cabinet. On top of the counter, behind the toilet, was a tube of triamcinolone cream (steroid applied to skin) and a tube of Neosporin (antibiotic applied to skin). Inside the unlocked cabinet above the toilet was a tube of mupirocin (antibiotic applied to skin), and a bottle of TUMS (anti-acid tablets).

In an interview on 02/06/2025 at 6:15 PM, R2 stated that they did not know what

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Record review of "Washington Resident Characteristic (Licensed Resident)", dated 02/05/2025, showed R1 moved-into the facility on [REDACTED]/2024 with a diagnosis of [REDACTED].

Record review of R1's Negotiated Service Agreement (NSA), dated 11/12/2024, showed that staff were to assist with administering and ordering all of R1's medications. Staff assisted with one to five medications twice per day.

In an observation on 02/07/2025 at 2:47 PM, a 0.33 oz (ounces) tube of oral pain relief gel, 1 FI (fluid) oz bottle of equate nasal mist, 1 FI oz bottle of top care nasal mist, 0.5 FI oz bottle of soothe xp eye drops, two bottles of 4 FI oz eyewash, a box with 24 tabs of AZO urinary tract defense supplement, a bottle with 100 caplets of 650 mg acetaminophen (a pain relief medication) and a box of 30 125 mg simethicone (gas relief medication) soft gel tablets were present in R1's unlocked bathroom cabinet.

In an observation On 02/07/2025 at 2:49 PM, a package of 36 tabs with Equate Antacid and Pain Relief (contains 325mg of aspirin), an 11 FI oz bottle of Kaopectate Bismuth Subsalicylate (treats upset stomach), and bottle of 3% hydrogen peroxide solution (topical antiseptic) was observed in R1's unlocked kitchen cabinet.

In an interview on 02/07/2025 at 2:56 PM, Staff H, Caregiver, stated that medications didn't belong in a resident's room if they required assistance with medications.

<Resident 2>

Record review of "Washington Resident Characteristic (Licensed Residents)", dated 02/05/2025, showed that R2 moved-into the facility on [REDACTED]/2024, was diagnosed with [REDACTED], required medication administration, and received nurse delegation.

Record review of R2's NSA, dated 01/10/2024, showed R2 required nurse delegation once per day and received medication services from staff three times per day for 6 to 10 medications.

In an observation on 02/06/2025 at 6:05 PM, a tube of Fluticasone (nasal spray to treat congestion) and a bottle of 3 percent hydrogen peroxide were seen in R2's unlocked bathroom mirror cabinet. On top of the counter, behind the toilet, was a tube of triamcinolone cream (steroid applied to skin) and a tube of Neosporin (antibiotic applied to skin). Inside the unlocked cabinet above the toilet was a tube of mupirocin (antibiotic applied to skin), and a bottle of TUMS (anti-acid tablets).

In an interview on 02/06/2025 at 6:15 PM, R2 stated that they did not know what

03.07.2025 10:29:16

State of Washington

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Statement of Deficiencies	License #: 2332	Compliance Determination #54155
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medications they took.

In an interview on 02/06/2025 at 6:30 PM, Staff A, Executive Director, stated that R2 should not have medications in their room.

In an interview on 02/07/2025 at 10:28 AM, Staff R, Nurse Delegator, stated that residents who received nurse delegation services should not have medications in their room and confirmed that R2 was delegated for medication services.

<Resident 4>

Record review of "Washington Resident Characteristic (Licensed Residents)", dated 02/05/2025, showed that R4 admitted to the facility on [REDACTED] 2024 and was diagnosed with [REDACTED].

Record review of R4's NSA, dated 01/16/2025, showed that staff were to administer all of R4's medications.

In an observation on 02/07/2025 at 12:32 PM, a box with 24 tabs of Imodium (medication to decrease the frequency of diarrhea), a 0.5 oz tube of Neosporin, 2 oz tube of hydrocortisone (skin cream used to reduce inflammation), and a bottle of Alka-Seltzer tablets (used to treat heartburn) were on R4's bathroom counter.

In an interview on 02/07/2025 at 2:47 PM, Staff B, Resident Care Director, said that the staff assisted R4 with her medications.

In an interview on 02/07/2025 at 2:56 PM, Staff H stated that medications didn't belong in a resident's room if they required assistance with medications.

<Resident 6>

Record review of "Washington Resident Characteristic (Licensed Residents)", dated 02/05/2025, showed that R6 moved into the facility on [REDACTED] 2021, received home health services, had a private caregiver, and received medication assistance from the facility staff.

Record review of R6's NSA, dated 06/17/2024, showed R6 received medication assistance twice per day for 6 to 10 medications and that staff would order, store, and prepare medication for self-administration.

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

medications they took.

In an interview on 02/06/2025 at 6:30 PM, Staff A, Executive Director, stated that R2 should not have medications in their room.

In an interview on 02/07/2025 at 10:26 AM, Staff R, Nurse Delegator, stated that residents who received nurse delegation services should not have medications in their room and confirmed that R2 was delegated for medication services.

<Resident 4>

Record review of "Washington Resident Characteristic (Licensed Residents)", dated 02/05/2025, showed that R4 admitted to the facility on [REDACTED]/2024 and was diagnosed with [REDACTED].

Record review of R4's NSA, dated 01/16/2025, showed that staff were to administer all of R4's medications.

In an observation on 02/07/2025 at 12:32 PM, a box with 24 tabs of Imodium (medication to decrease the frequency of diarrhea), a 0.5 oz tube of Neosporin, 2 oz tube of hydrocortisone (skin cream used to reduce inflammation), and a bottle of Alka-Seltzer tablets (used to treat heartburn) were on R4's bathroom counter.

In an interview on 02/07/2025 at 2:47 PM, Staff B, Resident Care Director, said that the staff assisted R4 with her medications.

In an interview on 02/07/2025 at 2:56 PM, Staff H stated that medications didn't belong in a resident's room if they required assistance with medications.

<Resident 6>

Record review of "Washington Resident Characteristic (Licensed Residents)", dated 02/05/2025, showed that R6 moved-into the facility on [REDACTED]/2021, received home health services, had a private caregiver, and received medication assistance from the facility staff.

Record review of R6's NSA, dated 06/17/2024, showed R6 received medication assistance twice per day for 6 to 10 medications and that staff would order, store, and prepare medication for self-administration.

03.07.2025 10:29:16

State of Washington

11/6

Statement of Deficiencies	License #: 2332	Compliance Determination #54155
Plan of Correction	Park View Villas	Completion Date
Page 6 of 49	Licensee: Park View Villas, LLC	02/25/2025

Record review of R6's Medication Administration Record (MAR), dated January 2025 through February 2025, showed acetaminophen as a medication available to administer to R6 when needed.

In an interview on 02/07/2025 at 2:18 PM, R6 stated that they did not know what medications they took, but that they did keep some medication in their room so they could take it when they wanted. R6 stated that they thought they weren't supposed to have medications in their room, but the facility charged per medication, and it was expensive, so keeping some in their room helped. R6 shared that they kept Tylenol in their apartment so they could take it every night. R6 stated that they kept those medications in their kitchen, up high, in the cabinets.

In an observation on 02/07/2025 at 2:30 PM, inside R6's kitchen, inside the cabinet above the stove, the following medications were observed: a bottle of Dayquil (used to treat cold and flu), a bottle of 500mg tablet Tylenol (pain reliever), a bottle of Zyrtec (allergy medication), a bottle of glucosamine (joint vitamin), a bottle of centrum multivitamin, a bottle of probiotics (digestive aid), and a bottle of alcohol 70 percent (topical antiseptic).

In an interview on 02/07/2025, Staff A stated that they did not know R6 had medications in their room and stated that R6 should not have them in there.

In an interview on 02/13/2025 at 2:00 PM, Staff A acknowledged that R6 did have medications in their room.

In an interview on 02/07/2025 at 5:00 PM, Staff G, Caregiver, stated that residents should not have medications in their room and was asked to remove the medications from resident rooms after it was reported medications were observed in resident rooms.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


 Administrator (or Representative)

3/10/25
 Date

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

Record review of R6's Medication Administration Record (MAR), dated January 2025 through February 2025, showed acetaminophen as a medication available to administer to R6 when needed.

In an interview on 02/07/2025 at 2:18 PM, R6 stated that they did not know what medications they took, but that they did keep some medication in their room so they could take it when they wanted. R6 stated that they thought they weren't supposed to have medications in their room, but the facility charged per medication, and it was expensive, so keeping some in their room helped. R6 shared that they kept Tylenol in their apartment so they could take it every night. R6 stated that they kept those medications in their kitchen, up high, in the cabinets.

In an observation on 02/07/2025 at 2:30 PM, inside R6's kitchen, inside the cabinet above the stove, the following medications were observed: a bottle of Dayquil (used to treat cold and flu), a bottle of 500mg tablet Tylenol (pain reliever), a bottle of Zyrtec (allergy medication), a bottle of glucosamine (joint vitamin), a bottle of centrum multivitamin, a bottle of probiotics (digestive aid), and a bottle of alcohol 70 percent (topical antiseptic).

In an interview on 02/07/2025, Staff A stated that they did not know R6 had medications in their room and stated that R6 should not have them in there.

In an interview on 02/13/2025 at 2:00 PM, Staff A acknowledged that R6 did have medications in their room.

In an interview on 02/07/2025 at 5:00 PM, Staff G, Caregiver, stated that residents should not have medications in their room and was asked to remove the medications from resident rooms after it was reported medications were observed in resident rooms.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

03.07.2025 10:29:16

State of Washington

12/6

Statement of Deficiencies	License #: 2332	Compliance Determination #54155
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WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide care as agreed upon in the negotiated service agreement (NSA) for 4 of 7 sampled residents (Resident 1 [R1], Resident 4 [R4], Resident 5 [R5], and Resident 7 [R7]). This failure placed R1, R4, R5, and R7 at risk for decreased quality of life and unmet care needs.

Findings included...

Record review of facility's Disclosure of Services, dated April 2023, showed that all outside provider services required on-going communications between outside provider and facility's community wellness team. The services were to be provided as agreed upon in the NSA. The disclosure showed that only assistance with showers were provided by facility staff and bed baths were not a provided service. It also showed that total assistance with bathing and bed baths were only available on a short-term basis (not exceeding 2 weeks). Review of the disclosure also showed that the facility did not allow outside assistance with medication except for residents receiving hospice services.

<Resident 1>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed R1 moved into the facility on [REDACTED]/2024, with a diagnosis of [REDACTED].

Record review of R1's NSA, dated 11/12/2024, showed that R1 received medication services, and that facility staff were responsible for ordering and administering all medication. The NSA did not show that the family provided any assistance with medication.

Record review of R1's MAR showed that on 01/05/2025, R1's family member assisted them with taking 3 medications (Celecoxib, Olanzapine and Oxcarbazepine) after the resident refused to take them. Review of the MAR administration notes section showed that staff documented they gave the refused medications to R1's family member to administer.

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

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide care as agreed upon in the negotiated service agreement (NSA) for 4 of 7 sampled residents (Resident 1 [R1], Resident 4 [R4], Resident 5 [R5], and Resident 7 [R7]). This failure placed R1, R4, R5, and R7 at risk for decreased quality of life and unmet care needs.

Findings included...

Record review of facility's Disclosure of Services, dated April 2023, showed that all outside provider services required on-going communications between outside provider and facility's community wellness team. The services were to be provided as agreed upon in the NSA. The disclosure showed that only assistance with showers were provided by facility staff and bed baths were not a provided service. It also showed that total assistance with bathing and bed baths were only available on a short-term basis (not exceeding 2 weeks). Review of the disclosure also showed that the facility did not allow outside assistance with medication except for residents receiving hospice services.

<Resident 1>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed R1 moved into the facility on [REDACTED]/2024, with a diagnosis of [REDACTED] ([REDACTED]).

Record review of R1's NSA, dated 11/12/2024, showed that R1 received medication services, and that facility staff were responsible for ordering and administering all medication. The NSA did not show that the family provided any assistance with medication.

Record review of R1's MAR showed that on 01/05/2025, R1's family member assisted them with taking 3 medications (Celecoxib, Olanzapine and Oxcarbazepine) after the resident refused to take them. Review of the MAR administration notes section showed that staff documented they gave the refused medications to R1's family member to administer.

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In an interview on at 4:49 PM, Collateral Contact 2 (CC2), R1's power of attorney (POA), stated that R1 sometimes refused medication, and the facility called the family to give it to them.

<Resident 4>

Record review of facility's "Washington Resident Characteristic," dated 02/05/2025, showed that R4 moved into the facility on [REDACTED]/2024.

Record review of R4's NSA, dated 01/16/2025 showed that resident required supervision/setup for baths once per week.

In an interview on 02/06/2025 at 4:47 PM, Staff B, Resident Care Director, stated that hospice came in to do R4's baths.

In an observation and interview on 02/07/2025 at 12:23 PM, R4 stated that they did not shower. R4 pulled up their pant leg, and there were flaky white patches covering all their exposed calf.

In an interview on 02/07/2025 at 2:43 PM, Staff B stated that there was a bath aide that came in to do R4's bath but they were not sure of the schedule.

In an interview on 02/07/2025 at 2:55 PM, Staff H, Caregiver, stated that the bath aide stopped coming about two months ago. Staff offered to wash R4's hair but did not do her showers. Staff H was in contact with the hospice nurse that didn't come in on any specified schedule.

In an interview on 02/07/2025 at 5:00PM, Staff A, Administrator, stated that they were unaware R4's bath aide no longer came to the facility to assist R4. Staff A stated they were not sure who bathed R4 if the bath aide was not coming to the facility.

Record review of R4's Medication Administration Record's (MAR), dated October 2024-February 2025, showed no showers were conducted for R4 through that time.

<Resident 5>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED] 2016, with a diagnosis of [REDACTED] ([REDACTED]).

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

In an interview on at 4:49 PM, Collateral Contact 2 (CC2), R1's power of attorney (POA), stated that R1 sometimes refused medication, and the facility called the family to give it to them.

<Resident 4>

Record review of facility's "Washington Resident Characteristic," dated 02/05/2025, showed that R4 moved into the facility on [REDACTED]/2024.

Record review of R4's NSA, dated 01/16/2025 showed that resident required supervision/setup for baths once per week.

In an interview on 02/06/2025 at 4:47 PM, Staff B, Resident Care Director, stated that hospice came in to do R4's baths.

In an observation and interview on 02/07/2025 at 12:23 PM, R4 stated that they did not shower. R4 pulled up their pant leg, and there were flaky white patches covering all their exposed calf.

In an interview on 02/07/2025 at 2:43 PM, Staff B stated that there was a bath aide that came in to do R4's bath but they were not sure of the schedule.

In an interview on 02/07/2025 at 2:56 PM, Staff H, Caregiver, stated that the bath aide stopped coming about two months ago. Staff offered to wash R4's hair but did not do her showers. Staff H was in contact with the hospice nurse that didn't come in on any specified schedule.

In an interview on 02/07/2025 at 5:00PM, Staff A, Administrator, stated that they were unaware R4's bath aide no longer came to the facility to assist R4. Staff A stated they were not sure who bathed R4 if the bath aide was not coming to the facility.

Record review of R4's Medication Administration Record's (MAR), dated October 2024-February 2025, showed no showers were conducted for R4 through that time.

<Resident 5>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED]/2016, with a diagnosis of [REDACTED] ([REDACTED]).

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Record review of R5's NSA, dated 01/02/2025, showed that R5 required staff assistance with showers once per week.

In an interview on 02/07/2025 at 3:51 PM, Collateral Contact 1 (CC1) stated that if R5 missed a shower then the staff would not attempt another shower until the following week. CC1 stated they had to call staff to ensure a shower was conducted for that week, even if there was a refusal for the assigned shower day.

Record review R5's MAR, dated January 2025, showed R5 refused two routine showers. One refusal on 01/16/2025 and the other on 01/27/2025, but no other showers were documented for that month despite the refusal.

In an interview on 02/07/2025 at 5:30 PM, Staff B said that the residents were assigned a specific shower day and if they refused it once then the care staff tried three more times within that day. The caregivers didn't go back between the refusal and the next shower day to attempt another shower.

In an interview on 02/11/2025 at 3:45 PM, Staff P, Regional Nurse, stated that caregivers documented showers after the refusal under PRN (as needed) showers in the MAR. Caregivers attempted to conduct residents' shower on the next shift.

<Resident 7>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R7 moved into the facility on [REDACTED] 2024, with symptoms of urinary incontinence (involuntary loss of bladder control).

Record review of R7's NSA, dated 11/04/2024, showed that R7 required extensive assistance with bathing. Showers should be conducted once per week, using a shower bench/chair. The NSA showed that R7 was at risk for skin breakdown due to decreased mobility and bowel/bladder incontinence.

In an interview on 02/07/2025 at 2:43 PM, Staff B said that R7 refused to get out of bed. The caregivers did a bed bath instead and try to work with them. Staff B stated they had been trying to reassess R7's care but had not been able to.

Record review of R7's MAR, dated December 2024, showed that no showers or bed baths were documented for R7 during the month of December. There was also no documentation of PRN showers.

In an interview on 02/07/2025 at 2:56 PM Staff H, stated that R7 chose to get sponge

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

Record review of R5's NSA, dated 01/02/2025, showed that R5 required staff assistance with showers once per week.

In an interview on 02/07/2025 at 3:51 PM, Collateral Contact 1 (CC1) stated that if R5 missed a shower then the staff would not attempt another shower until the following week. CC1 stated they had to call staff to ensure a shower was conducted for that week, even if there was a refusal for the assigned shower day.

Record review R5's MAR, dated January 2025, showed R5 refused two routine showers. One refusal on 01/16/2025 and the other on 01/27/2025, but no other showers were documented for that month despite the refusal.

In an interview on 02/07/2025 at 5:30 PM, Staff B said that the residents were assigned a specific shower day and if they refused it once then the care staff tried three more times within that day. The caregivers didn't go back between the refusal and the next shower day to attempt another shower.

In an interview on 02/11/2025 at 3:45 PM, Staff P, Regional Nurse, stated that caregivers documented showers after the refusal under PRN (as needed) showers in the MAR. Caregivers attempted to conduct residents' shower on the next shift.

<Resident 7>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R7 moved into the facility on [REDACTED]/2024, with symptoms of urinary incontinence (involuntary loss of bladder control).

Record review of R7's NSA, dated 11/04/2024, showed that R7 required extensive assistance with bathing. Showers should be conducted once per week, using a shower bench/chair. The NSA showed that R7 was at risk for skin breakdown due to decreased mobility and bowel/bladder incontinence.

In an interview on 02/07/2025 at 2:43 PM, Staff B said that R7 refused to get out of bed. The caregivers did a bed bath instead and try to work with them. Staff B stated they had been trying to reassess R7's care but had not been able to.

Record review of R7's MAR, dated December 2024, showed that no showers or bed baths were documented for R7 during the month of December. There was also no documentation of PRN showers.

In an interview on 02/07/2025 at 2:56 PM Staff H, stated that R7 chose to get sponge

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baths.

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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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) <u>April 10, 2025</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>3/10/25</u> _____ Date

WAC 398-78A-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 facility failed to ensure a fingerprint background check was completed within 120 days of hire for 1 of 4 sampled staff (Staff B). This failure placed 33 of 33 residents at risk for receiving care by an individual with a potentially disqualifying history

Findings included...

In an interview on 02/05/2025 at 10:51 AM Staff A, Executive Director, stated that they were responsible for employee onboarding.

Record review of the document titled, Park View Villas Employee Hire Date, dated 02/05/2025, showed Staff B, Resident Care Director, was hired on 08/22/2024.

Record review of Staff B's personnel file did not show a fingerprint background check for Staff B.

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

baths.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

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 facility failed to ensure a fingerprint background check was completed within 120 days of hire for 1 of 4 sampled staff (Staff B). This failure placed 33 of 33 residents at risk for receiving care by an individual with a potentially disqualifying history.

Findings included...

In an interview on 02/05/2025 at 10:51 AM Staff A, Executive Director, stated that they were responsible for employee onboarding.

Record review of the document titled, Park View Villas Employee Hire Date, dated 02/05/2025, showed Staff B, Resident Care Director, was hired on 08/22/2024.

Record review of Staff B's personnel file did not show a fingerprint background check for Staff B.

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

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In an interview on 02/07/2025 at 11:38 AM, Staff A was asked to provide the department with Staff B's final fingerprint result to review.

On 02/07/2025 at 2:15 PM, Staff A provided the department with Staff B's final background check that showed the background check result was received 12/30/2024. Staff B's 120th day of employment was 12/20/2024, with the background check results received 10 days after the required timeframe.

In an interview on 02/07/2025 at 6:55 PM, Staff A acknowledged that Staff B did not receive their fingerprint background check within the required timeframe. Staff A acknowledged that Staff B should not have worked at the facility past their 120th day of employment without the results.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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



Administrator (or Representative)



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 facility failed to ensure 2 of 2 sampled staff (Staff G and Staff Q) had a Washington state name and date of birth background check completed every two years. This failure placed 33 of 33 residents at risk of receiving

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

In an interview on 02/07/2025 at 11:38 AM, Staff A was asked to provide the department with Staff B's final fingerprint result to review.

On 02/07/2025 at 2:15 PM, Staff A provided the department with Staff B's final background check that showed the background check result was received 12/30/2024. Staff B's 120th day of employment was 12/20/2024, with the background check results received 10 days after the required timeframe.

In an interview on 02/07/2025 at 6:55 PM, Staff A acknowledged that Staff B did not receive their fingerprint background check within the required timeframe. Staff A acknowledged that Staff B should not have worked at the facility past their 120th day of employment without the results.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

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 facility failed to ensure 2 of 2 sampled staff (Staff G and Staff Q) had a Washington state name and date of birth background check completed every two years. This failure placed 33 of 33 residents at risk of receiving

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care by an individual with a potential disqualifying history.

Findings Included...

<Staff G>

Record review of the untitled staff roster, dated 02/05/2025, showed Staff G, Caregiver, was hired on 08/28/2007.

Record review of Staff G's personnel file showed results from a Washington state name and date of birth background check for 06/24/2019 and 06/14/2023. There was no background check result to review for 2021.

On 02/07/2025 at 5:00PM, the department requested to review the Washington state name and date of birth background check for Staff G from 2021.

Record review of an email received on 02/12/2025 at 2:33 PM showed Staff A, Executive Director, stated that the facility did not have a background check result on file for Staff G from 2021. Staff A stated that, although they found an authorization form that had been filled out on 07/02/2021, Staff A was able to confirm that the background check was never processed nor was a result obtained.

In an interview on 02/13/2025 at 2:00 PM, Staff A confirmed a 2021 background check was not conducted for Staff G. Staff A acknowledged Staff G's 2023 Washington state name and date of birth background check was conducted 720 days late.

<Staff Q>

Record review of the untitled staff roster, dated 02/05/2025, showed Staff Q, Caregiver, was hired 06/20/2017.

Record review of Staff Q's personnel record showed a final fingerprint background check dated July 25, 2017, a Washington state name and date of birth background check dated July 10, 2019, a Washington state name and date of birth background check dated July 16, 2021, and a Washington state name and date of birth background check dated July 18, 2023. The background check between July 2019 and July 2021 was six days late and the background check between July 2021 and July 2023 was two days late.

Record review of Staff Q's personnel record showed that there were no background check authorization request forms to review.

care by an individual with a potential disqualifying history.

Findings included...

<Staff G>

Record review of the untitled staff roster, dated 02/05/2025, showed Staff G, Caregiver, was hired on 08/29/2007.

Record review of Staff G's personnel file showed results from a Washington state name and date of birth background check for 06/24/2019 and 06/14/2023. There was no background check result to review for 2021.

On 02/07/2025 at 5:00PM, the department requested to review the Washington state name and date of birth background check for Staff G from 2021.

Record review of an email received on 02/12/2025 at 2:33 PM showed Staff A, Executive Director, stated that the facility did not have a background check result on file for Staff G from 2021. Staff A stated that, although they found an authorization form that had been filled out on 07/02/2021, Staff A was able to confirm that the background check was never processed nor was a result obtained.

In an interview on 02/13/2025 at 2:00 PM, Staff A confirmed a 2021 background check was not conducted for Staff G. Staff A acknowledged Staff G's 2023 Washington state name and date of birth background check was conducted 720 days late.

<Staff Q>

Record review of the untitled staff roster, dated 02/05/2025, showed Staff Q, Caregiver, was hired 06/20/2017.

Record review of Staff Q's personnel record showed a final fingerprint background check dated July 25, 2017, a Washington state name and date of birth background check dated July 10, 2019, a Washington state name and date of birth background check dated July 16, 2021, and a Washington state name and date of birth background check dated July 18, 2023. The background check between July 2019 and July 2021 was six days late and the background check between July 2021 and July 2023 was two days late.

Record review of Staff Q's personnel record showed that there were no background check authorization request forms to review.

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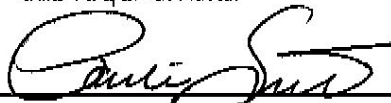
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In an interview on 02/13/2025 at 2:00 PM, Staff A acknowledged Staff C's Washington state name and date of birth background checks for 2021 and 2023 were not conducted within the required timeframes.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


Administrator (or Representative)

3/10/25
Date

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 interview and record review, the facility failed to ensure that 1 of 4 sampled Staff (Staff E) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within the required time frames. This failure placed 33 of 33 residents and staff at risk for exposure to TB.

Findings included...

Record review of the facility's employee roster, dated 02/05/2025, showed that Staff E, Caregiver, was hired 01/30/2024.

Record review of Staff E's TB testing record showed Staff E received their first intradermal tuberculin skin test (TST) by Mantoux-method on 03/14/2024. The test was initiated 41 days late

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

In an interview on 02/13/2025 at 2:00 PM, Staff A acknowledged Staff Q's Washington state name and date of birth background checks for 2021 and 2023 were not conducted within the required timeframes.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

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 interview and record review, the facility failed to ensure that 1 of 4 sampled Staff (Staff E) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within the required time frames. This failure placed 33 of 33 residents and staff at risk for exposure to TB.

Findings included...

Record review of the facility's employee roster, dated 02/05/2025, showed that Staff E, Caregiver, was hired 01/30/2024.

Record review of Staff E's TB testing record showed Staff E received their first intradermal tuberculin skin test (TST) by Mantoux-method on 03/14/2024. The test was initiated 41 days late.

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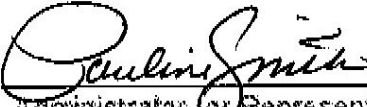
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In an interview on 02/05/2025 at 8:51 PM Staff A, Executive Director, stated that Staff B, Resident Care Coordinator, was responsible for ensuring new staff received their TB test within the required time frames. Staff A acknowledged Staff E's TB testing series was initiated late.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


 Administrator (or Representative)

3/10/25
 Date

WAC 388-76A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.85A RCW, Nursing assistants;

(c) Chapter 246-840 WAC, Practical and registered nursing;

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

In an interview on 02/05/2025 at 6:51 PM Staff A, Executive Director, stated that Staff B, Resident Care Coordinator, was responsible for ensuring new staff received their TB test within the required time frames. Staff A acknowledged Staff E's TB testing series was initiated late.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

(c) Chapter 246-840 WAC, Practical and registered nursing;

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(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had the required nurse delegation training for 2 of 2 staff (Staff D and Staff F) reviewed. This failure resulted in 2 of 2 residents (Resident 2 [R2] and Resident 3 [R3]) receiving nurse delegation services from unqualified staff.

Findings included...

RCW 18.88A.210 "Delegation- Basic and specialized nurse delegation training requirements. ... (3)(a) Before commencing any specific nursing care tasks authorized under this chapter, the nursing assistant must (i) provide to the delegating nurse a certificate of completion issued by the department of social and health services indicating the completion of basic core nurse delegation training, (ii) be regulated by the department of health pursuant to this chapter, subject to the uniform disciplinary act under chapter 18.130 RCW, and (iii) meet any additional training requirements identified by the *nursing care quality assurance commission. Exceptions to these training requirements must adhere to RCW 18.79.260(3)(e)(vi)..."

Washington Administrative Code (WAC) 246-840-930 "Criteria for delegation. (8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training; (d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions."

Record review of the Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", undated, showed the Registered Nurse (RN) would assess the residents to determine stability and predictability. All long-term care workers (LTCW) must have an active credential with the Washington State Department of health to be delegated. The RN delegator must verify that the medication technicians had the required certificates and credentials prior to being delegated to administer RN delegated tasks for the residents. The resident's task must be delegated if the task was to be completed by the LTCW. Residents that were not functionally able and/or not cognitively aware that they received medications, the LTCW would be authorized to administer those medications with delegation. The LTCW must

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had the required nurse delegation training for 2 of 2 staff (Staff D and Staff F) reviewed. This failure resulted in 2 of 2 residents (Resident 2 [R2] and Resident 3 [R3]) receiving nurse delegation services from unqualified staff.

Findings included...

RCW 18.88A.210 "Delegation- Basic and specialized nurse delegation training requirements...(3)(a) Before commencing any specific nursing care tasks authorized under this chapter, the nursing assistant must (i) provide to the delegating nurse a certificate of completion issued by the department of social and health services indicating the completion of basic core nurse delegation training, (ii) be regulated by the department of health pursuant to this chapter, subject to the uniform disciplinary act under chapter 18.130 RCW, and (iii) meet any additional training requirements identified by the *nursing care quality assurance commission. Exceptions to these training requirements must adhere to RCW 18.79.260(3)(e)(vi)..."

Washington Administrative Code (WAC) 246-840-930 "Criteria for delegation. (8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training; (d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions."

Record review of the Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", undated, showed the Registered Nurse (RN) would assess the residents to determine stability and predictability. All long-term care workers (LTCW) must have an active credential with the Washington State Department of health to be delegated. The RN delegator must verify that the medication technicians had the required certificates and credentials prior to being delegated to administer RN delegated tasks for the residents. The resident's task must be delegated if the task was to be completed by the LTCW. Residents that were not functionally able and/or not cognitively aware that they received medications, the LTCW would be authorized to administer those medications with delegation. The LTCW must

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be delegated for each resident task. The document showed for a resident to be assisted with their medications the resident must be both functionally, able to get the medication to where it needs to go and cognitively, aware they receive medications, but not know the name or the intended side effects.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide (HCA)

Record review of facility's 'Nurse Delegation Policies and Procedures', dated 01/22/2019, showed that delegating RN's will ensure competency of staff, NACs (Nursing Assistant Certification) and HCAs must show proof of training and NARs (Nursing Assistant Registered) must show proof of exempt status along with training.

<Staff D and Staff F>

Record review of document titled, 'Park View Villas Employee Hire Date,' dated 02/05/2025, showed that Staff D, Caregiver, was hired on 06/10/2024, and Staff F, Caregiver, was hired on 01/30/2024.

Record review of Department of Health (DOH) Provider Credential Search on 02/06/2025 showed that Staff D and Staff F held no active credential.

Record review of Staff D and Staff F's personnel files showed that there was no certificate of completion for the HCA training to review for either staff person.

Record review of the facility's nurse delegation records showed that there were no delegation records for Staff D nor Staff F

In an interview on 02/05/2025 at 3:41 PM, Staff A, Executive Director, stated that they were aware Staff D did not have their HCA credential.

In an interview on 02/06/2025 at 1:45PM, Staff B, Resident Care Director, stated they were the person responsible for scheduling and ensuring that only qualified staff were on the schedule. Staff B stated they were aware that there were two staff who did not have their credentials and that those staff included Staff D and Staff F. Staff B stated they were aware that Staff D and Staff F were administering medications to residents and that they should not be doing so because they lacked their HCA credential. Staff B stated they were not aware of any residents currently requiring nurse delegation.

In an interview on 02/06/2025 at 6:25 PM, Staff D said that R2 and R3 were nurse

be delegated for each resident task. The document showed for a resident to be assisted with their medications the resident must be both functionally, able to get the medication to where it needs to go and cognitively, aware they receive medications, but not know the name or the intended side effects.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide (HCA).

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<Staff D and Staff F>

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Record review of Department of Health (DOH) Provider Credential Search on 02/06/2025 showed that Staff D and Staff F held no active credential.

Record review of Staff D and Staff F's personnel files showed that there was no certificate of completion for the HCA training to review for either staff person.

Record review of the facility's nurse delegation records showed that there were no delegation records for Staff D nor Staff F.

In an interview on 02/05/2025 at 3:41 PM, Staff A, Executive Director, stated that they were aware Staff D did not have their HCA credential.

In an interview on 02/06/2025 at 1:45PM, Staff B, Resident Care Director, stated they were the person responsible for scheduling and ensuring that only qualified staff were on the schedule. Staff B stated they were aware that there were two staff who did not have their credentials and that those staff included Staff D and Staff F. Staff B stated they were aware that Staff D and Staff F were administering medications to residents and that they should not be doing so because they lacked their HCA credential. Staff B stated they were not aware of any residents currently requiring nurse delegation.

In an interview on 02/06/2025 at 6:25 PM, Staff D said that R2 and R3 were nurse

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delegated and that they couldn't pass medications to delegated residents.

In an interview on 02/06/2025 at 6:43 PM, Staff A, Executive Director, stated that a person did not require credentials to pass medications.

In an interview on 02/07/2025 at 10:38 AM, Staff R, Nurse Delegator, stated they communicate with Staff B every time they went to the facility and reviewed which residents were delegated and ensured Staff B had no questions. Staff R stated that nurse delegation services for residents were initiated by the facility, and they would call Staff R and ask that Staff R delegate staff for those specific residents. Staff R stated they only delegate staff who were properly credentialed and were unaware uncredentialed staff were passing medications. Staff R confirmed that staff required a HCA credential, Nursing Assistant Registered (NAR) or Nursing Assistant Certification (NAC) to be delegated. Staff R stated the previous facility nurse used to cover shifts when no available, qualified, staff person was scheduled to pass medications.

In an interview on 02/07/2025 at 4:47 PM, Staff B stated that Staff D and Staff F were designated as one of the medication technicians and that they were responsible for scheduling and training staff to pass medications in the facility. Staff B stated that one med technician had to be on each shift to pass medications to the residents. They acknowledged Staff D and F had not completed the required HCA training.

<Resident 2 and Resident 3>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that two of 33 residents required nurse delegation.

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R2 moved into the facility on [REDACTED] 2024 and R3 moved in [REDACTED] 2021. The document showed R2 and R3 had dementia (a condition that affects memory), required medication administration, and received nurse delegation.

In an interview on 02/07/2025 at 3:35 PM Staff A stated that the information documented on the "Washington Resident Characteristic," Roster was information taken directly from resident assessments.

Record review of R2's medication administration record (MAR), dated 12/01/2024 through 02/05/2025 showed Staff D administered their medications on 12/01/2024, 12/03/2024, 12/04/2024, 12/09/2024, 12/10/2024, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025 and 02/04/2025.

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delegated and that they couldn't pass medications to delegated residents.

In an interview on 02/06/2025 at 6:43 PM, Staff A, Executive Director, stated that a person did not require credentials to pass medications.

In an interview on 02/07/2025 at 10:36 AM, Staff R, Nurse Delegator, stated they communicate with Staff B every time they went to the facility and reviewed which residents were delegated and ensured Staff B had no questions. Staff R stated that nurse delegation services for residents were initiated by the facility, and they would call Staff R and ask that Staff R delegate staff for those specific residents. Staff R stated they only delegate staff who were properly credentialed and were unaware uncredentialed staff were passing medications. Staff R confirmed that staff required a HCA credential, Nursing Assistant Registered (NAR) or Nursing Assistant Certification (NAC) to be delegated. Staff R stated the previous facility nurse used to cover shifts when no available, qualified, staff person was scheduled to pass medications.

In an interview on 02/07/2025 at 4:47 PM, Staff B stated that Staff D and Staff F were designated as one of the medication technicians and that they were responsible for scheduling and training staff to pass medications in the facility. Staff B stated that one med technician had to be on each shift to pass medications to the residents. They acknowledged Staff D and F had not completed the required HCA training.

<Resident 2 and Resident 3>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that two of 33 residents required nurse delegation.

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R2 moved-into the facility on [REDACTED]/2024 and R3 moved in [REDACTED]/2021. The document showed R2 and R3 had dementia (a condition that affects memory), required medication administration, and received nurse delegation.

In an interview on 02/07/2025 at 3:35 PM Staff A stated that the information documented on the "Washington Resident Characteristic," Roster was information taken directly from resident assessments.

Record review of R2's medication administration record (MAR), dated 12/01/2024 through 02/05/2025 showed Staff D administered their medications on 12/01/2024, 12/03/2024, 12/04/2024, 12/09/2024, 12/10/2024, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025 and 02/04/2025.

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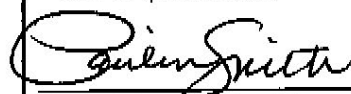
Record review of R3's MAR, dated 11/01/2024 through 02/05/2025, showed that Staff D administered their medications on 11/09/2024, 11/10/2024, 11/14/2024, 11/19/2024, 11/28/2024, 12/1/2024, 12/3/2024, 12/4/2024, 12/9/2024, 12/15/2024, 12/22/2024, 01/07/2025, 01/08/2025, 1/09/2025, 01/14/2025, 01/18/2025, 01/23/2025, 01/25/2025, 01/26/2025, 01/27/2025, 01/28/2025, 01/29/2025, 02/02/2025, 02/04/2025, and 02/05/2025.

Record review of R3's MAR, dated 11/01/2024 through 02/08/2025, showed that Staff F administered their medications on 11/01/2024, 11/06/2024, 11/20/2024, and 11/25/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Park View Villas is or will be in compliance with this law and / or regulation on (Date) Apr 1 19 2025

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



Administrator (or Representative)

3/10/25

Date

WAC 388-76A-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;

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on observations, interviews and record review, the facility failed to ensure that 5 out of 6 staff (Staff B, Staff D, Staff E, Staff F, and Staff J) had the required credentials to provide care and services to residents. This failure placed 33 of 33 residents at risk of receiving care from unqualified staff and at risk for unmet care needs.

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

Record review of R3's MAR, dated 11/01/2024 through 02/06/2025, showed that Staff D administered their medications on 11/09/2024, 11/10/2024, 11/14/2024, 11/19/2024, 11/28/2024, 12/1/2024, 12/3/2024, 12/4/2024, 12/9/2024, 12/15/2024, 12/22/2024, 01/07/2025, 01/08/2025, 1/09/2025, 01/14/2025, 01/19/2025, 01/23/2025, 01/25/2025, 01/26/2025, 01/27/2025, 01/28/2025, 01/29/2025, 02/02/2025, 02/04/2025, and 02/05/2025.

Record review of R3's MAR, dated 11/01/2024 through 02/06/2025, showed that Staff F administered their medications on 11/01/2024, 11/06/2024, 11/20/2024, and 11/25/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

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;

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This requirement was not met as evidenced by:

Based on observations, interviews and record review, the facility failed to ensure that 5 out of 6 staff (Staff B, Staff D, Staff E, Staff F, and Staff J) had the required credentials to provide care and services to residents. This failure placed 33 of 33 residents at risk of receiving care from unqualified staff and at risk for unmet care needs.

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Findings included...

WAC 388-112A-0106 "Who is required to obtain home care aide certification and by when? (1) All long-term care workers must obtain home care aide certification as provided in chapter 246-860 WAC. (2) The following individuals must obtain home care aide certification as follows... (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire."

WAC 246-860-020

"Long-term care workers and home care aide certification.

Any person who is hired on or after January 7, 2012, as a long-term care worker for the elderly or persons with disabilities, regardless of the employment title, must obtain certification as a home care aide, unless exempt under WAC 246-860-025. This includes, but is not limited to:

... (4) A direct care worker in a state licensed assisted living facility;"

WAC 388-112A-0400 "(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450. (b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement. (c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (b) Dementia specialty training as described in WAC 388-112A-0440; (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 (5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire. (6) For long-term care workers who have completed the 75-hour training and do not have a specialty training certificate that indicates completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs."

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

Findings included...

WAC 388-112A-0105 "Who is required to obtain home care aide certification and by when? (1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (2) The following individuals must obtain home care aide certification as follows... (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire."

WAC 246-980-020

"Long-term care workers and home care aide certification.

Any person who is hired on or after January 7, 2012, as a long-term care worker for the elderly or persons with disabilities, regardless of the employment title, must obtain certification as a home care aide, unless exempt under WAC 246-980-025. This includes, but is not limited to:

... (4) A direct care worker in a state licensed assisted living facility;"

WAC 388-112A-0400 "(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450. (b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement. (c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (b) Dementia specialty training as described in WAC 388-112A-0440; (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 (5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire. (6) For long-term care workers who have completed the 75-hour training and do not have a specialty training certificate that indicates completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs."

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WAC 388-112A-0480 "What are the specialty training requirements for applicants, resident managers, administrators, and other types of entity representatives in adult family homes, assisted living facilities, and enhanced services facilities? ... Assisted living facilities. (3) If an assisted living facility serves one or more residents with special needs, the assisted living facility administrator or designee must complete specialty training and demonstrate competency within one hundred twenty days of date of hire. (4) If a resident develops special needs while living in an assisted living facility, the assisted living facility administrator or designee has one hundred twenty days to complete specialty training and demonstrate competency, or demonstrate proof of specialty training."

<Staff D>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff D, Caregiver, was hired on 06/10/2024 for the swing shift (evening hours).

Record review of Department of Health (DOH) Provider Credential Search on 02/06/2025 showed that Staff D held no active credential.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide (HCA).

Record review of Staff D's personnel file showed specialty training for dementia and mental health were completed on 01/30/2025, 234 days after their start date.

In an interview on 02/06/2025 at 1:45PM, Staff B, Resident Care Director, stated that they were the person responsible for scheduling and ensuring that only qualified staff were on the schedule. Staff B stated that they were aware that there were two staff who did not have their credentials and that those staff included Staff D, Caregiver, and Staff F, Caregiver. Staff B stated that they were aware that Staff D and Staff F were administering medications to residents. Staff B stated that they were aware Staff D and Staff F should not be administering medications because they lack the credentials and training to do that.

In an interview on 02/05/2025 at 3:41 PM, Staff A, Executive Director, stated that there were two staff on the employee roster who did not have their Health Care Aide Certification. Staff A stated that they were aware those two staff were also past the due date for obtaining their certifications. Staff A stated that those two employees were Staff D and Staff E.

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

WAC 388-112A-0490 "What are the specialty training requirements for applicants, resident managers, administrators, and other types of entity representatives in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities. (3) If an assisted living facility serves one or more residents with special needs, the assisted living facility administrator or designee must complete specialty training and demonstrate competency within one hundred twenty days of date of hire. (4) If a resident develops special needs while living in an assisted living facility, the assisted living facility administrator or designee has one hundred twenty days to complete specialty training and demonstrate competency, or demonstrate proof of specialty training."

<Staff D>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff D, Caregiver, was hired on 06/10/2024 for the swing shift (evening hours).

Record review of Department of Health (DOH) Provider Credential Search on 02/06/2025 showed that Staff D held no active credential.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide (HCA).

Record review of Staff D's personnel file showed specialty training for dementia and mental health were completed on 01/30/2025, 234 days after their start date.

In an interview on 02/06/2025 at 1:45PM, Staff B, Resident Care Director, stated that they were the person responsible for scheduling and ensuring that only qualified staff were on the schedule. Staff B stated that they were aware that there were two staff who did not have their credentials and that those staff included Staff D, Caregiver, and Staff F, Caregiver. Staff B stated that they were aware that Staff D and Staff F were administering medications to residents. Staff B stated that they were aware Staff D and Staff F should not be administering medications because they lack the credentials and training to do that.

In an interview on 02/05/2025 at 3:41 PM, Staff A, Executive Director, stated that there were two staff on the employee roster who did not have their Health Care Aide Certification. Staff A stated that they were aware those two staff were also past the due date for obtaining their certifications. Staff A stated that those two employees were Staff D and Staff E.

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In an interview on 02/05/2025 at 6:25 PM, Staff D stated that on 12/03/2024, Staff A told them that they needed to complete the skills course for the HCA credentials. They stated that they had until 02/28/2025 to complete the credentialing test with DOH. Staff D's 120th date of employment was 10/08/2024 and their 200th date of employment was 12/27/2024.

Record review of the facility's caregiver schedule for January – February 2025, showed that Staff D was scheduled for a total of 20 days in January 2025 and 19 days in February 2025.

Record review of Resident 1's (R1) Medication Administration Record (MAR), dated 12/01/2024 – 02/05/2025 showed that Staff D assisted R1 with taking their medication on 12/01/2024, 12/03/2024, 12/04/2024, 12/09/2024, 12/10/2024, 12/11/2024, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025, and 02/04/2025.

Record review of Resident 2's (R2) MAR, dated 12/01/2024 through 02/05/2025 showed Staff D administered their medications on 12/01/2024, 12/03/2024, 12/04/2024, 12/09/2024, 12/10/2024, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025 and 02/04/2025.

Record review of Resident 3's (R3) MAR, dated 11/01/2024 through 02/06/2025, showed that Staff D administered their medications on 11/09/2024, 11/10/2024, 11/14/2024, 11/19/2024, 11/28/2024, 12/1/2024, 12/3/2024, 12/4/2024, 12/9/2024, 12/15/2024, 12/22/2024, 01/07/2025, 01/09/2025, 01/09/2025, 01/14/2025, 01/19/2025, 01/23/2025, 01/25/2025, 01/26/2025, 01/27/2025, 01/28/2025, 01/29/2025, 02/02/2025, 02/04/2025, and 02/05/2025.

Record review of Resident 4's (R4) MAR, dated 12/01/2024 - 02/05/2025, showed that Staff D assisted R4 with taking their medications on 12/20/2024 and 01/16/2025.

Record review of Resident 5's (R5) MAR, dated 12/01/2024 – 02/05/2025, showed that Staff D assisted R5 with taking their medications on 12/01/2024, 12/03/2025, 12/04/2024, 12/09/2024 through 12/11/2025, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025 and 02/04/2025.

Record review of Resident 7's (R7) MAR, dated 12/01/2024 – 02/05/2025, showed that Staff D assisted R7 with taking their medications on 12/05/2024, 12/06/2024, 12/08/2024, 12/12/2024, 12/18/2024 through 12/20/2024, 12/24/2024, 12/26/2024, 12/29/2024, 12/31/2024, 01/01/2025, 01/02/2025, 01/04/2025, 01/05/2025, 01/11/2025,

In an interview on 02/06/2025 at 6:25 PM, Staff D stated that on 12/03/2024, Staff A told them that they needed to complete the skills course for the HCA credentials. They stated that they had until 02/28/2025 to complete the credentialing test with DOH. Staff D's 120th date of employment was 10/08/2024 and their 200th date of employment was 12/27/2024.

Record review of the facility's caregiver schedule for January – February 2025, showed that Staff D was scheduled for a total of 20 days in January 2025 and 19 days in February 2025.

Record review of Resident 1's (R1) Medication Administration Record (MAR), dated 12/01/2024 – 02/05/2025 showed that Staff D assisted R1 with taking their medication on 12/01/2024, 12/03/2024, 12/04/2024, 12/09/2024, 12/10/2024, 12/11/2024, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025, and 02/04/2025.

Record review of Resident 2's (R2) MAR, dated 12/01/2024 through 02/05/2025 showed Staff D administered their medications on 12/01/2024, 12/03/2024, 12/04/2024, 12/09/2024, 12/10/2024, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2026, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025 and 02/04/2025.

Record review of Resident 3's (R3) MAR, dated 11/01/2024 through 02/06/2025, showed that Staff D administered their medications on 11/09/2024, 11/10/2024, 11/14/2024, 11/19/2024, 11/28/2024, 12/1/2024, 12/3/2024, 12/4/2024, 12/9/2024, 12/15/2024 12/22/2024, 01/07/2025, 01/08/2025, 1/09/2025, 01/14/2025, 01/19/2025, 01/23/2025, 01/25/2025, 01/26/2025, 01/27/2025, 01/28/2025, 01/29/2025, 02/02/2025, 02/04/2025, and 02/05/2025.

Record review of Resident 4's (R4) MAR, dated 12/01/2024 - 02/05/2025, showed that Staff D assisted R4 with taking their medications on 12/20/2024 and 01/16/2025.

Record review of Resident 5's (R5) MAR, dated 12/01/2024 – 02/05/2025, showed that Staff D assisted R5 with taking their medications on 12/01/2024, 12/03/2025, 12/04/2024, 12/09/2024 through 12/11/2025, 12/15/2024, 12/22/2024, 01/07/2025 through 01/09/2025, 01/14/2025, 01/19/2025, 01/21/2025 through 01/23/2025, 01/26/2025 through 01/29/2025, 02/02/2025 and 02/04/2025.

Record review of Resident 7's (R7) MAR, dated 12/01/2024 – 02/05/2025, showed that Staff D assisted R7 with taking their medications on 12/05/2024, 12/06/2024, 12/08/2024, 12/12/2024, 12/16/2024 through 12/20/2024, 12/24/2024, 12/26/2024, 12/29/2024, 12/31/2024, 01/01/2025, 01/02/2025, 01/04/2025, 01/05/2025, 01/11/2025,

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01/12/2025, 01/16/2025, and 01/18/2025

<Staff E>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff E, Caregiver, was hired on 01/30/2024 for the day shift.

Record review of DOH Provider Credential Search on 02/06/2025 showed that Staff E held no active credential.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide.

In an interview on 02/07/2025 at 4:52 PM, Staff B said that Staff E and D were not complete with the required HCA training.

In an interview on 02/06/2025 at 6:25 PM, Staff D stated that on 12/03/2024, Staff A told them, Staff E and Staff F that they needed to complete the skills course for the HCA credentials. They stated that they had until 02/28/2025 to complete the credentialing test with DOH.

Record review of the facility's caregiver schedule for January – February 2025, showed that Staff E was scheduled for a total of 22 days in January 2025 and 22 days in February 2025.

<Staff F>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff E, Caregiver, was hired on 01/30/2024 for the swing shift.

Record review of DOH Provider Credential Search on 02/06/2025 showed that Staff F held no active credential.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide.

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01/12/2025, 01/16/2025, and 01/18/2025

<Staff E>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff E, Caregiver, was hired on 01/30/2024 for the day shift.

Record review of DOH Provider Credential Search on 02/06/2025 showed that Staff E held no active credential.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide.

In an interview on 02/07/2025 at 4:52 PM, Staff B said that Staff E and D were not complete with the required HCA training.

In an interview on 02/06/2025 at 6:25 PM, Staff D stated that on 12/03/2024, Staff A told them, Staff E and Staff F that they needed to complete the skills course for the HCA credentials. They stated that they had until 02/28/2025 to complete the credentialing test with DOH.

Record review of the facility's caregiver schedule for January – February 2025, showed that Staff E was scheduled for a total of 22 days in January 2025 and 22 days in February 2025.

<Staff F>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff E, Caregiver, was hired on 01/30/2024 for the swing shift.

Record review of DOH Provider Credential Search on 02/06/2025 showed that Staff F held no active credential.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide.

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Record review of the facility's caregiver schedule for January – February 2025, showed that Staff E was scheduled for a total of 12 shifts in January 2025 and 13 shifts in February 2025.

In an interview on 02/07/2025 at 4:38 PM, Staff H, Caregiver, did not include Staff F in the list of staff members that were designated medication technicians. Staff H stated to become a medication technician, the staff member must shadow the medication technicians for a few days and then read a book.

In an interview on 02/07/2025 at 4:47 PM, Staff B stated that Staff F was designated as one of the medication technicians. Staff B stated that one med technician had to be on each shift to pass medications to the residents. They also stated that staff members go through Staff B to train for the medication cart.

In an interview on 02/07/2025 at 4:53 PM, Staff B said that Staff F was not making much progress on completing their cornerstone classes to be credentialed so they talked about taking them off the schedule.

In an interview on 02/06/2025 at 6:25 PM, Staff D stated that, on 12/03/2024, Staff A told them, Staff E and Staff F that they needed to complete the skills course for the HCA credentials. They stated that they had until 02/28/2025 to complete the credentialing test with DOH.

Record review of R3's MAR, dated 11/01/2024 through 02/05/2025, showed that Staff F administered their medications on 11/01/2024, 11/06/2024, 11/20/2024, and 11/25/2024.

Record review of R4's MAR dated 12/01/2024 – 02/05/2025 showed that Staff F assisted R4 with taking their medication on 01/08/2025, 01/10/2025, 01/17/2025, 01/27/2025, 01/29/2025.

Record review of R7's MAR dated 12/01/2024 – 02/05/2025 showed that Staff F assisted R7 with taking their medication on 12/02/2024, 12/04/2024, 01/06/2025, 01/08/2025, 01/10/2025, 01/13/2025, 01/16/2025, 01/17/2025, 01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025, 01/29/2025, and 01/31/2025.

<Staff J>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff J, Front Desk/Receptionist, was hired on 10/15/2024.

On 02/07/2025 at 12:41 PM, Staff J, Front Desk/Receptionist was observed pushing a

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Record review of the facility's caregiver schedule for January – February 2025, showed that Staff E was scheduled for a total of 12 shifts in January 2025 and 13 shifts in February 2025.

In an interview on 02/07/2025 at 4:38 PM, Staff H, Caregiver, did not include Staff F in the list of staff members that were designated medication technicians. Staff H stated to become a medication technician, the staff member must shadow the medication technicians for a few days and then read a book.

In an interview on 02/07/2025 at 4:47 PM, Staff B stated that Staff F was designated as one of the medication technicians. Staff B stated that one med technician had to be on each shift to pass medications to the residents. They also stated that staff members go through Staff B to train for the medication cart.

In an interview on 02/07/2025 at 4:53 PM, Staff B said that Staff F was not making much progress on completing their cornerstone classes to be credentialed so they talked about taking them off the schedule.

In an interview on 02/06/2025 at 6:25 PM, Staff D stated that, on 12/03/2024, Staff A told them, Staff E and Staff F that they needed to complete the skills course for the HCA credentials. They stated that they had until 02/28/2025 to complete the credentialing test with DOH.

Record review of R3's MAR, dated 11/01/2024 through 02/06/2025, showed that Staff F administered their medications on 11/01/2024, 11/06/2024, 11/20/2024, and 11/25/2024.

Record review of R4's MAR dated 12/01/2024 – 02/05/2025 showed that Staff F assisted R4 with taking their medication on 01/08/2025, 01/10/2025, 01/17/2025, 01/27/2025, 01/29/2025.

Record review of R7's MAR dated 12/01/2024 – 02/05/2025 showed that Staff F assisted R7 with taking their medication on 12/02/2024, 12/04/2024, 01/06/2025, 01/08/2025, 01/10/2025, 01/13/2025, 01/15/2025, 01/17/2025, 01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025, 01/29/2025, and 01/31/2025.

<Staff J>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff J, Front Desk/Receptionist, was hired on 10/15/2024.

On 02/07/2025 at 12:41 PM, Staff J, Front Desk/Receptionist was observed pushing a

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resident's wheelchair to their room.

In an observation and interview on 02/07/2025 at 2:01 PM, Staff J was carrying a blood pressure cuff, and they told the Department that they were on the way to obtain a vital sign for a resident.

Record review of DOH Provider Credential Search dated 02/06/2025, showed there were no active credentials for Staff J.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide.

Record review of the facility's caregiver schedule for January – February 2025, showed that Staff J was scheduled once per week, every week, on Friday mornings.

In an interview on 02/07/2025 at 2:53 PM, Staff B stated that the facility's process was to get new staff signed up with cornerstone as soon as possible so that they can take the test in 120 days and then credentialed by 200 days.

In an interview on 02/07/2025, at 4:52 PM, Staff B said that Staff J worked one day a week as a caregiver. They stated Staff J got cross trained as a caregiver, shortly after she got hired. Staff B stated that Staff J had not done the required training

<Staff B>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff B, Resident Care Director, was hired on 08/22/2024.

Record review of Staff B's personnel file showed specialty training for mental health was completed on 10/19/2024, 58 days after hire date and specialty training for dementia was completed on 01/30/2025, 169 days after hire date.

In an interview on 02/06/2025 at 1:46PM, Staff B stated that they were the person responsible for scheduling and ensuring that only qualified staff were on the schedule. Staff B stated that they were aware that there were two staff who did not have their credentials and that those staff included Staff D, Caregiver, and Staff F, Caregiver. Staff B stated that they were aware that Staff D and Staff F were administering medications to residents. Staff B stated that they were aware Staff D and Staff F should not be administering medications because they lack the credentials and training to do that.

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resident's wheelchair to their room.

In an observation and interview on 02/07/2025 at 2:01 PM, Staff J was carrying a blood pressure cuff, and they told the Department that they were on the way to obtain a vital sign for a resident.

Record review of DOH Provider Credential Search dated 02/06/2025, showed there were no active credentials for Staff J.

Record review of the facility's Caregiver Job Description, undated, showed caregivers must meet the certification requirements of this state. The document showed the facility's qualifications for caregivers were to be certified or registered as a nursing assistant or be a certified home care aide.

Record review of the facility's caregiver schedule for January – February 2025, showed that Staff J was scheduled once per week, every week, on Friday mornings.

In an interview on 02/07/2025 at 2:53 PM, Staff B stated that the facility's process was to get new staff signed up with cornerstone as soon as possible so that they can take the test in 120 days and then credentialed by 200 days.

In an interview on 02/07/2025, at 4:52 PM, Staff B said that Staff J worked one day a week as a caregiver. They stated Staff J got cross trained as a caregiver, shortly after she got hired. Staff B stated that Staff J had not done the required training

<Staff B>

Record review of document titled, "Park View Villas Employee Hire Date," dated 02/05/2025, showed that Staff B, Resident Care Director, was hired on 08/22/2024.

Record review of Staff B's personnel file showed specialty training for mental health was completed on 10/19/2024, 58 days after hire date and specialty training for dementia was completed on 01/30/2025, 159 days after hire date.

In an interview on 02/06/2025 at 1:45PM, Staff B stated that they were the person responsible for scheduling and ensuring that only qualified staff were on the schedule. Staff B stated that they were aware that there were two staff who did not have their credentials and that those staff included Staff D, Caregiver, and Staff F, Caregiver. Staff B stated that they were aware that Staff D and Staff F were administering medications to residents. Staff B stated that they were aware Staff D and Staff F should not be administering medications because they lack the credentials and training to do that.

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In an interview on 02/05/2025 at 3:41 PM, Staff A, Executive Director, stated that there were two staff on the employee roster who did not have their Health Care Aide Certification. Staff A stated that they were aware those two staff were also past the due date for obtaining their certifications. Staff A stated that those two employees were Staff D and Staff E.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 19, 2025

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


 Administrator (or Representative)

3/10/25
 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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

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

(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

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

In an interview on 02/05/2025 at 3:41 PM, Staff A, Executive Director, stated that there were two staff on the employee roster who did not have their Health Care Aide Certification. Staff A stated that they were aware those two staff were also past the due date for obtaining their certifications. Staff A stated that those two employees were Staff D and Staff E.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

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

(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

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(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure the negotiated service agreements (NSA) for 4 of 7 residents (Resident 4 [R4], Resident 5 [R5], Resident 6 [R6] and Resident 7 [R7]) correctly reflected the care and services as identified in the resident assessments. This failure placed 4 of 7 residents at risk for unmet care needs.

Findings included...

In an interview on 02/07/2025 at 3:35 PM Staff A, Executive Director, stated that the information documented on the "Washington Resident Characteristic" Roster, was information taken directly from resident assessments.

In an interview on 02/05/2025 at 1:05 PM, Staff A stated that Staff B, Resident Care Director, conducted all resident assessments and NSAs. Staff A stated that Staff B was also responsible for updating resident NSAs. Staff A stated that assessments were completed after a new resident moved in, annually, and if a resident experienced a change in condition.

In an interview on 02/06/2025 at 1:45 PM, Staff B stated that assessments were completed prior to move-in, within 14 days after a resident moved-in, annually, and when there was a change in condition.

<Resident 4>

Record review of the facility's document titled, 'Washington Resident Characteristic (Licensed Beds)', dated 02/05/2025, showed that R4 admitted to the facility on [REDACTED]/2024.

Record review of R4's resident notes entered by Staff B, dated 01/09/2025, showed that R4 began hospice services on 01/07/2025.

In an interview on 02/06/2025 at 4:36 PM, Staff H, Caregiver, stated that R4 was newly receiving hospice services. Staff H stated that the facility staff was required to conduct 2-hour checks and asked resident whether R4 wanted to have their laundry or housekeeping services performed.

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure the negotiated service agreements (NSA) for 4 of 7 residents (Resident 4 [R4], Resident 5 [R5], Resident 6 [R6] and Resident 7 [R7]) correctly reflected the care and services as identified in the resident assessments. This failure placed 4 of 7 residents at risk for unmet care needs.

Findings included...

In an interview on 02/07/2025 at 3:35 PM Staff A, Executive Director, stated that the information documented on the "Washington Resident Characteristic" Roster, was information taken directly from resident assessments.

In an interview on 02/05/2025 at 1:05 PM, Staff A stated that Staff B, Resident Care Director, conducted all resident assessments and NSAs. Staff A stated that Staff B was also responsible for updating resident NSAs. Staff A stated that assessments were completed after a new resident moved in, annually, and if a resident experienced a change in condition.

In an interview on 02/06/2025 at 1:45 PM, Staff B stated that assessments were completed prior to move-in, within 14 days after a resident moved-in, annually, and when there was a change in condition.

<Resident 4>

Record review of the facility's document titled, 'Washington Resident Characteristic (Licensed Beds),' dated 02/05/2025, showed that R4 admitted to the facility on [REDACTED]/2024.

Record review of R4's resident notes entered by Staff B, dated 01/09/2025, showed that R4 began hospice services on 01/07/2025.

In an interview on 02/06/2025 at 4:38 PM, Staff H, Caregiver, stated that R4 was newly receiving hospice services. Staff H stated that the facility staff was required to conduct 2-hour checks and asked resident whether R4 wanted to have their laundry or housekeeping services performed.

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In an interview on 02/07/2025 at 2:47 PM, Staff B stated that facility staff provided R4 with medication and laundry services, conducted frequent checks on the resident, and delivered their meals. Staff B stated that the outside hospice provider conducted their own checks of R4 and provided R4 with a bath aide who came to bathe them. Staff B stated that they did not know when the outside hospice provider came to the facility to provide services and care for R4. Staff B stated R4's family provided services to R4 but they did not know what services nor when R4's family provided those services to R4.

In an interview on 02/07/2025 at 2:58 PM, Staff H stated that R4's bathe aide stopped coming in about 2 months ago. The staff offered to wash R4's hair but have not conducted showers. Staff H was in contact with the hospice nurse, there was no schedule of R4's hospice visits.

Record review of R4's NSA, dated 1/18/2025, did not show that R4 received hospice services. The NSA did not show the facility staff was required to conduct checks every 2 hours nor that R4 received delivered meals from facility staff. The document did not show hospice services were coming in to provide services or the frequency of those services. There was also no mention of a bath aide, or their frequency.

<Resident 5>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED] 2016, with a diagnosis of [REDACTED] ([REDACTED]).

Record review of R5's NSA, dated 01/02/2025, showed that staff assisted R5 with 1-5 medications once per day.

In an interview on 02/07/2025 at 3:58 PM, Collateral Contact 1 (CC1) stated that they requested staff to change R5's medication frequency from once per day to twice per day to ensure staff checked on R5 in the evening.

Record review of R5's Medication Administration Record (MAR), dated November 2024 – February 2025, showed that R5 was prescribed four medications that were only to be taken once per day. The document showed one medication was administered at 9:00 AM daily while the other three are administered at 7:00 PM daily.

Record review of R5's NSA, dated 01/02/2025, showed that staff were responsible for assisting with showers once per week after breakfast. Days and times for this service were not specified. The document also showed that R5 did not routinely eat breakfast

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

In an interview on 02/07/2025 at 2:47 PM, Staff B stated that facility staff provided R4 with medication and laundry services, conducted frequent checks on the resident, and delivered their meals. Staff B stated that the outside hospice provider conducted their own checks of R4 and provided R4 with a bath aide who came to bathe them. Staff B stated that they did not know when the outside hospice provider came to the facility to provide services and care for R4. Staff B stated R4's family provided services to R4 but they did not know what services nor when R4's family provided those services to R4.

In an interview on 02/07/2025 at 2:56 PM, Staff H stated that R4's bathe aide stopped coming in about 2 months ago. The staff offered to wash R4's hair but have not conducted showers. Staff H was in contact with the hospice nurse, there was no schedule of R4's hospice visits.

Record review of R4's NSA, dated 1/16/2025, did not show that R4 received hospice services. The NSA did not show the facility staff was required to conduct checks every 2 hours nor that R4 received delivered meals from facility staff. The document did not show hospice services were coming in to provide services or the frequency of those services. There was also no mention of a bath aide, or their frequency.

<Resident 5>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED]/2016, with a diagnosis of [REDACTED] ([REDACTED]).

Record review of R5's NSA, dated 01/02/2025, showed that staff assisted R5 with 1-5 medications once per day.

In an interview on 02/07/2025 at 3:59 PM, Collateral Contact 1 (CC1) stated that they requested staff to change R5's medication frequency from once per day to twice per day to ensure staff checked on R5 in the evening.

Record review of R5's Medication Administration Record (MAR), dated November 2024 – February 2025, showed that R5 was prescribed four medications that were only to be taken once per day. The document showed one medication was administered at 9:00 AM daily while the other three are administered at 7:00 PM daily.

Record review of R5's NSA, dated 01/02/2025, showed that staff were responsible for assisting with showers once per week after breakfast. Days and times for this service were not specified. The document also showed that R5 did not routinely eat breakfast

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and lunch.

In an interview on 02/07/2025 at 2:39 PM, Staff B stated that R6 sleeps all day, they don't wake up until dinner time.

Record review of the document titled "Schedule: Showers", dated February 2025, showed R6 was scheduled to take a shower on 02/03/2025, in the evening after dinner.

<Resident 6>

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R6 admitted to the facility on [REDACTED]/2021. The document showed R6 had an oxygen delivery device.

Record review of R6's NSA, dated 06/17/2024, did not show R6 utilized oxygen devices.

In an observation on 02/07/2025 at 2:45 PM, a continuous positive airway pressure (CPAP) machine was observed on R6's bedside table.

In an interview on 02/07/2025 at 3:30 PM, Staff A stated that they did not know R6 used a CPAP machine and confirmed they did not see a CPAP machine mentioned anywhere in R6's NSA.

In an interview and observation on 02/07/2025 at 4:00 PM Staff A showed the department their computer screen that showed R6's assessment information. On the screen, Staff A demonstrated where R6 had been assessed to have a CPAP machine. Staff A stated that the information did not carry over to the NSA. When asked how staff would have known about R6 requiring a CPAP if it was not in the NSA, Staff A stated they did not know.

In an interview on 02/13/2025 at 2:00 PM, Staff P, Corporate Nurse, stated that Staff B had been educated how to add a CPAP to R6's NSA.

<Resident 7>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/08/2025 showed that R7 moved into the facility on [REDACTED]/2024, with symptoms of urinary incontinence (involuntary loss of bladder control).

Record review of R7's NSA, dated 11/04/2024, showed that R7 required extensive

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and lunch.

In an interview on 02/07/2025 at 2:39 PM, Staff B stated that R5 sleeps all day, they don't wake up until dinner time.

Record review of the document titled "Schedule: Showers", dated February 2025, showed R5 was scheduled to take a shower on 02/03/2025, in the evening after dinner.

<Resident 6>

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R6 admitted to the facility on [REDACTED]/2021. The document showed R6 had an oxygen delivery device.

Record review of R6's NSA, dated 06/17/2024, did not show R6 utilized oxygen devices.

In an observation on 02/07/2025 at 2:45 PM, a continuous positive airway pressure (CPAP) machine was observed on R6's bedside table.

In an interview on 02/07/2025 at 3:30 PM, Staff A stated that they did not know R6 used a CPAP machine and confirmed they did not see a CPAP machine mentioned anywhere in R6's NSA.

In an interview and observation on 02/07/2025 at 4:00 PM Staff A showed the department their computer screen that showed R6's assessment information. On the screen, Staff A demonstrated where R6 had been assessed to have a CPAP machine. Staff A stated that the information did not carry over to the NSA. When asked how staff would have known about R6 requiring a CPAP if it was not in the NSA, Staff A stated they did not know.

In an interview on 02/13/2025 at 2:00 PM, Staff P, Corporate Nurse, stated that Staff B had been educated how to add a CPAP to R6's NSA.

<Resident 7>

Record review of facility's document titled, 'Washington Resident Characteristic (Licensed Beds),' dated 02/05/2025 showed that R7 moved into the facility on [REDACTED]/2024, with symptoms of urinary incontinence (involuntary loss of bladder control).

Record review of R7's NSA, dated 11/04/2024, showed that R7 required extensive

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assistance with showers once per week. R7 required a shower bench/chair.

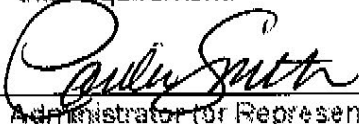
In an interview on 02/07/2025 at 2:56 PM Staff H stated that R7 chose to get sponge baths and became agitated if staff pushed for showers.

In an interview on 02/07/2025 at 2:45 PM, Staff B said that R7 refused to get out of bed. The caregivers did do a bed bath instead and try to work with them. They state they have been trying to reassess R7's care but have not been able to. Staff B acknowledged that bed baths were not in the care plan.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) Apr 10, 2025

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



Administrator (or Representative)

3/10/25
Date

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

(5) If the assisted living facility increases the scope of services that it chooses to provide, the assisted living facility must promptly provide written notice to the residents and residents' representative, if any, and must indicate the date on which the increase in the scope of care or services is effective.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide the services listed in their disclosure of services for 2 of 7 residents (Resident 4 [R4] and Resident 5 [R5]) for laundry and bathing assistance services. This failure resulted in 2 of 33 residents not receiving the minimum expected care and services disclosed by the facility.

Findings included...

Record review of the facility's Disclosure of Services, dated April 2023, showed that if there [was] a failure in outside provider services then the facility [would] begin to provide that service and/or make arrangements for an outside provider to do so. Any

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assistance with showers once per week. R7 required a shower bench/chair.

In an interview on 02/07/2025 at 2:56 PM Staff H stated that R7 chose to get sponge baths and became agitated if staff pushed for showers.

In an interview on 02/07/2025 at 2:43 PM, Staff B said that R7 refused to get out of bed. The caregivers did do a bed bath instead and try to work with them. They state they have been trying to reassess R7's care but have not been able to. Staff B acknowledged that bed baths were not in the care plan.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

(5) If the assisted living facility increases the scope of services that it chooses to provide, the assisted living facility must promptly provide written notice to the residents and residents' representative, if any, and must indicate the date on which the increase in the scope of care or services is effective.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide the services listed in their disclosure of services for 2 of 7 residents (Resident 4 [R4] and Resident 5 [R5]) for laundry and bathing assistance services. This failure resulted in 2 of 33 residents not receiving the minimum expected care and services disclosed by the facility.

Findings included...

Record review of the facility's Disclosure of Services, dated April 2023, showed that if there [was] a failure in outside provider services then the facility [would] begin to provide that service and/or make arrangements for an outside provider to do so. Any

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changes [would] be reflected in the negotiated services agreement (NSA). The disclosure showed that all outside provider services required on-going communications with the facility's community wellness team and that services would be provided as agreed upon in the NSA. The document also showed that only assistance with showers were provided by facility staff and bed baths were not a provided service. It also showed that total assistance with bathing and bed baths were only available on a short-term basis (not exceeding 2 weeks).

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Coordinator, conducted resident assessments and NSAs and was responsible for ensuring resident NSAs were updated.

In an interview on 02/06/2025 at 6:55 PM, Staff A stated that outside providers were first cleared by the front office before initiating services with residents. Staff A stated that outside provider notes were in the resident hard charts and that was how the facility documented those services. Staff A confirmed that outside providers included private caregivers who came to the facility to assist residents, hospice providers and associated staff, home health, and outside therapy staff. Staff A stated that resident NSAs specified whether an outside provider delivered a service to a resident or whether facility staff was responsible.

In an interview on 02/07/2025 at 6:41 PM, Staff A said the facility's Disclosure of Services had not changed since she took over the facility on 03/20/2023.

In an interview on 02/07/2025 at 6:00 PM, Staff A stated that they were responsible for billing for resident services.

<Resident 4>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R4 moved into the facility on [REDACTED] 2024 was diagnosed with [REDACTED] ([REDACTED]) and was on hospice care.

Record review of R4's NSA, dated 01/16/2025, showed that the family performed the bathing services for R4. R4 required supervision and set up for baths.

In an interview on 02/06/2025 at 4:47, Staff B stated that hospice staff were responsible for bathing R4 and therefore facility staff did not provide bathing services to R4.

In an observation and interview on 02/07/2025 at 12:23 PM, R4 stated that they did not shower. R4 showed their leg; there were flaky white patches covering their exposed calf.

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changes [would] be reflected in the negotiated services agreement (NSA). The disclosure showed that all outside provider services required on-going communications with the facility's community wellness team and that services would be provided as agreed upon in the NSA. The document also showed that only assistance with showers were provided by facility staff and bed baths were not a provided service. It also showed that total assistance with bathing and bed baths were only available on a short-term basis (not exceeding 2 weeks).

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Coordinator, conducted resident assessments and NSAs and was responsible for ensuring resident NSAs were updated.

In an interview on 02/06/2025 at 6:55 PM, Staff A stated that outside providers were first cleared by the front office before initiating services with residents. Staff A stated that outside provider notes were in the resident hard charts and that was how the facility documented those services. Staff A confirmed that outside providers included private caregivers who came to the facility to assist residents, hospice providers and associated staff, home health, and outside therapy staff. Staff A stated that resident NSAs specified whether an outside provider delivered a service to a resident or whether facility staff was responsible.

In an interview on 02/07/2025 at 5:41 PM, Staff A said the facility's Disclosure of Services had not changed since she took over the facility on 03/20/2023.

In an interview on 02/07/2025 at 6:00 PM, Staff A stated that they were responsible for billing for resident services.

<Resident 4>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R4 moved-into the facility on [REDACTED]/2024 was diagnosed with [REDACTED] ([REDACTED]) and was on hospice care.

Record review of R4's NSA, dated 01/16/2025, showed that the family performed the bathing services for R4. R4 required supervision and set up for baths.

In an interview on 02/06/2025 at 4:47, Staff B stated that hospice staff were responsible for bathing R4 and therefore facility staff did not provide bathing services to R4.

In an observation and interview on 02/07/2025 at 12:23 PM, R4 stated that they did not shower. R4 showed their leg; there were flaky white patches covering their exposed calf.

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In an interview on 02/07/2025 at 2:43 PM, Staff B said that there was a bath aide that came in to do R4's bath but they were not sure of the schedule.

In an interview on 02/07/2025 at 2:56 PM, Staff H, Caregiver, stated that R4's bath aide from hospice stopped coming about 2 months ago. Staff offered to wash R4's hair but hadn't done her showers. Staff H was in contact with the hospice nurse but stated that they did not come in on any specified schedule.

In an interview on 02/07/2025 at 5:00PM, Staff A stated that they were unaware R4's bath aide no longer came to the facility to assist R4. Staff A stated they were not sure who bathed R4 if the bath aide was not coming to the facility.

Record review of R4's Medication Administration Record (MAR), dated October 2024-February 2025, did not show facility staff administered a shower for R4.

Record review of R4's progress notes, dated 11/01/2024 through 02/05/2025, showed there was no note that showed R4 received a bath. The notes also showed there was no notice of increase in services to review.

<Resident 5>

Record review of facility's Disclosure of Services, dated April 2023, showed that the facility was to clean bed linens and bath towels weekly at no additional fee.

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2026, showed that R5 moved into the facility on [REDACTED]/2016, with a diagnosis of [REDACTED].

In an interview on 02/07/2025 at 3:59 PM, Collateral Contact 1 (CC1) stated that recently R5's sheets were not changed for over 3 weeks. CC1 stated that they told the care staff who responded and stated that they did not change R5's sheets because R5 was sleeping. CC1 stated that they waited 3 weeks for the facility but then had to go to the facility to change and launder R5's sheets themselves.

In an interview on 02/07/2025 at 5:30 PM, Staff B stated that housekeeping was responsible for weekly linen changes and caregivers were to change them when they were soiled, however, if a resident was asleep, staff did not change the sheets.

In an interview on 02/07/2025 at 7:00 PM, Staff A stated that if a resident was asleep during the weekly linen-change time, staff were to re-approach until the linens were

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In an interview on 02/07/2025 at 2:43 PM, Staff B said that there was a bath aide that came in to do R4's bath but they were not sure of the schedule.

In an interview on 02/07/2025 at 2:56 PM, Staff H, Caregiver, stated that R4's bath aide from hospice stopped coming about 2 months ago. Staff offered to wash R4's hair but hadn't done her showers. Staff H was in contact with the hospice nurse but stated that they did not come in on any specified schedule.

In an interview on 02/07/2025 at 5:00PM, Staff A stated that they were unaware R4's bath aide no longer came to the facility to assist R4. Staff A stated they were not sure who bathed R4 if the bath aide was not coming to the facility.

Record review of R4's Medication Administration Record (MAR), dated October 2024-February 2025, did not show facility staff administered a shower for R4.

Record review of R4's progress notes, dated 11/01/2024 through 02/05/2025, showed there was no note that showed R4 received a bath. The notes also showed there was no notice of increase in services to review.

<Resident 5>

Record review of facility's Disclosure of Services, dated April 2023, showed that the facility was to clean bed linens and bath towels weekly at no additional fee.

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED]/2016, with a diagnosis of [REDACTED].

In an interview on 02/07/2025 at 3:59 PM, Collateral Contact 1 (CC1) stated that recently R5's sheets were not changed for over 3 weeks. CC1 stated that they told the care staff who responded and stated that they did not change R5's sheets because R5 was sleeping. CC1 stated that they waited 3 weeks for the facility but then had to go to the facility to change and launder R5's sheets themselves.

In an interview on 02/07/2025 at 5:30 PM, Staff B stated that housekeeping was responsible for weekly linen changes and caregivers were to change them when they were soiled, however, if a resident was asleep, staff did not change the sheets.

In an interview on 02/07/2025 at 7:00 PM, Staff A stated that if a resident was asleep during the weekly linen-change time, staff were to re-approach until the linens were

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able to be changed and laundered.

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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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


Administrator (or Representative)

3/10/2025
Date

WAC 388-76A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 7 residents (Resident 2 (R2) and Resident 4 (R)) or their representatives signed their negotiated service agreement (NSA) at least annually. This failure placed these two residents at risk for receiving care they did not agree to.

Findings included...

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Director, was responsible for completing resident NSAs.

<Resident 2>

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R2 was admitted to the facility on [REDACTED] 2024.

Record review of R2's NSA, dated 01/10/2024, showed that it was signed by Staff A, Executive Director on 01/11/2024. No other signatures were present on the NSA.

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

able to be changed and laundered.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 7 residents (Resident 2 [R2] and Resident 4 [R]) or their representatives signed their negotiated service agreement (NSA) at least annually. This failure placed these two residents at risk for receiving care they did not agree to.

Findings included...

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Director, was responsible for completing resident NSAs.

<Resident 2>

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R2 was admitted to the facility on [REDACTED]/2024.

Record review of R2's NSA, dated 01/10/2024, showed that it was signed by Staff A, Executive Director on 01/11/2024. No other signatures were present on the NSA.

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In an interview on 02/06/2025 at 1:45PM, Staff B stated that they completed resident NSAs. Staff B stated that they were aware R2's NSA was not signed by the resident nor their representative.

In an interview on 02/06/2025 at 4:10 PM, Staff A stated that there were no other NSA's for R2 for review. Staff A acknowledged there was no signed NSA on file for R2.

<Resident 4>

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R4 was admitted to the facility on [REDACTED]/2024.

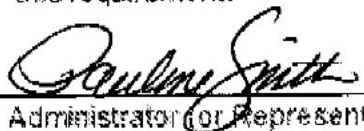
Record review of R4's NSA, dated 01/16/2025, showed no signature from the resident nor family member (representative). There was also no signature from a facility representative.

In an interview on 02/07/2025 at 5:41 PM, Staff A acknowledged there was not a signed NSA available for review for R4.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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



Administrator (or Representative)

3/10/25
Date

WAC 368-76A-2990 Heating-cooling Temperature. The assisted living facility must:

- (1) Equip each resident-occupied building with an approved heating system capable of maintaining a minimum temperature of 70 F. The assisted living facility must
- (b) Maintain the assisted living facility at a minimum of 68 F during waking hours, except in rooms:
- (3) Equip each assisted living facility with a backup source of heat in enough common areas to keep all residents adequately warm during interruptions of normal heating operations;

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

In an interview on 02/06/2025 at 1:45PM, Staff B stated that they completed resident NSAs. Staff B stated that they were aware R2's NSA was not signed by the resident nor their representative.

In an interview on 02/06/2025 at 4:10 PM, Staff A stated that there were no other NSA's for R2 for review. Staff A acknowledged there was no signed NSA on file for R2.

<Resident 4>

Record review of "Washington Resident Characteristic (Licensed Residents)," dated 02/05/2025, showed that R4 was admitted to the facility on [REDACTED]/2024.

Record review of R4's NSA, dated 01/16/2025, showed no signature from the resident nor family member (representative). There was also no signature from a facility representative.

In an interview on 02/07/2025 at 5:41 PM, Staff A acknowledged there was not a signed NSA available for review for R4.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

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

(1) Equip each resident-occupied building with an approved heating system capable of maintaining a minimum temperature of 70 F. The assisted living facility must:

(b) Maintain the assisted living facility at a minimum of 68 F during waking hours, except in rooms:

(3) Equip each assisted living facility with a backup source of heat in enough common areas to keep all residents adequately warm during interruptions of normal heating operations;

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This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure the temperature in 4 of 4 areas (resident dining room, west hallway, and east hallway, and resident accessible women's restroom) met requirements. These failures placed 33 of 33 residents at risk for a diminished quality of life due to inadequate heating.

Findings included...**<Women's bathroom>**

In an interview on 02/05/2025 at 1:30 PM, Resident 11 stated that they did not use the women's bathroom because it was too cold. R11 stated that residents stay away from that bathroom because it was too cold to use.

In an observation on 02/05/2025 at 2:54 PM the temperature in the women's bathroom was measured, at 56.6 degrees Fahrenheit. This temperature was observed with Staff A, Executive Director, who confirmed the temperature of the bathroom.

In an interview on 02/05/2025 at 4:30 PM, Staff S, maintenance assistant, stated that the women's bathroom on the main floor was always freezing.

<East hallway>

In an observation on 02/05/2025 at 3:00 PM, the east hallway was measured at 59 degrees Fahrenheit.

In an observation on 02/05/2025 at 4:30 PM, the facility's furnace was observed with 15 inches of duct tape covering the bottom left vertical edge.

In an interview on 02/06/2025 at 3:15 PM, Staff S stated that the east hallway heating system had not worked the entire time they had worked there, which was 7 years. Staff S stated that in the past 7 years, the facility had received at least 3 to 4 bids for a new system.

<West hallway>

In an interview on 02/06/2025 at 2:45 PM, Staff I, Maintenance Supervisor, stated that they had received a bid from a heating and cooling company on 12/24/2024 for the

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This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure the temperature in 4 of 4 areas (resident dining room, west hallway, and east hallway, and resident accessible women's restroom) met requirements. These failures placed 33 of 33 residents at risk for a diminished quality of life due to inadequate heating.

Findings included...

<Women's bathroom>

In an interview on 02/05/2025 at 1:30 PM, Resident 11 stated that they did not use the women's bathroom because it was too cold. R11 stated that residents stay away from that bathroom because it was too cold to use.

In an observation on 02/05/2025 at 2:54 PM the temperature in the women's bathroom was measured, at 56.6 degrees Fahrenheit. This temperature was observed with Staff A, Executive Director, who confirmed the temperature of the bathroom.

In an interview on 02/05/2025 at 4:30 PM, Staff S, maintenance assistant, stated that the women's bathroom on the main floor was always freezing.

<East hallway>

In an observation on 02/05/2025 at 3:00 PM, the east hallway was measured at 59 degrees Fahrenheit.

In an observation on 02/05/2025 at 4:30 PM, the facility's furnace was observed with 15 inches of duct tape covering the bottom left vertical edge.

In an interview on 02/06/2025 at 3:15 PM, Staff S stated that the east hallway heating system had not worked the entire time they had worked there, which was 7 years. Staff S stated that in the past 7 years, the facility had received at least 3 to 4 bids for a new system.

<West hallway>

In an interview on 02/06/2025 at 2:45 PM, Staff I, Maintenance Supervisor, stated that they had received a bid from a heating and cooling company on 12/24/2024 for the

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west hallway.

In an interview on 02/05/2025 at 2:32 PM, Staff I stated that the east side and west side ventilation and heating system was determined to be too small to service the area. They learned this when the west side heating went down the day before Christmas, 12/24/2024. Staff I stated that residents had reported to them that the hallways were cold. Staff I stated it gets very cold in both hallways and that was the only way for residents to get to their rooms.

In an interview on 02/05/2025 at 2:42 PM, Staff I stated that there was no maintenance log and that there had been no maintenance to the HVAC (heating/cooling) system since they began working at the facility one year ago.

<Dining room>

On 02/05/2025 at 4:16 PM, the Honeywell thermostat in the dining room, located on the center of the east wall was set to 62 degrees Fahrenheit (F). Three residents were also observed sitting at the dining room table wearing winter jackets and one was wearing a vest.

In an interview on 02/06/2025 at 3:45 PM, Collateral Contact 3 (CC3) and Collateral Contact 4 (CC4) stated that their company had given 3 or 4 bids on the east hallway heating system. They also stated that they increased the thermostat temperature to 70 degrees as it had been set to 62 degrees.

Record review of facility furnace and heating system maintenance records showed there were no maintenance records for the facility furnace and heating systems.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


Administrator (or Representative)

3/10/25
Date

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

west hallway.

In an interview on 02/05/2025 at 2:32 PM, Staff I stated that the east side and west side ventilation and heating system was determined to be too small to service the area. They learned this when the west side heating went down the day before Christmas, 12/24/2024. Staff I stated that residents had reported to them that the hallways were cold. Staff I stated it gets very cold in both hallways and that was the only way for residents to get to their rooms.

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

Administrator (or Representative)

Date

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WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

- (a) Provide separate areas for handling clean laundry and soiled laundry;
- (b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;
- (c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;
- (d) Ensure all staff persons wear gloves and use other appropriate infection control practices when handling soiled laundry; and
- (e) Have a utility sink and a table or counter for folding clean laundry.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide the necessary supplies and equipment to staff to ensure the safe handling, cleaning, and storing of linens consistent with acceptable methods of infection control in 2 of 2 laundry rooms. This failure placed 33 of 33 residents and staff at risk of exposure of infectious disease.

Findings included...

Record review of document titled "Village Concepts Standard Operating Procedure Title: Bloodborne Pathogen and Infection Control Policy," undated, showed that gloves were not a substitute for good hand washing and that handwashing was a critical component to reduce exposure to infectious material and reduce cross-contamination. The document stated that staff were required to wash their hands before obtaining clean linens, putting on gloves, providing personal care to residents, preparing and/or serving food and beverages, after contact with blood, body fluids, or secretions, after contact with dirty linen, urinals, or other soiled resident equipment, and after removing their gloves. The document detailed that staff were to use a generous amount of soap rubbing their hands under running warm water for at least 20 seconds then to dry their hands with a paper towel. It said after staff dried their hands, they were to obtain a clean paper towel to turn off the faucet and to use that paper towel to open the door proceeding to discard the paper towel. The document stated that the wellness department (caregiving staff and medication technicians), maintenance department, and housekeeping department were identified as positions with a high-risk exposure to situations that required the utilization of standard precautions.

<Commercial Laundry>

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

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<Commercial Laundry>

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Record review of document titled 'Housekeeping, Linen Service, and Cleaning Standards,' dated 02/12/2024, showed that staff were to strip and remake resident beds weekly. The document said if using facility linens, staff were to obtain clean linens from the linen closet and take them to the resident's room and take the soiled bed linens off the bed and place them in a laundry hamper.

Record review of the facility's Disclosure of Services, dated April 2023, showed that "weekly laundry services [were] provided to include cleaning bed linens and bath towels at no additional fee." The disclosure of services said that any additional laundry service more than the weekly laundering of sheets and towels would be in the resident negotiated service agreement. The services provided in the disclosure applied to residents residing in one of the licensed assisted living beds.

Record review of the facility's water temperature log, prior to 02/07/2025, showed the facility did not have a water temperature log available to review for the commercial laundry room.

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed Resident 1 (R1) moved into the facility on [REDACTED] 2024, Resident 5 (R5) moved in on [REDACTED] 2016, and Resident 8 (R8) moved in on [REDACTED] 2025.

Record review of facility's 'Village Concepts: 24-hour report,' dated 02/06/2025 showed that R5 had nausea and vomiting.

In an interview on 02/07/2025 at 3:59 PM, Collateral Contact 1 (CC1) stated that, recently, R5's sheets were not changed for over 3 weeks. CC1 stated that they told the care staff who responded and stated that they did not change R5's sheets because R5 had been sleeping. CC1 stated that they had to go to the facility to change and launder R5's sheets themselves.

On 02/07/2025 at 4:01 PM, a brown, oblong shaped stain was observed on R5's sheets. CC1 stated that they were notified that R5 vomited on 02/06/2025. CC1 changed R5's sheets on 02/07/2025 for R5.

In an observation and interview on 02/07/2025 at 2:09 PM, Staff K, housekeeper, provided a tour of the commercial laundry room. Inside the laundry room were two commercial laundry machines. Inside the washer were various bed linens (sheets) being washed all together. Staff K confirmed the linens inside the washer were resident bed linens. Staff K stated that all the residents' weekly linens were washed together in the commercial laundry room and that the resident sheets were not laundered separately. There was no utility sink. The department measured the hand-washing sink's water temperature at 56.4 degrees Fahrenheit. Staff K stated that they did not usually use the sink in the commercial laundry room because the water was cold, but that they sometimes used hand sanitizer or used the cold water to wash their hands.

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Record review of document titled 'Housekeeping, Linen Service, and Cleaning Standards,' dated 02/12/2024, showed that staff were to strip and remake resident beds weekly. The document said if using facility linens, staff were to obtain clean linens from the linen closet and take them to the resident's room and take the soiled bed linens off the bed and place them in a laundry hamper.

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In an interview on 02/07/2025 at 5:30 PM, Staff B said that housekeeping staff were responsible for changing linens once per week and laundering the linens in the commercial laundry room.

Record review of an email received on 02/14/2025 at 9:34 AM showed that Staff A, Executive Director, confirmed the facility washed all resident linens together.

<Care Staff Laundry>

Record review of the facility's water temperature log, prior to 02/07/2025, showed the facility did not have a water temperature log available to review for the care staff laundry room.

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that Resident 9 (R9) moved into the facility on [REDACTED] 2021.

Record review of document titled "Village Concepts: 24-hour report," dated 01/03/2025, showed R9's cough was getting worse, and their laundry was in the washer.

Record review of document titled "Village Concepts: 24-hour report," dated 01/18/2025, showed a note that R9's "incontinent clothes in bay on floor did not start in case more clothes get wet."

Record review of document, titled, "Village Concepts: 24-hour report," dated 01/21/2025, showed that R9 began vomiting and alert charting was started. The document also showed that R9 wet their pants, and the wet pants were in the laundry room.

On 02/05/2025 at 4:07 PM, the care staff laundry room was toured with Staff I, Maintenance Director. There were two large machines: a washer and a dryer. There were magnetic tags with resident room numbers on it. There was one sink with tubing attached to the faucet. No hand soap, hand sanitizer, nor paper towels were seen near the sink nor in any of the cabinets. There was no utility sink. There were no separately identified dirty utility nor dirty laundry space and there was no label that showed where clean laundry was kept. There were unlabeled white sheets in the dryer.

In an interview on 02/05/2025 at 4:10 PM, Staff I stated that they did not know how staff washed their hands when they handled laundry in that laundry room, nor did they know where the dirty and clean laundry was processed.

In an interview on 02/07/2025 at 5:30 PM, Staff B said that housekeeping staff were responsible for changing linens once per week and laundering the linens in the commercial laundry room.

Record review of an email received on 02/14/2025 at 9:34 AM showed that Staff A, Executive Director, confirmed the facility washed all resident linens together.

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Record review of document titled "Village Concepts: 24-hour report," dated 01/18/2025, showed a note that R9's "incontinent clothes in bay on floor did not start in case more clothes get wet."

Record review of document, titled, "Village Concepts: 24-hour report," dated 01/21/2025, showed that R8 began vomiting and alert charting was started. The document also showed that R9 wet their pants, and the wet pants were in the laundry room.

On 02/05/2025 at 4:07 PM, the care staff laundry room was toured with Staff I, Maintenance Director. There were two large machines: a washer and a dryer. There were magnetic tags with resident room numbers on it. There was one sink with tubing attached to the faucet. No hand soap, hand sanitizer, nor paper towels were seen near the sink nor in any of the cabinets. There was no utility sink. There were no separately identified dirty utility nor dirty laundry space and there was no label that showed where clean laundry was kept. There were unlabeled white sheets in the dryer.

In an interview on 02/05/2025 at 4:10 PM, Staff I stated that they did not know how staff washed their hands when they handled laundry in that laundry room, nor did they know where the dirty and clean laundry was processed.

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On 02/07/2025 at 2:01 PM, Staff J, Front Desk/Receptionist and Caregiver, showed the department the care-staff laundry room. Staff J stated that resident laundry was supposed to be washed separately and the only way to keep the laundry separate was to use a hamper. Staff J stated that they had to use the wellness room sink across the hall when they did wash their hands to process laundry and that they had never washed their hands in that actual laundry room.

In an interview on 02/07/2025 at 5:30 PM, Staff B, Resident Care Director, stated that care staff were responsible for changing resident linens for all non-scheduled times, including when linens were soiled. Staff B stated that the care staff performed laundry services in the care staff laundry 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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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

Pauline Smith

Administrator (or Representative)

3/10/25

Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

- (1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff completed proper hand hygiene when preparing and providing food services in 1 of 1 assisted living facility kitchens. This failure placed 33 of 33 residents at risk for exposure to food-borne illnesses.

Findings included...

246-215-02310

"Hands and arms—When to wash (FDA Food Code 2-301.14).

Food employees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and...

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

On 02/07/2025 at 2:01 PM, Staff J, Front Desk/Receptionist and Caregiver, showed the department the care-staff laundry room. Staff J stated that resident laundry was supposed to be washed separately and the only way to keep the laundry separate was to use a hamper. Staff J stated that they had to use the wellness room sink across the hall when they did wash their hands to process laundry and that they had never washed their hands in that actual laundry room.

In an interview on 02/07/2025 at 5:30 PM, Staff B, Resident Care Director, stated that care staff were responsible for changing resident linens for all non-scheduled times, including when linens were soiled. Staff B stated that the care staff performed laundry services in the care staff laundry room.

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- (3) After caring for or handling service animals or aquatic animals as specified under WAC 246-215-02415(2);...
- (5) After handling soiled equipment or utensils;
- (6) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;...
- (8) Before donning gloves for working with ready-to-eat food unless a glove change is not the result of contamination; and
- (9) After engaging in other activities that contaminate the hands or gloves."

WAC 246-215-03300 "Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305. (2) Except when washing fruits and vegetables as specified under WAC 246-215-03318 or as specified in subsection (4) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, SINGLE-USE gloves, or dispensing EQUIPMENT. (3) FOOD EMPLOYEES shall minimize bare hand and arm contact with exposed FOOD that is not in a READY-TO-EAT form."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."

Record review of document titled "Village Concepts Standard Operating Procedure Title: Bloodborne Pathogen and Infection Control Policy," undated, showed that gloves were not a substitute for good hand washing and that handwashing was a critical component to reduce exposure to infectious material and reduce cross-contamination. The document stated that staff were required to wash their hands before obtaining clean linens, putting on gloves, providing personal care to residents, preparing and/or serving food and beverages, after contact with blood, body fluids, or secretions, after contact with dirty linen, urinals, or other soiled resident equipment, and after removing their gloves. The document detailed that staff were to use a generous amount of soap rubbing their hands under running warm water for at least 20 seconds then to dry their hands with a paper towel. It said after staff dried their hands, they were to obtain a clean paper towel to turn off the faucet and to use that paper towel to open the door proceeding to discard the paper towel. The document stated that the wellness department (caregiving staff and medication technicians), maintenance department, and housekeeping department were identified as positions with a high-risk exposure to situations that required the utilization of standard precautions.

On 02/05/2025 at 12:16 PM, Staff M, Dining Dishwasher, was seen entering the kitchen, obtained chocolate cake, and returned to serve the resident's the chocolate cake. Staff M did not wash their hands when entering the kitchen, prior to obtaining the cake, nor prior to delivering to the residents.

On 02/05/2025 at 7:00 PM, Staff A, Executive Director, stated that Resident 2's (R2) dog was made a [REDACTED], so they did not think it was a problem to allow the dog in the dining room while food was served, and residents were eating.

In an observation on 02/05/2025 at 11:37 AM, Staff N, Dining Server, entered the

(3) After caring for or handling service animals or aquatic animals as specified under WAC 246-215-02415(2);...

(5) After handling soiled equipment or utensils;

(6) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;...

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On 02/05/2025 at 12:18 PM, Staff M, Dining Dishwasher, was seen entering the kitchen, obtained chocolate cake, and returned to serve the resident’s the chocolate cake. Staff M did not wash their hands when entering the kitchen, prior to obtaining the cake, nor prior to delivering to the residents.

On 02/05/2025 at 7:00 PM, Staff A, Executive Director, stated that Resident 2’s (R2) dog was made a [REDACTED], so they did not think it was a problem to allow the dog in the dining room while food was served, and residents were eating.

In an observation on 02/06/2025 at 11:37 AM, Staff N, Dining Server, entered the

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kitchen, did not wash their hands, and proceeded to serve the plates with food to residents in the dining room.

In an observation on 02/06/2025 at 11:42 AM, Staff O, Dining Cook, was observed transferring ready to eat mayo salad to another container, barehanded, without gloves nor using a utensil.

In an observation on 02/06/2025 at 11:41 AM, Staff J, Front Desk/Receptionist, entered the kitchen, obtained the residents plate of food, and served it without washing their hands.

In an observation on 02/06/2025 at 11:53 Staff M entered kitchen without washing their hands.

In an observation on 02/06/2025 at 11:54 AM Staff J entered the kitchen without washing their hands and brought out a tray of food and then served the food to residents.

In an observation on 02/06/2025 at 11:55 AM, Staff N entered the kitchen without washing their hands, obtained the resident meal from the refrigerator, and then served the meal to the residents.

In an observation on 02/06/2025 at 11:55 AM, Staff J entered the kitchen without washing their hands, grabbed plate of food, and returned to the dining room and served the plate to three residents.

In an observation on 02/06/2025 at 11:57 AM, Staff N re-entered the kitchen, again, without washing their hands, obtained more resident meals from the refrigerator, and then served the meals to the residents.

In an observation on 02/06/2025 at 11:57 AM, Staff J re-entered the kitchen, again, without washing their hands, placed unserved plates back in the refrigerator, then grabbed a tray of ready-made plates to serve to residents. Staff J returned to the dining room and served the plates to the residents.

In an interview on 02/06/2025 at 2:35 PM, Staff L, Dining Supervisor, said that everyone must wash their hands when they come into the kitchen, after changing tasks, and after touching dirty dishes.

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kitchen, did not wash their hands, and proceeded to serve the plates with food to residents in the dining room.

In an observation on 02/06/2025 at 11:42 AM, Staff O, Dining Cook, was observed transferring ready to eat mayo salad to another container, barehanded, without gloves nor using a utensil.

In an observation on 02/06/2025 at 11:41 AM, Staff J, Front Desk/Receptionist, entered the kitchen, obtained the residents plate of food, and served it without washing their hands.

In an observation on 02/06/2025 at 11:53 Staff M entered kitchen without washing their hands.

In an observation on 02/06/2025 at 11:54 AM Staff J entered the kitchen without washing their hands and brought out a tray of food and then served the food to residents.

In an observation on 02/06/2025 at 11:55 AM, Staff N entered the kitchen without washing their hands, obtained the resident meal from the refrigerator, and then served the meal to the residents.

In an observation on 02/06/2025 at 11:55 AM, Staff J entered the kitchen without washing their hands, grabbed plate of food, and returned to the dining room and served the plate to three residents.

In an observation on 02/06/2025 at 11:57 AM, Staff N re-entered the kitchen, again, without washing their hands, obtained more resident meals from the refrigerator, and then served the meals to the residents.

In an observation on 02/06/2025 at 11:57 AM, Staff J re-entered the kitchen, again, without washing their hands, placed unserved plates back in the refrigerator, then grabbed a tray of ready-made plates to serve to residents. Staff J returned to the dining room and served the plates to the residents.

In an interview on 02/06/2025 at 2:35 PM, Staff L, Dining Supervisor, said that everyone must wash their hands when they come into the kitchen, after changing tasks, and after touching dirty dishes.

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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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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

Pauline Smith

Administrator (or Representative)

3/10/25

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete on-going assessment when a change of condition occurred for 2 of 7 sampled residents (Resident 5(R5) and Resident 7 (R7)) This failure placed R5 and R7 at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents

Findings included...

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Director, conducted all resident assessments. Staff A stated that assessments were completed after a new resident moved in, annually, and if a resident experienced a change in condition.

In an interview on 02/06/2025 at 1:45 PM, Staff B stated that assessments were completed prior to move-in, within 14 days after a resident moved-in, annually, and when there was a change in condition. Staff B stated that there were no residents

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

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete on-going assessment when a change of condition occurred for 2 of 7 sampled residents (Resident 5[R5] and Resident 7 [R7]). This failure placed R5 and R7 at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included....

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Director, conducted all resident assessments. Staff A stated that assessments were completed after a new resident moved in, annually, and if a resident experienced a change in condition.

In an interview on 02/06/2025 at 1:45 PM, Staff B stated that assessments were completed prior to move-in, within 14 days after a resident moved-in, annually, and when there was a change in condition. Staff B stated that there were no residents

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requiring nurse delegation.

Record review of facility's, 'Standard Operating Procedure,' dated 03/09/2023, showed that all assisted living and memory care residents will, at a minimum be assessed, by a nurse 14-day post admission.

<Resident 5 (R5)>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED] 2016, with a diagnosis of [REDACTED].

Record review of R5's NSA, dated 11/10/2024, showed that R5 was evaluated as a fall risk and that the facility staff would notify R5's family after each fall.

Record review of R5's Resident Notes, dated 11/01/2024 through 02/05/2025, showed that R5 had falls on 11/13/2024, 11/27/2024, 12/19/2024, twice on 01/01/2025, and on 01/02/2025. None of the notes showed Collateral Contact 1 (CC1), R5's power of attorney, was contacted after these falls.

In an interview on 02/07/2025 at 2:50 PM, Staff H, Caregiver, stated that after a resident fell, if they did not hit their head then, the staff gets them off the floor with two people, write a report, contacts the resident's primary care provider, conducts a set of vital signs, calls the family, the nurse and the administrator and then fax the report to Staff A. The resident was then placed on alert charting for a week. After the second and third fall, the resident was to be reassessed.

Record review of R5's Resident notes, dated 11/01/2024 through 02/05/2025, showed that R5 sustained more falls on 01/10/2025, and 01/27/2025. The resident representative was only contacted for the fall on 01/27/2025, the document did not show that the representative was contacted for any other fall.

Record review of R5's NSA, dated 11/10/2024, showed R5 was evaluated as a weight loss risk. The staff must weigh resident and record it once per month. The facility staff must follow physician orders for weighing resident, weigh resident at the same time on weight days and notify the the physician of any unplanned weight loss according to the parameters set by the physician.

Record review of R5's Resident Notes from November 2024 – February 2025 showed on 11/14/2025, R5 had a weight loss of 5 pounds from the previous month. Facility faxed primary care provider but did not receive any new orders. There were no other notes regarding R5's weight.

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requiring nurse delegation.

Record review of facility's, 'Standard Operating Procedure,' dated 03/09/2023, showed that all assisted living and memory care residents will, at a minimum be assessed, by a nurse 14-day post admission.

<Resident 5 (R5)>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R5 moved into the facility on [REDACTED]/2016, with a diagnosis of [REDACTED] ([REDACTED]).

Record review of R5's NSA, dated 11/10/2024, showed that R5 was evaluated as a fall risk and that the facility staff would notify R5's family after each fall.

Record review of R5's Resident Notes, dated 11/01/2024 through 02/05/2025, showed that R5 had falls on 11/13/2024, 11/27/2024, 12/19/2024, twice on 01/01/2025, and on 01/02/2025. None of the notes showed Collateral Contact 1 (CC1), R5's power of attorney, was contacted after these falls.

In an interview on 02/07/2025 at 2:56 PM, Staff H, Caregiver, stated that after a resident fell, if they did not hit their head then, the staff gets them off the floor with two people, write a report, contacts the resident's primary care provider, conducts a set of vital signs, calls the family, the nurse and the administrator and then fax the report to Staff A. The resident was then placed on alert charting for a week. After the second and third fall, the resident was to be reassessed.

Record review of R5's Resident notes, dated 11/01/2024 through 02/05/2025, showed that R5 sustained more falls on 01/10/2025, and 01/27/2025. The resident representative was only contacted for the fall on 01/27/2025, the document did not show that the representative was contacted for any other fall.

Record review of R5's NSA, dated 11/10/2024, showed R5 was evaluated as a weight loss risk. The staff must weigh resident and record it once per month. The facility staff must follow physician orders for weighing resident, weigh resident at the same time on weight days and notify the the physician of any unplanned weight loss according to the parameters set by the physician.

Record review of R5's Resident Notes from November 2024 – February 2025 showed on 11/14/2025, R5 had a weight loss of 5 pounds from the previous month. Facility faxed primary care provider but did not receive any new orders. There were no other notes regarding R5's weight.

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Record review of the R5's Medication Administration Record (MAR), dated from November 2024 – February 2025, did not show any record of monthly weight being conducted once per month.

Record review of R5's NSA, dated 01/02/2025, showed that R5 did not normally eat breakfast and lunch. Staff must also deliver trays to their room for dinner.

In an interview on 02/07/2025 at 2:39 PM, Staff B stated that R5 didn't usually wake up until dinner time.

Record review of R5's Resident Assessment shows that assessments were only conducted on 11/10/2023 and 01/02/2025.

<Resident 7 >

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R7 moved into the facility on [REDACTED]/2024, with symptoms of urinary incontinence (involuntary loss of bladder control).

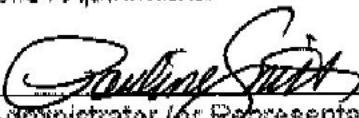
Record review of R7's Resident Assessment, showed that R7's assessments were conducted on 5/3/2024 before moving in and on 06/04/2024 more than 14 days after move in.

Record review of facility's, "Standard Operating Procedure," dated 03/09/2023, showed that all assisted living and memory care residents will, at a minimum be assessed, by a nurse 14-day post admission.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


Administrator (or Representative)

3/10/25
Date

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

Record review of the R5's Medication Administration Record (MAR), dated from November 2024 – February 2025, did not show any record of monthly weight being conducted once per month.

Record review of R5's NSA, dated 01/02/2025, showed that R5 did not normally eat breakfast and lunch. Staff must also deliver trays to their room for dinner.

In an interview on 02/07/2025 at 2:39 PM, Staff B stated that R5 didn't usually wake up until dinner time.

Record review of R5's Resident Assessment shows that assessments were only conducted on 11/10/2023 and 01/02/2025.

<Resident 7 >

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R7 moved into the facility on [REDACTED]/2024, with symptoms of urinary incontinence (involuntary loss of bladder control).

Record review of R7's Resident Assessment, showed that R7's assessments were conducted on 5/3/2024 before moving in and on 06/04/2024 more than 14 days after move in.

Record review of facility's, 'Standard Operating Procedure,' dated 03/09/2023, showed that all assisted living and memory care residents will, at a minimum be assessed, by a nurse 14-day post admission.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

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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:

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 4 [R4], and Resident 7 [R7]) received a full assessment within 14 days of their move-in date. This failure placed two of 33 residents at risk for unmet care needs.

Findings included...

In an interview on 02/05/2025 at 1:06 PM, Staff A, Executive Director, stated that Staff B, Resident Care Director, conducted all resident assessments. Staff A stated that assessments were completed after a new resident moved in, annually, and if a resident experienced a change in condition.

In an interview on 02/06/2025 at 1:46 PM, Staff B stated that assessments were completed prior to move-in, within 14 days after a resident moved-in, annually, and when there was a change in condition. Staff B stated that there were no residents requiring nurse delegation.

Record review of facility's, 'Standard Operating Procedure,' dated 03/08/2023, showed that all assisted living and memory care residents would receive an assessment by a nurse within 14-days of their move-in.

<Resident 1>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2026, showed that R1 moved into the facility on [REDACTED]/2024.

Record review of R1's Resident Assessment showed R1 received a pre-admission assessment on 09/19/2024. The next follow-up assessment was dated 10/16/2024, more than 14 days after move-in.

Record review of all R1's assessments showed there was no full resident assessment conducted after their move-in. The limited follow-up assessment was completed 22

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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:

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 4 [R4], and Resident 7 [R7]) received a full assessment within 14 days of their move-in date. This failure placed two of 33 residents at risk for unmet care needs.

Findings included...

In an interview on 02/05/2025 at 1:05 PM, Staff A, Executive Director, stated that Staff B, Resident Care Director, conducted all resident assessments. Staff A stated that assessments were completed after a new resident moved in, annually, and if a resident experienced a change in condition.

In an interview on 02/06/2025 at 1:45 PM, Staff B stated that assessments were completed prior to move-in, within 14 days after a resident moved-in, annually, and when there was a change in condition. Staff B stated that there were no residents requiring nurse delegation.

Record review of facility's, 'Standard Operating Procedure,' dated 03/09/2023, showed that all assisted living and memory care residents would receive an assessment by a nurse within 14-days of their move-in.

<Resident 1>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R1 moved into the facility on [REDACTED]/2024.

Record review of R1's Resident Assessment showed R1 received a pre-admission assessment on 09/16/2024. The next follow-up assessment was dated 10/16/2024, more than 14 days after move-in.

Record review of all R1's assessments showed there was no full resident assessment conducted after their move-in. The limited follow-up assessment was completed 22

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days after their move-in.

<Resident 2>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R2 moved into the facility on [REDACTED]/2024, had a diagnosis of [REDACTED] ([REDACTED]) and required nurse delegation.

Record review of R2's Resident Assessment showed R2 received a pre-admission assessment on 01/10/2024. That assessment was unsigned and did not show who completed it. The next follow-up assessment was documented as a signature from the previous facility nurse, dated 02/08/2024.

Record review of R2's focused, delegation-specific assessment, showed it was completed on 02/08/2024 by Staff R, Nurse Delegator.

No other assessments were available to review for R2. The record review for R2 showed R2 did not receive a full assessment after their move-in date.

Record review of R2's NSA, dated 01/10/2024, showed that it was signed by Staff A, Executive Director on 01/11/2024. No other signatures were present on the NSA.

In an interview on 02/05/2025 at 1:45PM, Staff B stated that they were aware R2's did not have a full assessment on-file for review.

In an interview on 02/06/2025 at 4:10 PM, Staff A stated that there were no other assessments were on file for R2 for review.

<Resident 4>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R4 moved into the facility on [REDACTED] 2024.

Record review of R4's Resident Assessment showed that R4's received a preadmission assessment on 02/28/2024. The next assessment documented was dated on 05/04/2024, more than 14 days after R4's move in date to the facility.

<Resident 7 (R7)>

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

days after their move-in.

<Resident 2>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R2 moved into the facility on [REDACTED]/2024, had a diagnosis of [REDACTED] ([REDACTED]) and required nurse delegation.

Record review of R2's Resident Assessment showed R2 received a pre-admission assessment on 01/10/2024. That assessment was unsigned and did not show who completed it. The next follow-up assessment was documented as a signature from the previous facility nurse, dated 02/09/2024.

Record review of R2's focused, delegation-specific assessment, showed it was completed on 02/06/2024 by Staff R, Nurse Delegator.

No other assessments were available to review for R2. The record review for R2 showed R2 did not receive a full assessment after their move-in date.

Record review of R2's NSA, dated 01/10/2024, showed that it was signed by Staff A, Executive Director on 01/11/2024. No other signatures were present on the NSA.

In an interview on 02/06/2025 at 1:45PM, Staff B stated that they were aware R2's did not have a full assessment on-file for review.

In an interview on 02/06/2025 at 4:10 PM, Staff A stated that there were no other assessments were on file for R2 for review.

<Resident 4>

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R4 moved into the facility on [REDACTED]/2024.

Record review of R4's Resident Assessment showed that R4's received a preadmission assessment on 02/26/2024. The next assessment documented was dated on 06/04/2024, more than 14 days after R4's move in date to the facility.

<Resident 7 (R7)>

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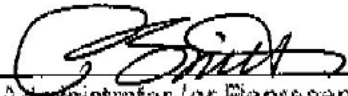
Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R7 moved into the facility on [REDACTED] 2024, with symptoms of urinary incontinence.

Record review of R7's Resident Assessments, showed that R7's assessments were conducted on 6/3/2024 before moving in and on 06/04/2024 more than 14 days after move in.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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



Administrator (or Representative)

5/10/25
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 areas (Interior facility and Exterior facility). These failures placed 33 of 33 residents at risk for a diminished quality of life due to unmaintained living conditions.

Findings included...

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

Record review of facility's document titled, "Washington Resident Characteristic (Licensed Beds)," dated 02/05/2025, showed that R7 moved into the facility on [REDACTED]/2024, with symptoms of urinary incontinence.

Record review of R7's Resident Assessments, showed that R7's assessments were conducted on 5/3/2024 before moving in and on 06/04/2024 more than 14 days after move in.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 areas (Interior facility and Exterior facility). These failures placed 33 of 33 residents at risk for a diminished quality of life due to unmaintained living conditions.

Findings included...

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<Interior Facility>

In an interview on 02/05/2025 at 1:30 PM, Resident 11 stated that they did not use the women's bathroom because it was too cold. R11 stated that residents stay away from that bathroom because it was too cold to use.

In an observation on 02/05/2025 at 2:54 PM, the temperature in the women's bathroom was measured, at 58.6 degrees Fahrenheit. This temperature was observed with Staff A, Executive Director, who confirmed the temperature of the bathroom.

In an interview on 02/05/2025 at 4:30 PM, Staff S, Maintenance Assistant, stated that the women's bathroom on the main floor was always freezing.

In an observation on 02/05/2025 at 3:00 PM, the east hallway was measured at 59 degrees Fahrenheit.

In an observation on 02/05/2025 at 4:30 PM, the facility's furnace was observed with 15 inches of duct tape covering the bottom left vertical edge.

In an interview on 02/06/2025 at 3:15 PM, Staff S stated that the east hallway heating system had not worked the entire time they had worked there, which was 7 years. Staff S stated that in the past 7 years, the facility had received at least 3 to 4 bids for a new system.

In an interview on 02/06/2025 at 2:45 PM, Staff I, Maintenance Director, stated that they had received a bid from a heating and cooling company on 12/24/2024 for the west hallway.

In an interview on 02/05/2025 at 2:32 PM, Staff I stated that the east side and west side ventilation and heating system was determined to be too small to service the area. They learned this when the west side heating went down the day before Christmas, 12/24/2024. Staff I stated that residents had reported to them that the hallways were cold. Staff I stated it gets very cold in both hallways and that was the only way for residents to get to their rooms.

In an interview on 02/05/2025 at 2:42 PM, Staff I stated that there was no maintenance log and that there had been no maintenance to the HVAC (heating/cooling) system since they began working at the facility one year ago.

On 02/05/2025 at 4:18 PM, the Honeywell thermostat in the dining room, located on the center of the east wall was set to 62 degrees Fahrenheit (F). Three residents were also observed sitting at the dining room table wearing winter jackets and one was wearing a

<Interior Facility>

In an interview on 02/05/2025 at 1:30 PM, Resident 11 stated that they did not use the women's bathroom because it was too cold. R11 stated that residents stay away from that bathroom because it was too cold to use.

In an observation on 02/05/2025 at 2:54 PM, the temperature in the women's bathroom was measured, at 56.6 degrees Fahrenheit. This temperature was observed with Staff A, Executive Director, who confirmed the temperature of the bathroom.

In an interview on 02/05/2025 at 4:30 PM, Staff S, Maintenance Assistant, stated that the women's bathroom on the main floor was always freezing.

In an observation on 02/05/2025 at 3:00 PM, the east hallway was measured at 59 degrees Fahrenheit.

In an observation on 02/05/2025 at 4:30 PM, the facility's furnace was observed with 15 inches of duct tape covering the bottom left vertical edge.

In an interview on 02/06/2025 at 3:15 PM, Staff S stated that the east hallway heating system had not worked the entire time they had worked there, which was 7 years. Staff S stated that in the past 7 years, the facility had received at least 3 to 4 bids for a new system.

In an interview on 02/06/2025 at 2:45 PM, Staff I, Maintenance Director, stated that they had received a bid from a heating and cooling company on 12/24/2024 for the west hallway.

In an interview on 02/05/2025 at 2:32 PM, Staff I stated that the east side and west side ventilation and heating system was determined to be too small to service the area. They learned this when the west side heating went down the day before Christmas, 12/24/2024. Staff I stated that residents had reported to them that the hallways were cold. Staff I stated it gets very cold in both hallways and that was the only way for residents to get to their rooms.

In an interview on 02/05/2025 at 2:42 PM, Staff I stated that there was no maintenance log and that there had been no maintenance to the HVAC (heating/cooling) system since they began working at the facility one year ago.

On 02/05/2025 at 4:16 PM, the Honeywell thermostat in the dining room, located on the center of the east wall was set to 62 degrees Fahrenheit (F). Three residents were also observed sitting at the dining room table wearing winter jackets and one was wearing a

03.07.2025 10:29:16

State of Washington

Statement of Deficiencies	License #: 2332	Compliance Determination #54155
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vest.

In an interview on 02/05/2025 at 3:45 PM, Collateral Contact 3 (CC3) and Collateral Contact 4 (CC4) stated that their company had given 3 or 4 bids on the east hallway heating system. They also stated that they increased the thermostat temperature to 70 degrees as it had been set to 62 degrees.

Record review of facility furnace and heating system maintenance records showed there were no maintenance records for the facility furnace and heating systems.

In an observation on 02/05/2025 at 12:29 PM, there was 2 ceiling tiles missing in 2nd floor hallway on the E side of the building.

In an interview on 02/05/2025 at 12:29 PM, Staff I stated that there was a bubble on the ceiling and the pipe was replaced. They have left the ceiling open for a few weeks to dry out the dry wall.

In an observation on 02/05/2025 at 1:01 PM, there were 2 floor panels removed on the 2nd floor hallway on the K side of the building.

In an interview on 02/05/2025 at 1:01 PM, Staff I stated that the floor panels were removed 12 – 14 days ago due to a leak.

In an observation and interview on 02/05/2025 at 12:34 PM, there was a 2 inch wide hole in the wall, behind the resident laundry room door on the east side of the building. Staff I stated that they just noticed that there was a hole in the wall.

<Exterior Facility>

In an observation on 02/07/2025 at 5:56 PM, in the unlocked maintenance shed there was various items stacked on top of each other in disrepair such as 2 motorized chairs, 1 wheel chair, 1 walker, 2 traffic cones, 1 refrigerator, 9 cans of paint, 1 microwave, 2 rolls of extension cords, 1 unmounted toilet bowl, and a vacuum, all covered in dust and debris.

In an observation on 02/07/2025 at 5:58 PM, in an unattached trailer with a tarp covering next to the buildings, were various appliances parts such as a refrigerator door, and washing machines.

In an interview on 02/07/2025 at 6:16 PM, Staff A admitted that all the items were trash, and that the facility planned on renting a dumpster to get rid of the items.

vest.

In an interview on 02/06/2025 at 3:45 PM, Collateral Contact 3 (CC3) and Collateral Contact 4 (CC4) stated that their company had given 3 or 4 bids on the east hallway heating system. They also stated that they increased the thermostat temperature to 70 degrees as it had been set to 62 degrees.

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In an observation on 02/07/2025 at 5:58 PM, in an unattached trailer with a tarp covering next to the buildings, were various appliances parts such as a refrigerator door, and washing machines.

In an interview on 02/07/2025 at 6:18 PM, Staff A admitted that all the items were trash, and that the facility planned on renting a dumpster to get rid of the items.

03.07.2025 10:29:16

State of Washington

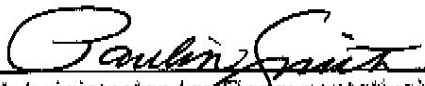
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Statement of Deficiencies	License #: 2332	Compliance Determination #54155
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Plan/Attestation Statement

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) April 10, 2025

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


Administrator (or Representative)

3/10/25
Date

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

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date



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

03/07/2025

Park View Villas, LLC
Park View Villas
2020 A St Se Ste 101
Auburn, WA 98002

RE: Park View Villas # 2332

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/25/2025 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 Return the Plan/Attestation Statement and report with signatures to:

Jody Just, Field Services Administrator
Residential Care Services
Region 3, Unit E
Preferred methods:

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

eFax: (360) 992-7969

Email: rcsregion3email@dshs.wa.gov

Optional method:

800 NE 136th Ave Ste 200

Vancouver, WA 98684

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

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

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

Review of provided pet records showed the facility was out of compliance with the required and recommended vaccination for 2 of 3 pet records reviewed, however, the facility corrected this by scheduling the necessary appointment and provided the Department documentation of the missing immunization (rabies vaccination for the two deficient pets). All other pet related records met required regulations, and the facility acknowledged the regulatory requirements for maintaining pet records for the future.

WAC 388-78A-2821 Design, construction review, and approval plans.

(2) The assisted living facility will meet the following requirements:

(d) Construction. Comply with the following requirements during the construction phase:

(i) The assisted living facility will not begin construction until all of the following items are complete:

(A) Construction review services has approved construction documents or granted authorization to begin construction;

(B) The local jurisdictions have issued a building permit; and

(C) The construction review services will issue an "authorization to begin construction" when the construction documents have been conditionally approved.

(ii) Submit to the department for review any addenda or modifications to the construction documents.

(e) Project closeout. The facility will not use any new or remodeled areas for resident use of licensed space until:

- (i) The department has approved construction documents;
- (iii) The facility notifies the department in writing when construction is completed and includes:
 - (A) Copy of the local jurisdiction's approval for occupancy;
 - (B) Copy of reduced floor plans; and
 - (C) A room schedule.

Based on interview, observation, and record review, the facility failed to notify the Department and Construction Review Services (CRS) of planned room modifications that occurred in March 2023. Before exiting the full inspection, the facility submitted their application to CRS for review of these changes and verbalized understanding of this requirement for all future facility modifications.

WAC 388-78A-2950 Water supply. The assisted living facility must:

- (6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

Based on observation, interview, and record review, the facility failed to maintain resident accessible sinks between the required temperature of 105 degrees Fahrenheit(F) and 120 degrees Fahrenheit(F) when they measured below 100 degrees Fahrenheit in 2 of 2 resident accessible restrooms. The facility hired a plumber who came onsite on 02/06/2025 and fixed a broken pipe outside the restrooms on 02/07/2025 before the Department's exit on 02/07/2025.

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

After observation and interview, the facility failed to have the previous inspection results available for review by the public within the facility during the full inspection. Prior to the Department exiting the facility, the previous inspection was placed in a binder made accessible for review by residents, staff, and public visitors for review.

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:

Email: RCSIDR@dshs.wa.gov; or

Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (360)397-9556.

Sincerely,



Jody Just, Field Services Administrator
Region 3, Unit E
Residential Care Services

Enclosure