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

Caring Places Management, LLC
Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

RE: Riverside Place License # 2363

Dear Administrator:

This letter addresses Compliance Determination(s) 66323 (Completion Date 09/30/2025) and 63288 (Completion Date 08/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/30/2025 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-2310-2-f

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

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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

The department completed data collection for an unannounced on-site follow-up on 07/29/2025 of:

Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

This document references the following SOD dated: 08/01/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 22 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor

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

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

Clinton Fridley
Residential Care Services

08/12/2025
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)

8-25-25
Date

WAC 388-78A-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law:

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interview and records review, the facility failed to ensure staff were individually delegated to each resident's individual delegation task for 1 of 1 delegated staff reviewed (Staff C). This failure resulted in 3 of 3 residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]) receiving delegated services from a staff person not delegated to administer their tasks and placed the residents at risk for harm and injury due to untrained and unsupervised care staff providing care they were not trained to provide.

Findings included...

Revised Code of Washington (RCW) 18.20.010 The legislature finds that many residents of community-based long-term care facilities are vulnerable, and their health and well-being are dependent on their caregivers. The quality, skills, and knowledge of their caregivers are often the key to good care. The legislature finds that the need for well-trained caregivers is growing as the state's population ages and residents' needs increase.

Washington Administrative Code (WAC) 246-840-930 "(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. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision…12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (b) The delegated nursing task is specific to one patient and is not transferable to another patient;(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide."

Record review of the undated facility policy titled, "Medication Administration," stated that medication administration was the most restrictive medication category and required administration only by "an LPN [licensed practical nurse], RN [registered nurse], ARNP [advanced registered nurse practitioner], physician, pharmacist, certified nursing assistant or nursing assistant registered following RN delegation protocols.[The] RN must assure the medication service category is planned, directed, and supervised by… providing training to all medication administration staff and documenting the training, [and] observing , evaluating, and documenting each staff person administering medication annually, or more often as needed."

Record review of the facility's plan of correction, dated 05/15/2025, showed the facility would immediately review and update all nurse delegation records to ensure each staff member was clearly and individually delegated to each resident's specific task to be incompliance with the WAC and delegation regulations. The delegating RN was required to maintain and update the delegation logs to show staff to resident assignments and review them monthly. All medication administration by delegated staff would be audited weekly for 90 days to ensure full compliance.

Record reviews of the undated resident roster showed 20 of 22 memory care residents received nurse delegation services.

Record review of the facility's employee HR (human resources) list, undated, showed Staff C, Medication Aide, started employment at the facility on 06/13/2025.

Record review of the facility provided worked staffing schedules, dated 06/29/2025 through 08/02/2025, showed Staff C was scheduled for 12-hour shifts as the medication technician from 6:00 PM until 6:00 AM every Thursday, Friday, and Saturday.

Record review of the facility's delegated staff list, dated 07/28/2025, showed Staff B, Resident Care Nurse, was the delegating nurse, and had reviewed all credentials to

ensure all were accurate, current, and in good standing. It also included that Staff B had observed, trained, and felt confident in the delegate's ability to perform delegated tasks. The document did not have Staff C listed as a delegate.

R1
Record review of R1's delegation assessment, dated 06/26/2025, showed R1 was delegated for their oral, topical (on the skin), patch, and rectal suppository medications related to R1's dementia (a progressive brain disorder that affects a person's memory, judgement, reasoning, and ability to perform activities of daily living needs). Review of the listed delegated medication aides showed Staff C was not listed for oral and topical medications related to R2's dementia.

R2
Record review of R2's delegation assessment, dated 06/26/2025, showed R2 was delegated for their oral and topical medications related to R2's dementia. Review of the listed delegated medication aides showed Staff C was not listed for oral and topical medications related to R2's dementia.

R3
Record review of R3's delegation assessment, dated 06/26/2025, showed R3 was delegated for their oral medications related to R3's dementia. Review of the listed delegated medication aides showed Staff C was not listed for oral medications related to R3's dementia.

Record review of R1, R2, and R3's Medication Administration Record (MAR), dated 07/01/2025 through 07/29/2025, showed Staff C administered all three residents delegated medication tasks for 12 of 28 days.

In an interview on 07/30/2025 at 11:02 AM, Staff B stated Staff C was not RN delegated to administer residents delegated tasks. Staff B stated Staff C did not have all their required documentation to be delegated.

This is a recurring deficiency previously cited on 01/23/2025 and an uncorrected deficiency previously cited on 04/01/2025 and 01/23/2025.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) 9.10.25 .

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

Administrator (or Representative)

8.25.25
Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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 03/19/2025 of:
Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

This document references the following SOD dated: 04/01/2025

The following sample was selected for review during the unannounced on-site visit: 7 of 20 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit Z
PO Box 99250
Lakewood, WA 98496

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

Cory Cisneros
Residential Care Services

04/10/2025
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)

May 15, 25
Date

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 agreed upon in the service plan (negotiated service agreement [NSA]) for 2 of 5 sampled residents (Resident 3 [R3], and Resident 7 [R7]). This failure placed both residents at risk for unmet care needs by not receiving the care agreed upon in their NSA.

Findings included...

Record review of the undated facility policy titled "Medication Administration," stated that the facility RN "must assure the medication service category [was] planned, directed, and supervised by."

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-2160 by 03/09/2025.

<Resident 3>

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-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 agreed upon in the service plan (negotiated service agreement [NSA]) for 2 of 5 sampled residents (Resident 3 [R3], and Resident 7 [R7]). This failure placed both residents at risk for unmet care needs by not receiving the care agreed upon in their NSA.

Findings included...

Record review of the undated facility policy titled “Medication Administration,” stated that the facility RN “must assure the medication service category [was] planned, directed, and supervised by.”

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-2160 by 03/08/2025.

<Resident 3>

Record review of the undated resident roster showed that R3 moved in [redacted]/2024, had a diagnosis of [redacted] and was receiving hospice services.

Record review of R3's NSA, dated 03/04/2025, showed that R3 required full assistance with showers and staff would assist with showers until the service is provided by hospice. The document also showed that showers are to be conducted on Tuesday mornings and Saturday mornings.

Record review of the R3's shower log dated 02/16/2025-03/19/2025, showed that R3 only had showers after the attestation date of 03/08/2025, on 03/12/2025 at 2:30 PM, a Wednesday, and 03/19/2025 at 2:30 PM, another Wednesday. There were no other entries that showed staff attempted a second shower for the week on another day.

In an interview on 03/19/2025 at 4:19 PM, Staff G, Resident Care Coordinator, acknowledged that staff are responsible for R3's showers because the service hasn't been moved over to hospice.

<Resident 7>

Record review of the undated resident roster showed that R7 moved in [redacted]/2021, had a diagnosis of [redacted] and was receiving hospice services.

Record review of R7's NSA dated 03/02/2025, showed that R7 required assistance with medications, it then goes on to say that any medications in pill form are crushed.

Record review of R7's NSA, dated 03/02/2025, showed R7 could not feed themselves and required staff to feed them for all meals.

Record review of R7's medication administration record showed a medication order that said medications may be crushed and showed facility staff had signed twice daily that they crushed R7's medications and administered them to R7.

In an interview on 03/19/2025 at 4:04 PM, Staff G confirmed Staff G stated that staff administer R7's medications sometimes but confirmed that R7's NSA said R7's medication services were self with assistance.

In an interview on 03/19/2025 at 4:05 PM, Staff G and Staff Q, Regional Director of Operations, acknowledged that R7's NSA was incorrect and that R7's medication services should have shown medication administration because some of R7's medications were crushed and administered by staff.

Record review of R7's MAR, dated 03/2025, shows that R7 was prescribed acetaminophen (treat pain) tablets twice per day, sertraline (treat mood disorders) tablets once per day and trazadone (used to treat mood disorders) tablets once per day.

This is a uncorrected and recurring deficiency previously cited on 03/28/2023 and 01/23/2025.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) MAY 15 2025

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

Administrator (or Representative) — Date: 4.11.25

WAC 388-78A-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law.

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were individually delegated to each resident's individual delegation task for 1 of 1 delegated staff reviewed (Staff F). This failure caused 2 of 7 delegated residents (Resident 8 [R8] and Resident 11 [R11]) to receive delegated services from a staff person not delegated to administer their tasks and placed both residents at risk for harm and injury due to untrained and unsupervised care staff providing care they were not trained to provide.

Findings included...

RCW 18.20.010 The legislature finds that many residents of community-based long-term care facilities are vulnerable, and their health and well-being are dependent on their caregivers. The quality, skills, and knowledge of their caregivers are often the key

Record review of R7's MAR, dated 03/2025, shows that R7 was prescribed acetaminophen (treat pain) tablets twice per day, sertraline (treat mood disorders) tablets once per day and trazadone (used to treat mood disorders) tablets once per day.

This is a uncorrected and recurring deficiency previously cited on 03/28/2023 and 01/23/2025.

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, Riverside Place 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-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law:

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were individually delegated to each resident's individual delegation task for 1 of 1 delegated staff reviewed (Staff F). This failure caused 2 of 7 delegated residents (Resident 8 [R8] and Resident 11 [R11]) to receive delegated services from a staff person not delegated to administer their tasks and placed both residents at risk for harm and injury due to untrained and unsupervised care staff providing care they were not trained to provide.

Findings included…

RCW 18.20.010 The legislature finds that many residents of community-based long-term care facilities are vulnerable, and their health and well-being are dependent on their caregivers. The quality, skills, and knowledge of their caregivers are often the key

to good care. The legislature finds that the need for well-trained caregivers is growing as the state's population ages and residents' needs increase.

WAC 246-840-930 12(b) The delegated nursing task is specific to one patient and is not transferable to another patient;(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide.

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-2310(2)(f) by 03/08/2025.

Record review of the undated facility policy titled “Medication Administration,” stated that medication administration was the most restrictive medication category and required administration only by “an LPN, RN, ARNP, physician, pharmacist, certified nursing assistant or nursing assistant registered following RN delegation protocols.[The] RN must assure the medication service category is planned, directed, and supervised by… providing training to all medication administration staff and documenting the training, [and] observing , evaluating, and documenting each staff person administering medication annually, or more often as needed.”

Record review of the undated resident roster showed 20 of 20 memory care residents received nurse delegation services.

Record review of the undated document titled” Riverside Delegated Resident List,” showed the name of seven residents, their apartment number, their delegated tasks, the last date tasks were reviewed by Staff E, and the next date a review was due. The list did not show which staff member was delegated for each resident and task. The list showed R2, R4, R5, R8, R10, R11, and R13 as the residents who received delegated services.

<Staff F>

Record review of the untitled facility staff list showed Staff F, Caregiver, was hired on 02/20/2024.

Record review of the document titled “Riverside Delegated Staff List,” signed 02/06/2025 by Staff E, Resident Care Nurse, showed Staff F was initially delegated on 02/11/2025. The document did not show which resident Staff F was delegated to; there was no resident-specific information. At the bottom of the document, it stated “each delegate has agreed to assume responsibility for each delegated task.”

Record review of the nurse delegation binder that contained delegated resident

delegation assessments was reviewed.

Review of R13's delegation assessment showed Staff F was delegated to their tasks on 02/11/2025.

Review of R2, R4, R5, R8, R10, and R11's delegation assessments did not show Staff F was delegated to provide them with their delegated tasks.

<Resident 8 and Resident 11>

Record review of R8's delegation assessment, dated 02/06/2025, showed R8 received delegated services for patch medication administration, topical medication administration, and eye drop medication administration. The document did not show Staff F as a delegated staff to administer R8's delegated tasks.

Record review of R8's medication administration record, dated 03/08/2025 through 03/19/2025 showed R8 was prescribed eye drops and that the eye drops required delegation. The record showed Staff F administered the eye drops on 03/11/2025, 03/16/2025, 03/17/2025, and 03/18/2025.

Record review of R11's delegation assessment, dated 01/01/2025, showed R11 received delegated services for oral medications and nasal spray. The document did not show Staff F as a delegated staff to administer R11's delegated tasks.

Record review of R11's medication administration record, dated 03/08/2025 through 03/19/2025, showed R11 was prescribed trazodone (a medication used to help an individual sleep) and that the medication required staff were nurse delegated to administer trazodone to R11. The record showed Staff F administered trazodone on 03/11/2025, 03/16/2025, 03/17/2025, and 03/18/2025.

In an interview on 03/19/2025 at 3:50 PM, Staff E stated that they were the RN Delegator for the facility.

In an interview on 03/19/2025 at 4:50 PM, Staff E stated that they did not delegate each individual staff person for each individual resident's delegated tasks. Staff E confirmed that Staff F was only delegated to R13.

In an interview on 03/19/2025 at 5:30 PM, Staff Q, Regional Director of Operations, Staff U, Office Manager, and Staff E acknowledged the facility was not compliant with nurse delegation regulations.

Statement of Deficiencies	License #: 2363	Compliance Determination #:56579
Plan of Correction	Riverside Place	Completion Date
Page 7 of 13	Licensee: Caring Places Management, LLC	04/01/2025

This is a uncorrected deficiency previously cited on 01/23/2025

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) May 15, 25.

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

Administrator (or Representative) — Date: 4.21.25

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to institute appropriate infection prevention practices to limit the spread of infectious illnesses in 1 of 1 memory care units. This failure placed all residents, visitors, and staff at risk for exposure to infectious diseases.

Findings included...

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-2610 by 03/08/2025.

Record review of document titled, "Hand Washing," dated 02/17/2016, showed staff were expected to wash their hands after handling soiled laundry or items with bodily

This is a uncorrected deficiency previously cited on 01/23/2025.

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, Riverside Place 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-2610 Infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to institute appropriate infection prevention practices to limit the spread of infectious illnesses in 1 of 1 memory care units. This failure placed all residents, visitors, and staff at risk for exposure to infectious diseases.

Findings included…

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-2610 by 03/08/2025.

Record review of document titled, “Hand Washing,” dated 02/17/2016, showed staff were expected to wash their hands after handling soiled laundry or items with bodily

fluids and after conducting housekeeping tasks. The policy also stated that the use of gloves does not replace handwashing.

In an observation on 03/19/2025 at 1:22 PM, there was not a soap dispenser at the only sink in the hopper room that is designated to receive the soiled laundry and house cleaning supplies.

In an interview on 03/19/2025 at 1:22 PM, Staff T, housekeeper, stated that the hopper room sink had no soap dispenser for staff to use. Staff T stated that they rarely use the sink. Staff T stated that they do not wash their hands and only change their gloves when laundering soiled laundry. Staff T stated that if they had to wash their hands, they would use a bathroom.

In an interview on 03/19/2025 at 4:30 PM, Staff U, Office Manager, stated that they were responsible for ensuring all staff completed the re-training on hand hygiene.

In an observation on 03/19/2025 at 4:34 PM, Staff G, Resident Care Coordinator, and Staff H, Medication Aide, enter the restroom to help Staff M, Caregiver, with a resident needing care.

In an observation on 03/19/2025 at 4:38 PM, Staff G, Staff H and Staff M exited the restroom with the resident. Staff G washed their hands.

In an observation on 03/19/2025 at 4:40 PM, Staff G told Staff H and Staff M to wash their hands after helping resident with care.

In an interview on 03/19/2025 at 5:15 PM, Staff U and Staff G acknowledged that staff should wash their hands after handling soiled items and removing their gloves.

This is a uncorrected deficiency previously cited on 01/23/2025.

Statement of Deficiencies	License #: 2363	Compliance Determination #:55579
Plan of Correction	Riverside Place	Completion Date
Page 9 of 13	Licensee: Caring Places Management, LLC	04/01/2025

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) May 15, 25.

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

Administrator (or Representative) — Date: 4.21.25

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to safely store supplies in 3 of 3 indoor locations (Resident 2 [R2] and Resident 13 [R13] room and Resident Dining Room) in a memory care facility. This failure placed all 22 residents at risk for injury due to ingesting hazardous ingredients.

Findings included...

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-3100 by 03/08/2025.

Record review of the undated facility policy titled," Cleaning Resident Rooms and Furnishings," showed that all equipment and supplies would be stored in the commercial laundry room and the door would be locked. The document stated that the [cleaning] supplies would always be locked in a separate cabinet.

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, Riverside Place 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-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to safely store supplies in 3 of 3 indoor locations (Resident 2 [R2] and Resident 13 [R13] room and Resident Dining Room) in a memory care facility. This failure placed all 22 residents at risk for injury due to ingesting hazardous ingredients.

Findings included…

Record review of the facility plan of correction, signed 02/14/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-3100 by 03/08/2025.

Record review of the undated facility policy titled," Cleaning Resident Rooms and Furnishings," showed that all equipment and supplies would be stored in the commercial laundry room and the door would be locked. The document stated that the [cleaning] supplies would always be locked in a separate cabinet.

Record review of the resident roster, dated 03/19/2025, showed 20 of 20 residents with a diagnosis of [redacted], lived at the facility.

<Resident 13>

In an observation on 03/19/2025 at 2:12 PM, R13's unlocked kitchen cabinet showed a 14 fluid ounce canister of First Alert EZ Fire Potassium Spray (a spray meant to contain fires), an 18 fluid ounce bottle of Dawn dishwashing liquid and an unlabeled bottle of aroma villa reed diffuser.

In an interview on 03/19/2025 at 2:14 PM, Staff M, Caregiver, stated that chemicals were not supposed to be in resident rooms.

In an observation on 03/19/2025 at 2:20, Staff M removed the found chemicals from R13's room.

<Resident 2>

In an observation on 03/19/2025 at 2:06 PM, a 19 oz bottle of Great Value Disinfecting Spray, a 14.7 fl oz bottle of Gain Ultra Clean Dishwashing Liquid and a 50 fl oz bottle of Equate Liquid Hand Soap was in the unlocked cabinet under the kitchenette sink in R2's room. There was also a bottle (unspecified amount) of Sand Fog Reed Diffuser located on the shelf mounted on the right-side wall in R2's room.

In an observation and interview on 03/19/2025 at 2:11 PM, Staff M acknowledged that chemicals were not supposed to be in R2's room. Staff M removed the chemicals from the room.

<Resident Dining>

In an observation on 03/19/2025 at 1:18 PM, a 32-ounce bottle of odor ban deodorizer was seen in the unlocked cabinets in the resident dining cabinets.

In an interview on 03/19/2025 at 1:25 PM, Staff T, housekeeper, stated that chemicals were stored in the soiled utility room and that chemicals were not supposed to be outside of the hopper room in unlocked cabinets.

In an interview on 03/19/2025 at 1:29 PM, Staff T acknowledged that the deodorizer was

in an unlocked cabinet and not supposed to be there.

In an interview on 03/19/2025 at 5:20PM, Staff U, Office Manager, acknowledged chemicals should not have been accessible to residents.

This is a uncorrected deficiency previously cited on 01/23/2025.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) May 15 25

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

Administrator (or Representative) — Date: 4.21.25

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to implement their facility's fall policy for 1 of 1 resident reviewed (Resident 14 [R14]). This failure placed the resident at risk for unidentified injuries.

Findings included...

Record review of the facility policy titled "Minimizing Falls," dated 05/16/2023, showed that if a resident fall occur[ed], staff should complete a full head-to-toe evaluation, vital signs, assessment of orientation, and neurological checks if the incident was not witnessed. The policy also notes that after the resident is evaluated and stabilized then the staff should complete an objective documentation in CommuniCare, including a factual statement of incident or how resident was found, evaluation (or assessment), treatment and notification of proper chain of command.

in an unlocked cabinet and not supposed to be there.

In an interview on 03/19/2025 at 5:20PM, Staff U, Office Manager, acknowledged chemicals should not have been accessible to residents.

This is a uncorrected deficiency previously cited on 01/23/2025.

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-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to implement their facility's fall policy for 1 of 1 resident reviewed (Resident 14 [R14]). This failure placed the resident at risk for unidentified injuries.

Findings included…

Record review of the facility policy titled “Minimizing Falls,” dated 05/16/2023, showed that if a resident fall occur[ed], staff should complete a full head-to-toe evaluation, vital signs, assessment of orientation, and neurological checks if the incident was not witnessed. The policy also notes that after the resident is evaluated and stabilized then the staff should complete an objective documentation in CommuniCare, including a factual statement of incident or how resident was found, evaluation (or assessment), treatment and notification of proper chain of command.

<Resident 14>

Record review of the undated resident roster showed R14 moved in on [redacted]/2024 and had a diagnosis of [redacted].

Record review of a facility investigation report, dated 03/17/2025, showed that R14 had an unwitnessed fall in the hallway.

Record review of R14's incident investigation report, dated 03/17/2025, showed that R14 last set of documented vital signs were conducted on 12/26/2024. There were no other documented vital signs collected after R14's fall incident.

Record review of R14's resident record showed there was no post-fall assessment completed after R14 fell on 03/17/2025.

In an interview on 03/19/2025 at 4:12 PM, Staff G, Resident Care Coordinator, stated that vital signs were not conducted for R14 after the fall incident. Staff G confirmed that the last vital signs were conducted on 12/26/2024 and acknowledged this did not reflect compliance with the facility policy.

In an interview on 03/19/2025 at 5:00 PM, Staff E, Resident Care Nurse, stated that they did not complete an assessment of R14 after they fell on 03/17/2025. Staff E and Staff G, Resident Care Coordinator, confirmed an assessment was not conducted for R14 after they fell on 03/17/2025. Both Staff E and Staff G stated that an assessment should have been completed after the unwitnessed fall occurred.

In an interview on 03/19/2025 at 5:30 PM, Staff Q, Regional Director of Operations, acknowledged the facility did not follow their policy after R14 had an unwitnessed fall on 03/17/2025.

This is a uncorrected deficiency previously cited on 01/23/2025.

Statement of Deficiencies	License #: 2363	Compliance Determination #:55579
Plan of Correction	Riverside Place	Completion Date
Page 13 of 13	Licensee: Caring Places Management, LLC	04/01/2025

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) May 15 25.

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

Administrator (or Representative) — Date: 4.21.25

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, Riverside Place 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverside Place
Provider Type: Assisted Living Facility
License/Cert.#: 2363
Compliance Determination #: 53068
Intake ID: 162245
Investigator: Emily Boniface
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/14/2025 through 01/23/2025
Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment- not receiving necessary services
Physical Environment- not providing necessary supplies to residents

Investigation Methods:

Sample:
Total residents: 22
Resident sample size: 6
Closed records sample size: 0

Observations:
Staff to resident interactions
Resident to resident interactions
Resident rooms
Resident care equipment
Dining
Activities
Residents
Identified resident

Interviews:
Kitchen staff
Business office manager
Housekeeping staff
Family members
Residents
Nursing staff
Identified staff
Identified resident

Record Reviews:
Medical records
Hospital records
State reporting log
Facility policies
Personnel files
Staff training records
Staff patterns
Resident Specific Records

Investigation Summary:

Findings related to this complaint are cited under the statements of deficiency for the facility's full inspection on 01/14/2025 under WAC 388-78A-2130 (2) (3)a,b (5)b and WAC 388-78A-2160 .

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 01/14/2025, 01/15/2025 and 01/17/2025 of:

Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

This document references the following complaint numbers: 162245.

The following sample was selected for review during the unannounced on-site visit: 6 of 22 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit Z
PO Box 99250
Lakewood, WA 98496

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

02/05/2025
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)

3-21-25 2-14-25
Date

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 agreed upon in the service plan (negotiated service agreement [NSA]) for 3 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3]). This failure placed all three residents at risk for unmet care needs by not receiving the care agreed upon in their NSA.

Findings included...

<Resident 1>

Record review of the undated characteristic roster showed R1 admitted to the facility on [redacted] 2021, diagnosed with [redacted] required nurse delegation, medication administration, and minimal physical assistance.

Record review of R1's NSA, dated 03/22/2024, showed R1 required staff to place a walker by their bedside and encourage use, needed minimal assistance to independently attend and eat meals, could swallow pills whole and could tell staff when they were in pain.

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-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 agreed upon in the service plan (negotiated service agreement [NSA]) for 3 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3]). This failure placed all three residents at risk for unmet care needs by not receiving the care agreed upon in their NSA.

Findings included...

<Resident 1>

Record review of the undated characteristic roster showed R1 admitted to the facility on [redacted]/2021, diagnosed with [redacted], required nurse delegation, medication administration, and minimal physical assistance.

Record review of R1's NSA, dated 03/22/2024, showed R1 required staff to place a walker by their bedside and encourage use, needed minimal assistance to independently attend and eat meals, could swallow pills whole and could tell staff when they were in pain.

In an interview and observation on 01/15/2025 at 5:21 PM, Staff H, Lead Medication Aide, prepared a syringe with morphine (pain medication) for R1. Staff H stated that due to R1's recent decline, the morphine medication order was changed from an "as-needed" medication to "scheduled," for every 3 hours. Staff H stated R1 could no longer sit up in bed or eat and required two-person assistance for all cares and transfers.

On 01/15/2025 at 5:30 PM, R1 was observed in a hospital bed asleep. R1's walker was not near the bed but in their living room. Staff H gave R1 the morphine liquid mixture and massaged it into R1's cheek. R1 coughed during and after administration. Staff H stated R1 could no longer swallow pills nor tell staff when they were in pain.

In an interview and observation on 01/15/2025 at 5:40 PM, Staff H stated the facility kept all Residents NSAs in a white binder located in the medication room. Staff H showed the department the binder where the resident's working care plans were located. Staff H stated that the personal care currently being provider to R1 for bathing, assistance level needed during cares (2 -person assistance instead of one person), administering hospice medications, hospital bed, and meal changes was not following R1's NSA as it was written.

In an interview on 01/17/2025 at 6PM, Staff G, Resident Care Coordinator, stated R1's care was not delivered according to the NSA.

<Resident 2>

Record review of the undated characteristic roster showed R2 was admitted to the facility on [redacted]/2024 and was diagnosed with [redacted].

Record review of documents titled," daily morning stand up meetings," dated 01/06/2025 through 01/15/2025 did not show R2 listed as a shower recipient for those days.

Record review of R2's NSA dated 10/29/2024 and most recent working care plan dated 01/09/2025 showed R2 should receive a shower twice per week, on Sunday and Thursday mornings. The NSA specified that R2 preferred showers in the morning.

Record review of R2's shower log, dated 01/17/2025, showed R2 did not receive a shower 4 times between 12/22/2024 and 1/12/2025. R2 did not receive a shower on 12/22/2024, 12/29/2024, 01/05/2025, and 01/12/2025 as shown in their NSA. The notation on the shower log for those dates showed "shower not completed." Between the dates of 10/20/2024 and 01/16/2025 16 of 26 recorded showers were not given in the morning. The time administered ranged from 1:15PM to 11:55 PM for those 16 occurrences.

Record review of R2's NSA, dated 01/09/2025, showed female staff should assist resident with showering. Review of the shower log showed a male staff assisted with R2's shower on 01/11/2025, an unscheduled shower day.

Record review of alert notes, dated 11/13/2024 to 11/18/2024, showed R2 required antibiotics to treat a urinary tract infection beginning 11/13/2024.

Record review of alert notes, dated 12/27/2024 through 01/01/2025, showed R2 developed a rash on their skin on 12/27/2024.

In an interview on 01/16/2025 at 5:00 PM, Collateral Contact 1, the department case manager, stated they had received repeated concerns from R2's durable power of attorney (DPOA) that R2 had not been receiving their showers as planned and written in R2's NSA.

In an interview on 01/17/2025 at 8:35 PM, Staff A, Administrator, stated they were aware R2's DPOA had concerns with R2's care inconsistent with the NSA.

In an interview on 01/22/2025 at 6:00 PM, Collateral Contact 2 (CC2), R2's DPOA, stated they had picked R2 up from the facility on multiple occasions and R2 was malodorous with greasy hair. CC2 stated they made complaints to the facility administrator as recently as 01/09/2025. CC2 stated they would shower R2 when they came to visit and that they were told by staff R2 was receiving their showers despite R2 developing skin yeast infections and urinary tract infections from lack of hygiene. CC2 stated they requested a copy of a shower log for R2 and was told a shower log did not exist.

In an interview on 01/21/2025 at 2:13 PM, Staff A stated the working care plans in the binder in the medication room had the last completed and signed NSA for each resident and were the NSA's caregivers used for care instructions.

<Resident 3>

Record review of the undated characteristic roster showed R3 admitted to the facility on [redacted]/2024 and was diagnosed with [redacted].

Record review of R3's NSA undated, showed R3 should receive a shower on Tuesday and Saturday morning and required full assistance with their shower.

Record review of R3's shower log, dated 01/17/2025, showed R3 received a shower four times between 12/17/2024 and 01/13/2025. The dates R3 received a shower were 12/17/2024, 12/23/2024, 12/28/2024 and 1/13/2025.

Record review of documents titled," daily morning stand up meetings," dated 01/06/2025 through 01/15/2025 did not show R3 listed as a shower recipient for their scheduled showers on 01/07/2025 and 01/11/2025. These documents showed R3 listed as a resident with skin concerns for all of these dates.

Record review of a progress note entered by Staff H on 12/31/2024, showed R3 had redness to their groin and had redness and a small skin tear on their bottom areas.

In an interview on 01/23/2025 at 1:30 PM Staff A confirmed the last completed and most up-to-date NSA for each resident was located in the working care plan binder in the medication room.

This is a recurring deficiency previously cited on 03/28/2023.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) 3-21-25 3-8-25

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

Administrator (or Representative) 2-14-25 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:

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

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009.

This requirement was not met as evidenced by:

Record review of documents titled," daily morning stand up meetings," dated 01/06/2025 through 01/15/2025 did not show R3 listed as a shower recipient for their scheduled showers on 01/07/2025 and 01/11/2025. These documents showed R3 listed as a resident with skin concerns for all of these dates.

Record review of a progress note entered by Staff H on 12/31/2024, showed R3 had redness to their groin and had redness and a small skin tear on their bottom areas.

In an interview on 01/23/2025 at 1:30 PM Staff A confirmed the last completed and most up-to-date NSA for each resident was located in the working care plan binder in the medication room.

This is a recurring deficiency previously cited on 03/28/2023.

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-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:

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

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009 .

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure 7 of 8 sampled staff (Staff D, Staff F, Staff I, Staff M, Staff N, Staff O, Staff R) obtained and maintained certification as a Home Care Aide (HCA). This failure placed all 22 residents at risk for receiving care from unqualified staff.

Findings included…

WAC 246-980-030
(2) A long-term care worker is no longer eligible to provide care without a credential under the following circumstances:
(a) The long-term care worker does not successfully complete all of the training required by RCW 74.39A.074 (1) within one hundred twenty calendar days from their date of hire;
(b) The long-term care worker has not obtained their certification within two hundred calendar days from their date of hire, or two hundred sixty calendar days if granted a provisional certificate under RCW 18.88B.041.

On 01/14/2025, the department requested facility staff records and staff schedules during an unannounced full inspection.

On 01/14/2025, the department received staff personnel records.

On 01/15/2025, 01/17/2025, and 01/23/2025, the department received staff schedules.

<Staff D>

Record review of the facility's employee Human Resources (HR) list, undated, showed Staff D, Caregiver, was hired on 09/19/2023.

Record review of the facility schedule for 09/29/2024 through 01/18/2025 showed Staff D was scheduled 3 to 4 shifts per week.

Record review of Staff D's personnel file did not show an active HCA certification.

Review of the Department of Health (DOH) Credential search conducted on 01/23/2025 showed Staff D's HCA was pending. Staff D's HCA credential status was 288 days late as of 01/23/2025.

No other credentials were provided for review. No other credentials were found in the DOH credential search.

Record review of screen shots of text communications between Staff D and Staff A,

Administrator, showed Staff D applied for their HCA exam on 11/05/2024.

In an interview on 01/15/2025 at 5:00PM, Staff A stated that Staff D had not scheduled their final HCA examination.

<Staff F>

Record review of the facility's employee HR list, undated, showed Staff F, Caregiver, was hired on 02/20/2024.

Record review of the facility’s staff schedule for 09/29/2024 through 01/18/2025 showed Staff F was scheduled to work 3 to 4 shifts per week. The schedule showed Staff F was trained to administer medications on 09/30/2024, 10/01/2024, 10/07/2024, 10/08/2024, and 10/12/2024.

Record review of Staff F's personnel file did not show an active HCA certification.

Review of the DOH credential search conducted on 01/23/2025 showed Staff F's HCA certificate was pending.

Staff F's HCA credential status was 137 days late as of 01/23/2025.

No other credentials were provided for review. No other credentials were found in the DOH credential search.

Record review of Resident 1's (R1) MAR for October 2024 through January 2025 showed Staff F checked R1's blood sugar levels and administered insulin.

Record review of Resident 4's (R4) MAR for October 2024 through January 2025 showed that Staff F had checked their blood sugar levels 29 times which required nurse delegation.

There were no records available to review to show Staff F was properly credentialed to receive nurse delegation nor administer delegated tasks to residents.

In an interview on 01/15/2025 at 3:05 PM, Staff E, Resident Care Nurse, stated staff must have their HCA certification to be eligible to receive and perform delegated tasks.

<Staff I>

Record review of the facility's employee HR list, undated, showed Staff I, Caregiver, was hired on 08/29/2023.

Record review of the facility schedule for 09/29/2024 through 01/18/2025 showed Staff I was scheduled to work 1 to 2 shifts per week.

Review of the DOH credential search on 01/23/2025 showed Staff I's HCA and Provisional HCA were pending.

As of 01/23/2025 Staff I's HCA credential status was 307 days late.

The facility did not have an active credential for Staff I to review. No other credentials were found in the DOH credential search.

<Staff R>

Record review of the facility's employee HR list, undated, showed Staff R, Caregiver, was hired on 09/06/2023.

Record review of the facility’s schedule for 09/29/2024 through 01/18/2025 showed Staff R was scheduled 3 to 4 shifts per week

In an interview on 01/17/2025 at 1:44 PM, Staff R introduced themselves as an HCA and stated that they had been working at the facility for over a year. Staff R then stated they had not taken the HCA test.

In an interview and observation on 01/17/2025 at 8:00 PM, Staff A, showed their computer screen with the application and payment information for Staff R's HCA test. The application and payment to test had been submitted on 01/16/2025.

Record review of the DOH credential search on 01/23/2025 showed Staff R's HCA certification was pending. As of 01/23/2025, Staff R's HCA credential status was 301 days late.

The facility did not have an active credential for Staff R to review. No other credentials were found in the DOH credential search.

In an interview on 01/17/2025 at 5:00 PM, Staff A, stated that Staff D, F, I, and R did not

have their HCA credentials and were not qualified to work with residents. Staff A acknowledge Staff D, F, I, and R had been providing residents with care. Staff A stated that Staff U, Office Manager, and Staff A were responsible for ensuring staff were properly trained and credentialed upon hire.

In an interview on 01/17/2025 at 8:15 PM, Staff E, Resident Care Nurse, stated that they were the person responsible for reviewing staff credentials for the facility, including for staff who perform delegated tasks.

<Staff M>

Record review of the facility's employee HR list, undated, showed Staff M, Caregiver, was hired on 01/25/2021.

Record review of Staff M's personnel file showed they last renewed their HCA on 11/27/2024.

Department of Health credential search on 01/23/2025 showed Staff M previously held a Nursing Assistant Registered that expired on 09/18/2023. The search showed Staff M first obtained their HCA on 04/24/2024.

Staff M was not credentialed between 09/18/2023 and 04/24/2024. There was no certification between 09/18/2023 and 04/25/2024 and then a lapse between 09/18/2024 and 11/27/2024

<Staff N>

Record review of the facility's employee HR list, undated, showed Staff N, Caregiver, was hired on 07/01/2022.

Record review of Staff N's personnel file showed that their HCA was last renewed on 12/09/2024 and that the expiration date was 12/02/2024. Staff N had a 7-day lapse of their credential.

Record review of the staff schedule showed Staff N worked 12/03/2024, 12/04/2024, and 12/05/2024 while their credential was expired.

<Staff O>

Record review of the facility's employee HR list, undated, showed Staff O, Caregiver,

was hired on 12/04/2013.

Record review of Staff O's personnel file showed that their HCA expired 12/17/2024 and was renewed on 01/02/2025. Staff O had a 14-day credential lapse between 12/17/2024 and 01/02/2025.

Record review of R2's delegation assessment showed that Staff E delegated tasks for R2 to Staff O for blood glucose checks and insulin administration on 12/23/2024 when Staff O's credential was expired.

In an interview on 01/15/2025 at 3:45 PM, Staff E stated that they had verified Staff O's credential on 01/01/2025 and rescinded their nurse delegation due to a lapsed credential. Staff O stated that Staff O was never taken off the schedule during the time their credential had lapsed.

In an interview on 01/17/2025 at 5:00 PM, Staff A, Administrator, stated that Staff D, F, I, and R did not have their HCA credentials and were not qualified to work with residents. Staff A acknowledge Staff D, F, I, and R had been providing residents with care. Staff A stated that Staff U, Office Manager, and Staff A were responsible for ensuring staff were properly trained and credentialed upon hire. Staff A stated that they did not know that Staff H, Staff M, Staff N, and Staff O had lapses in their certification in the past year.

On 01/17/2025 at 5:05 PM the department requested the facility produce a safety plan for staffing the facility because the facility schedule did not reflect enough qualified caregiving staff to meet the safety and needs of the residents with the current staffing plan provided.

On 01/17/2025 at 6:30 PM, the facility provided a safety plan that included the removal of unqualified staff from the schedule and replacement of those vacancies with current qualified staff and agency-contract caregivers.

In an interview on 01/17/2025 at 8:15 PM, Staff E, Resident Care Nurse, stated that they were the person responsible for reviewing staff credentials for the facility, including for staff who perform delegated tasks.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) 3.21.25 3.8.25

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

Administrator (or Representative) 2.14.25 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident's representative to the extent he or she is willing and capable, if the resident has one;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled residents (Resident 3 [R3]) had a Negotiated Service Agreement (NSA) within 30-days of admission and failed to ensure 4 of 6 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]) NSA's were updated when there was a change in condition or the NSA no longer met their needs. The facility also failed to involve the resident's representative in the updating of 1 of 6 resident's NSA. These failures placed all 4 residents at risk of unmet care needs, uninformed decisions, and receiving the wrong care by staff not trained on their care needs.

Findings included...

In an interview on 01/21/2025 at 11:30 AM, Staff A, Administrator, stated the facility's

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, Riverside Place 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-2130 Service agreement planning. The assisted living facility must:

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled residents (Resident 3 [R3]) had a Negotiated Service Agreement (NSA) within 30-days of admission and failed to ensure 4 of 6 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]) NSA's were updated when there was a change in condition or the NSA no longer met their needs. The facility also failed to involve the resident's representative in the updating of 1 of 6 resident's NSA. These failures placed all 4 residents at risk of unmet care needs, uninformed decisions, and receiving the wrong care by staff not trained on their care needs.

Findings included...

In an interview on 01/21/2025 at 11:30 AM, Staff A, Administrator, stated the facility's

NSA was also their assessments.

<Resident 1>

Record review of the facility's undated characteristic roster showed R1 admitted to the facility on [redacted]/2021, diagnosed with [redacted], required nurse delegation, medication administration, and minimal physical assistance.

Record review of R1's signed NSA, dated 03/22/2024, showed R1 required staff to place a walker by their bedside and encourage use, needed minimal assistance to independently attend and eat meals, could swallow pills whole and could tell staff when they were in pain.

Record review of R1's delegation assessment completed on 11/08/2024 at 10:29 AM by Staff E, Registered Care Nurse, showed that resident had was admitted to hospice services and hospice medications were delegated with frequent lorazepam (controlled medication for anxiety) administration.

Record review of R1's NSAs dated 07/04/2024 and 10/28/2024 did not show the changes to R1's care as a result of entering hospice on 11/08/2024 nor reflect the change in condition resulting in R1's mobility, transfer, bathing, toileting, meal assistance, medication delegation, and communication changes.

In an interview on 01/14/2025 at 3:15 PM, Staff E stated they do not delegate hospice medications or tasks to the facility staff.

Record review of the document titled, " Riverside Delegated Resident List," showed R1 was delegated for PRN (as-needed medications), Topical (skin), Patch, and hospice tasks.

In an interview and observation on 01/15/2025 at 5:21 PM, Staff H, Lead Medication Aide, prepared a syringe with morphine (pain medication) for R1. Staff H stated that due to R1's recent decline, the morphine medication order was changed from an "as-needed" medication to "scheduled," for every 3 hours. Staff H stated R1 could no longer sit up in bed or eat and required two-person assistance for all cares and transfers.

On 01/15/2025 at 5:30 PM, R1 was observed in a hospital bed asleep. R1's walker was not near the bed but in their living room. Staff H gave R1 the morphine liquid mixture and massaged it into R1's cheek. R1 coughed during and after administration. Staff H stated R1 could no longer swallow pills nor tell staff when they were in pain.

In an interview and observation on 01/15/2025 at 5:40 PM, Staff H stated the NSAs in

the white binder in the medication room were where staff found resident specific caregiving instructions and information. Staff H showed the department the binder where the resident's working care plans were located. Staff H stated that the care provided to R1 was different than the information in the NSA.

In an interview on 01/17/2025 at 6PM, Staff G, Resident Care Coordinator stated R1's care was not delivered according to the NSA and stated that they were aware the hospice care plan and services should have been incorporated into R1's NSA with a care plan update.

In an interview on 01/17/2025 at 6:30 PM, Collateral Contact 3(CC3), R1's Hospice RN, stated they do not delegate to the facility staff as the facility is responsible for delegating to their own staff. CC3 stated the hospice company provides extensive education and written materials with their separate care plan that is given to the facility.

<Resident 2>

Record review of the undated facility's characteristic roster showed R2 admitted to the facility on [redacted]/2024 and was diagnosed with [redacted].

Record review of documents titled," daily morning stand up meetings," dated 01/06/2025 through 01/15/2025 did not show R2 listed as a shower recipient for those days.

Record review of R2's NSA dated 10/29/2024 and most recent working care plan dated 01/09/2025 showed R2 should receive a shower twice per week, on Sunday and Thursday mornings. The NSA specified that R2 preferred showers in the morning.

Record review of R2's shower log, dated 01/17/2025, showed R2 did not receive a shower 4 times between 12/22/2024 and 1/12/2025. Between the dates of 10/20/2024 and 01/16/2025 16 of 26 recorded showers were not given in the morning. The time administered ranged from 01:15PM to 11:55 PM for those 16 occurrences.

Record review of R2's NSA, dated 01/09/2025, showed female staff should assist resident with showering. Review of the shower log showed a male staff assisted with R2's shower on 01/11/2025, an unscheduled shower day.

Record review of alert notes, dated 11/13/2024 to 11/18/2024, showed R2 required antibiotics to treat a urinary tract infection beginning 11/13/2024.

Record review of alert notes, dated 12/27/2024 through 01/01/2025, showed R2

developed a rash on their skin on 12/27/2024.

In an interview on 01/16/2025 at 5:00 PM, Collateral Contact 1, the department case manager, stated they had received repeated concerns from R2's durable power of attorney (DPOA) that R2 had not been receiving their showers as planned and written in R2's NSA nor receiving their medications as prescribed.

In an interview on 01/17/2025 at 8:35 PM, Staff A, Administrator, stated they were aware R2's DPOA had concern with R2's care inconsistent with the NSA.

In an interview on 01/22/2025 at 6:00 PM, Collateral Contact 2 (CC2), R2's DPOA, stated they had picked R2 up from the facility on multiple occasions and R2 was malodorous with greasy hair. CC2 stated they made complaints to the facility administrator as recently as 01/09/2025. CC2 stated they would shower R2 when they came to visit and that they were told by staff R2 was receiving their showers despite R2 developing skin yeast infections and urinary tract infections from lack of hygiene. CC2 stated they requested a copy of a shower log for R2 and was told a shower log did not exist. (CC2), stated R2 was supposed to be on Eliquis since it was ordered in 10/25/2024, but was concerned R2 did not receive it until mid-November because of questions CC2 received from staff about the medication around that time. CC2 stated they asked the facility to have female caregivers give R2 their showers and that was not added until January when CC2 demanded it be added and filed a formal complaint.

<Resident 3>

Record review of R3's "resident info sheet" undated, showed that the resident moved into the facility on [redacted]/2024 and had a diagnosis of [redacted].

Record review of R6's NSA dated 07/22/2024, showed their initial evaluation at move-in. The next NSA was completed on 8/26/2024. R3's 30-day NSA was completed 4 days late.

<Resident 4>

Record review of R4's "resident info sheet" undated, showed that the resident moved into the facility on [redacted]/2022. The document also showed the resident has a diagnosis of [redacted], and [redacted] and they required nurse delegation.

Record review of R4's NSA dated 8/1/2024 stated that the resident was involved in resident altercations in which they were the aggressor on the following dates:
-01/23/2024

-02/02/2024
-02/17/2024
-03/06/2024
-03/13/2024
-05/19/2024
-06/14/2024
-06/23/2024
-08/10/2024
-09/24/2024
-10/11/2024
-10/19/2024

In an interview on 01/15/2025 at 3:03 PM, staff E stated that the facility reached out to the department case manager, CC1, regarding finding a new placement for R4 due to numerous resident- to- resident altercations.

In an interview on 01/17/2025 at 11:38 AM, CC1 stated that she spoke with the facility staff and that they will be reaching out to community to find an alternate placement for R4.

In an interview on 01/22/2025 at 04:16 PM with Collateral Contact 4 (CC4), they stated that they were concerned about R4 being placed somewhere else but hasn't spoken to anyone about it. They wanted to get in contact with the department case manager, but they don't agree with the facility and the case manager already seeking alternate placement options.

Record review of R4's progress notes on 12/13/2024, showed that facility contacted CC4, to report a resident-to-resident altercation that R4 for was involved in. The document also showed that Staff G, told CC4 that she spoke with a HCS case manager about R4's behavior but did not report notifying CC4 about alternate placement for R4. The note also stated that CC4 would be awaiting any new information.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) 3-21-25 3.8.25.

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

Administrator (or Representative) — Date: 2.14.25

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain prescribed medications in a timely manner for 4 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3] and Resident 5 [R5]). This failure placed all four residents at risk of harm from untreated health conditions due to medications not being given as prescribed.

Findings included...

Record review of the facility policy titled "Missing or unavailable medication procedure," undated, showed that facility staff were responsible to order medications and ensure medication refills were ordered at least 7-10 days prior to a resident running out of their medication. The policy stated staff were to notify the resident's family of the medication issue, fill out an incident report if a dose was missed, and to document the reason for missed dose. The policy stated not to write "not available" as the only reason.

<Resident 1>

Record review of the undated characteristic roster showed R1 admitted to the facility on [redacted] 2021, diagnosed with [redacted] required nurse delegation, medication administration, and minimal physical assistance.

Record review of R1's signed NSA, dated 03/22/2024, showed R1 required medication ordering and medication administration services for oral, patch, topical, and rectal medications.

Record review of R1's MAR showed that R1 missed lidocaine on 1 day in January 2025, 4 days in December 2024, and 2 days in October 2024. They were all marked as waiting on delivery.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain prescribed medications in a timely manner for 4 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3] and Resident 5 [R5]). This failure placed all four residents at risk of harm from untreated health conditions due to medications not being given as prescribed.

Findings included…

Record review of the facility policy titled "Missing or unavailable medication procedure," undated, showed that facility staff were responsible to order medications and ensure medication refills were ordered at least 7-10 days prior to a resident running out of their medication. The policy stated staff were to notify the resident's family of the medication issue, fill out an incident report if a dose was missed, and to document the reason for missed dose. The policy stated not to write "not available" as the only reason.

<Resident 1>

Record review of the undated characteristic roster showed R1 admitted to the facility on [redacted]/2021, diagnosed with [redacted], required nurse delegation, medication administration, and minimal physical assistance.

Record review of R1's signed NSA, dated 03/22/2024, showed R1 required medication ordering and medication administration services for oral, patch, topical, and rectal medications.

Record review of R1's MAR showed that R1 missed lidocaine on 1 day in January 2025, 4 days in December 2024, and 2 days in October 2024. They were all marked as waiting on delivery.

<Resident 2>

Record review of the facility's undated characteristic roster showed R2 admitted to the facility on [redacted]/2024 and was diagnosed with [redacted], required nurse delegation, and medication administration services.

Record review of R2's NSAs dated 10/29/2024 and most recent working care plan dated 01/09/2025, showed R2 required full medication administration by staff and received delegated medication services. Under the assistance required section it stated, " assist with medications per PCP orders, monitor resident for proper medication ingestion, communicate with PCP (primary care provider) and HCP (healthcare provider), [and] medications ordered through non-house pharmacy."

Record review of R2's MAR for 06/01/2024 through 06/30/2024 showed Losartan (medication for blood pressure) was not given on 06/08/2024 due to medication non-availability. The MAR showed nystatin (medication applied to skin for rash from yeast) was not given on 06/10/2024 through 06/19/2024 due to non-availability.

Record review of the facility's note entered on 06/10/2024 stated the medication was ordered but no other notes to review reflecting attempts to obtain either medication for R2.

Record review of R2's MAR, dated 10/01/2024 through 12/31/2024 showed R2 was prescribed Eliquis (medication to thin blood and prevent clots). The original order was entered on R2's MAR on 10/26/2024 and stated " Take two 5 mg tablets (10 mg total) twice daily by mouth for 7 days. Then 5 mg twice daily." The record showed the medication was not given and marked as discontinued.

Record review of R2's discharge paperwork from urgent care, dated 11/11/2024, showed an order for Eliquis that stated "Take two 5 mg tablets (10 mg total) twice daily by mouth for 7 days. Then 5 mg twice daily."

Record review of a fax sent to R2's primary care provider on 11/13/2024 showed a question from the facility staff asking if R2 should be taking Eliquis. The doctor responded and stated R2 should be taking this medication.

Record review of R2's physician order dated November 14th, 2024, the same order was entered onto R2's MAR, however, that order was also marked as discontinued and no medication was ever given under that order.

R2's MAR showed another order for Eliquis was entered on R2's MAR that stated, "give one 5mg tab twice daily." The MAR showed Eliquis was administered beginning 11/14/2024. On 12/22/2024, the MAR showed it was not given due to lack of availability.

There were no notes available to review that showed why Eliquis was ordered twice and never given nor that R2's family and durable power of attorney (DPOA) were notified of the missed doses. As a result, R2 did not receive their prescribed medication for 19 days between 10/25/2024 and 11/14/2024.

In an interview on 01/16/2025 at 5:00 PM, Collateral Contact 1, the department case

manager, stated they had received repeated concerns from R2's durable power of attorney (DPOA) that R2 had not been receiving their medications as prescribed.

In an interview on 01/17/2025 at 8:35 PM, Staff A, Administrator, stated they were aware R2's DPOA had concern with R2's care.

In an interview on 01/22/2025 at 6:00 PM, Collateral Contact 2 (CC2), R2's DPOA, stated R2 was supposed to be receiving Eliquis since it was ordered in 10/25/2024, but became concerned it had yet to be given when facility staff began asking CC2 questions about the medication in mid-November. CC2 was not sure when the facility actually started giving R2 the medication.

<Resident 3>

Record review of R3's "resident info sheet" showed R3 was admitted to the facility on [redacted]/2024 and has a diagnosis of [redacted] and [redacted].

Record review of R3's NSA, dated 01/13/2025, showed R3 required medication assistance by staff. The document also showed that resident's medications are ordered through house pharmacy.

Record review of R3's MAR for October 2024, November 2024, December 2024 and January 2025, R3 was unable to take melatonin a total of 7 days due to waiting on delivery.

Record review of R3's MAR for October 2024, November 2024, December 2024 and January 2025, R3 was unable to take digestive enzymes for a total of 8 days due to waiting on delivery.

Record review of R3's progress notes does not show that there were missed medications on any of the days identified.

<Resident 5>

Record review of R5's "resident info sheet" showed R5 was admitted to the facility on [redacted]/2017 and has a diagnosis of [redacted] and [redacted].

Record review of R5's NSA, dated 8/1/2024, showed R5 required medication assistance by staff. The document also showed that staff is responsible for reordering medications for residents.

Record review of R5's "resident progress notes" dated 12/06/2024, showed R5 was wheezing but was unable to use their PRN inhaler due to waiting on a refill.

Record review of R5's MAR dated 01/03/2025, showed R5 was unable to take their daily acetaminophen (pain reliver) due to waiting on delivery.

In an interview on 01/15/2025 at 3:03 PM, staff E stated that medication aides are responsible for ordering meds. They also state that if medication is not available, the

resident is placed on alert, a progress note is done, and the primary care provider is faxed.

Record review of R5's progress notes does not show a documentation on 01/03/2025 for a missed acetaminophen dose.

In an interview on 01/15/2025 at 3:05 PM, Staff E, Resident Care Nurse, stated medication aides were responsible for ordering and re-ordering all resident medications.

In an interview on 01/15/2025 at 5:00 PM, Staff H, Lead Medication Aide, stated medication aides are responsible for ordering and re-ordering all resident medication. Staff H stated staff are supposed to document a note and place the resident on alert and document a note if a medication is out or awaiting delivery.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) 3-21-25 3.8.25.

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

Administrator (or Representative) — Date: 2.14.25

WAC 388-78A-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff, however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law.

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure staff were trained, credentialed, and qualified when 3 of 5 sampled staff (Staff B, Staff F, and Staff O) performed delegated tasks for 3 of 3 residents. The facility also failed to ensure a qualified nurse delegator had verified that 1 of 8 delegated staff (Staff O) had active

resident is placed on alert, a progress note is done, and the primary care provider is faxed.

Record review of R5's progress notes does not show a documentation on 01/03/2025 for a missed acetaminophen dose.

In an interview on 01/15/2025 at 3:05 PM, Staff E, Resident Care Nurse, stated medication aides were responsible for ordering and re-ordering all resident medications.

In an interview on 01/15/2025 at 5:00 PM, Staff H, Lead Medication Aide, stated medication aides are responsible for ordering and re-ordering all resident medication. Staff H stated staff are supposed to document a note and place the resident on alert and document a note if a medication is out or awaiting delivery.

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, Riverside Place 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-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law:

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure staff were trained, credentialed, and qualified when 3 of 5 sampled staff (Staff B, Staff F, and Staff O) performed delegated tasks for 3 of 3 residents. The facility also failed to ensure a qualified nurse delegator had verified that 1 of 9 delegated staff (Staff O) had active

credentials before delegating to that staff. This failure placed all three residents at risk for harm and injury due to untrained and unsupervised care staff providing care they were not trained to provide.

Findings included…

WAC 246-840-930
Criteria for delegation:
(8) Verify that the nursing assistant or home care aide:
(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
(10) If the registered nurse delegator determines delegation is appropriate, the nurse:
(a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care.
(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks and may be more frequent. (13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient."
(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least every two weeks for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

Record review of the facility policy titled " Medication Administration," dated 05/04/2024, showed that medication administration meant all "Medications in this category [could] only be given by an LPN, RN, ARNP, physician, pharmacist, certified nursing assistant or nursing assistant registered following RN delegation protocols."

Record review of the facility's characteristic roster showed that 22 of 22 residents required nurse delegation and that, of those, 20 residents required medication administration services.

Record review of the "riverside delegated resident list," showed 9 residents had been delegated. Those residents included R1, R2, R4, R5, R8, R9, R10, R11, and R12.

Record review of the "riverside delegated staff list," showed 9 staff delegated to perform nurse delegated tasks. Staff that had been delegated by Staff E, Resident Care Nurse, included Staff B, C, G, H, M, N, O, P, and U. Staff E's, name and signature under the statement that stated " As Delegating RN, I have reviewed credentials and ensured all accurate, current and in good standing. All Credentials kept in personnel file in community. I have observed, trained and feel confident in delegate's ability to perform delegated tasks. Each delegate has agreed to assume responsibility for each delegated task. Delegates verbalize understanding of how to contact RND with questions." The document was signed 01/01/2025.

R1
Record review of the undated characteristic roster showed R1 admitted to the facility on [redacted]/2021, diagnosed with [redacted], required nurse delegation, medication administration, and minimal physical assistance.

Record review of R1's delegation assessment completed on 11/08/2024 at 10:29 AM by Staff E, Registered Care Nurse, showed that resident had was admitted to hospice services and hospice medications were delegated with frequent lorazepam (controlled medication for anxiety) administration.

In an interview on 01/14/2025 at 3:15 PM, Staff E stated they do not delegate hospice medications or tasks to the facility staff.

Record review of the document titled, " Riverside Delegated Resident List," showed R1 was delegated for PRN (as-needed medications), Topical (skin), Patch, and hospice tasks.

On 01/15/2025 at 5:30 PM, Staff H, Lead Medication Aide, was observed administering morphine (a pain medication) to R1. While R1 was lying back with their head tipped back in the bed, eyes closed and mouth hanging slightly open, Staff H inserted the syringe in R1's mouth and massaged the cheek. When asked if they usually sit R1 up

when giving medications, Staff H replied, “I don’t know what I'm supposed to do right now." During and after the administration R1 was observed coughing.

In an interview on 01/17/2025 at 6:30 PM, Collateral Contact 3(CC3), R1's Hospice RN, stated they do not delegate to the facility staff as the facility is responsible for delegating to their own staff. CC3 stated the hospice company provides extensive education and written materials with their separate care plan that is given to the facility.

R2
Record review of the undated characteristic roster showed R2 admitted to the facility on [redacted]/2024 and was diagnosed with [redacted] required nurse delegation, and medication administration services.

Record review of R2's NSAs dated 10/29/2024 and most recent working care plan dated 01/09/2025 showed R2 required full medication administration by staff and received delegated medication services including blood sugar checks and insulin administration.

R4

Record review of R4's "resident info sheet", undated, showed that she was admitted to the facility on [redacted]/2022. It also showed that she is diagnosed with [redacted] and [redacted].

Record review of R4's NSA dated 11/25/2024, showed that R4 requires medication assistance and had nurse delegated tasks.

Record review of R4's delegation assessment dated 12/02/2024 shows that they have delegation for blood sugar checks and assistance dialing the insulin pen. The document also specified which staff was delegated to perform those delegated tasks.

<Staff F>

Record review of the facility's employee HR list, undated, showed Staff F, Caregiver, was hired on 02/20/2024.

Record review of the facility’s staff schedule for 09/29/2024 through 01/18/2024 showed Staff F was scheduled to work 3 to 4 shifts per week. The schedule showed Staff F was trained to administer medications on 09/30/2024, 10/01/2024, 10/07/2024, 10/08/2024, and 10/12/2024.

Record review of Staff F's personnel file did not show an active HCA certification.

Review of the Department of health credential search conducted on 01/23/2025 showed Staff F's HCA certificate was pending.

No other credentials were provided for review. No other credentials were found in the DOH credential search.

Record review of R2's MAR for October 2024 through January 2025 showed Staff F checked R2's blood sugar levels and administered insulin.

Record review of R1's MAR for October 2024 through January 2025 showed Staff F administered R1 their delegated medications.
Record review of R1's delegation assessment dated 11/08/2024 and

Record review of R4's MAR for November 2024 through January 2025 showed that Staff F had checked their blood sugar levels 29 times which required nurse delegation. Staff F dialed R4's long-acting insulin pen 13 days in November 2024, 15 days in December 2024, and 5 days in January 2025.

Record review of R4's MAR for November 2024, December 2024 and January 2025 showed that Staff F, Caregiver, dialed R4's long-acting insulin pen 13 days in November 2024, 15 days in December 2024, and 5 days in January 2025.

Record review of R4's MAR for November 2024, December 2024 and January 2025 showed that Staff F, Caregiver, completed R4's blood sugar checks 1 day in December 2024.

Record review of R4's delegation assessment dated 12/02/2024 did not show Staff F was delegated to perform blood sugar checks or dial the insulin pen.

Record review of facility's delegation binder did not show that Staff F completed the required training or had received the required nurse delegation certificates to be delegated to perform R1, R2, or R4's tasks.

In an interview on 01/15/2025 at 3:05 PM with Staff E, stated that they delegated the tasks after the nurse delegation certificates get issued. They also provided the nurse delegation binder with all the delegated certificates for the department to review. Staff E stated staff must have their HCA certification to be eligible to receive and perform delegated tasks.

<Staff B>
Record review of R4's MAR for November 2024, December 2024 and January 2025 showed that Staff B, Caregiver, completed R4's blood sugar checks 13 days in November 2024, 14 days in December 2024 and 5 days in January 2025.

Record review of R4's MAR for November 2024, December 2024 and January 2025 showed that Staff B, Caregiver, dialed R4's short acting insulin pen 13 days in November 2024, 13 days in December 2024, and 3 days in January 2025.

Record review of R4's delegation assessment, dated 12/01/2024, does not show Staff B as delegated to complete R4's blood sugar checks and dial their insulin pen.

In an interview on 01/15/2024 at 2:43 PM, Staff B stated that if a staff member became nurse delegated then they could perform the delegated tasks for any of the residents. They stated that delegation is task specific not resident and task specific.

<Staff O>
Record review of the facility's employee HR list, undated, showed Staff O, Caregiver, was hired on 12/04/2013.

Record review of Staff O's personnel file showed that their HCA expired 12/17/2024 and was renewed on 01/02/2025. Staff O had a 14-day credential lapse between 12/17/2024 and 01/02/2025.

Record review of R2's delegation assessment showed that Staff E delegated tasks for R2 to Staff O for blood glucose checks and insulin administration on 12/23/2024 when Staff O's credential was expired.

In an interview on 01/15/2025 at 3:45 PM, Staff E stated that they had verified Staff O's credential on 01/01/2025 and rescinded their nurse delegation due to a lapsed credential. Staff E stated that Staff O was never taken off the schedule during the time their credential had lapsed.

In an interview on 01/15/2025 at 3:03 PM Staff E stated that any staff member available that is on a resident's specific delegation list are able to complete delegated tasks for any resident.

In an interview on 01/15/2025 at 3:45 PM, Staff E stated that they did not take the nurse delegation training course and were not the overseeing delegating nurse. Staff E stated they were not sure the frequency of task review required for insulin administration, or aware of the required documentation to nurse delegate.

Statement of Deficiencies	License #: 2363	Compliance Determination #53066
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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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) 3.21.25 3.8.25

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

Administrator (or Representative) — Date: 2.14.25

WAC 388-78A-2610 infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interviews, observations and record reviews, the facility failed to institute appropriate infection prevention practices to limit the spread of infectious illnesses in 1 of 1 memory care units. This failure placed all residents, visitors, and staff at risk for exposure to infectious diseases.

Findings include...

Record review of the facility's handwashing policy stated that staff will wash their hands before handling medication, before handling any food, and dietary employees must wash hands at kitchen sink upon reentry into kitchen.

In an interview and observation on 01/14/2025 at 12:57 PM, Staff S, Dietary Manager, was observed entering the kitchen and washing their hands at a sink that did not contain soap. They were then observed wiping their hands on their pants they were wearing. Staff S asked another kitchen staff member how to turn on the sink at the only designated handwashing station in the kitchen.

In an observation on 01/15/2025 at 4:02 PM, Staff M, caregiver, entered the kitchen and grabbed a cup from a stack and poured a beverage for a resident without washing their

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interviews, observations and record reviews, the facility failed to institute appropriate infection prevention practices to limit the spread of infectious illnesses in 1 of 1 memory care units. This failure placed all residents, visitors, and staff at risk for exposure to infectious diseases.

Findings Include...

Record review of the facility's handwashing policy stated that staff will wash their hands before handling medication, before handling any food, and dietary employees must wash hands at kitchen sink upon reentry into kitchen.

In an interview and observation on 01/14/2025 at 12:57 PM, Staff S, Dietary Manager, was observed entering the kitchen and washing their hands at a sink that did not contain soap. They were then observed wiping their hands on their pants they were wearing. Staff S asked another kitchen staff member how to turn on the sink at the only designated handwashing station in the kitchen.

In an observation on 01/15/2025 at 4:02 PM, Staff M, caregiver, entered the kitchen and grabbed a cup from a stack and poured a beverage for a resident without washing their

hands.

In an observation on 01/15/2025 at 4:48 PM, Staff H, Medication Aide, entered the kitchen without washing their hands. They filled up a pitcher of water.

In an observation on 01/15/2025 at 4:25 PM, Staff M, entered the kitchen without washing their hands and filled up a cup for a resident.

In an observation on 01/15/2025 at 4:27 PM, Staff M, re-entered the kitchen without washing their hands and then grabbed two plates of food to serve to residents. They propped the door open and continued to serve plates to the residents.

In an interview on 01/15/2025 at 4:14 PM, Staff S stated that dietary employees are supposed to prevent the spread of infection by washing their hands upon entering the kitchen, before and after they take their gloved on and off, and after each task.

In an interview on 01/15/2025 at 8:10 PM, Staff A stated that Staff A and Staff E were responsible for ensuring staff compliance with the facility's infection prevention policy and that they observed staff to ensure they are following the policy.

In an observation and interview on 01/14/2025 at 12:37 PM, there was no soap at the sink in the soiled linen room. Staff A stated that there should be soap and a soap dispenser for staff to wash their hands in the facility’s dirty utility room. Staff A stated they did not know how staff were washing their hands without it. There were clean backstock of gloves and personal protective equipment in the soiled utility room. Staff confirmed the clean supplies were intended to be stored in the dirty utility room and acknowledged the cross-contamination issue.

In an observation and interview on 01/15/2025 at 4:52 PM, Staff H, Lead medication aide, was observed handing R4 their insulin pen without cleaning the area and did not advise R4 to clean the area prior to injection. Staff H stated they failed to follow infection prevention guidelines during resident care.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 2.14.25

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to properly store supplies in 3 of 3 indoor locations (Resident 1 [R1] and Resident 3 [R3] room and Resident Dining Room) in a memory care facility. This failure placed all 22 residents at risk for injury due to ingesting hazardous ingredients.

Findings included...

Record review of the facility's undated characteristic roster showed 22 of 22 residents had a diagnosis of [redacted] or [redacted]

<Dining Room>

In an observation on 01/14/2025 at 12:13 PM, 13 residents were observed eating lunch in the dining room.

In an observation on 01/14/2025 at 1:06 PM, the department toured the resident dining

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to properly store supplies in 3 of 3 indoor locations (Resident 1 [R1] and Resident 3 [R3] room and Resident Dining Room) in a memory care facility. This failure placed all 22 residents at risk for injury due to ingesting hazardous ingredients.

Findings included…

Record review of the facility's undated characteristic roster showed 22 of 22 residents had a diagnosis of [redacted] or [redacted].

<Dining Room>

In an observation on 01/14/2025 at 12:13 PM, 13 residents were observed eating lunch in the dining room.

In an observation on 01/14/2025 at 1:06 PM, the department toured the resident dining

room with facility staff. Three residents remained seated after their lunch. Observed in the cabinets of that room were 4 different cleaning agents:
-A 30-ounce box of Arm and Hammer-brand, extra strength, odor eater carpet cleaner
-A bottle of generic brand labeled bathroom cleaner with bleach
-Room sense 100 with ingredients including Water 7732-18-5: non-ionic surfactant 66455-14-9 propyl glycol methyl ether, Polyethylene Doritos monooleate
-A canister of Lysol-brand disinfectant spray.

In an interview on 01/14/2025 at 1:10 PM, Staff A, Administrator, stated that all cleaning supplies were supposed to be locked up and not left out in resident accessible areas.

In an interview on 01/14/2025 at 1:11 PM, Staff T, housekeeper, Staff T stated they had worked at the facility since 2022. Staff T stated they did not know how or when the cleaning products in the dining room cabinet got there or whose they were.

In an interview on 01/17/2025 at 6:00 PM, Staff G, Resident Care Coordinator, stated that they did not know how clothing items ended up in the dining room cabinets but thought perhaps some of the residents put it there as they will sometimes rummage through unlocked cabinets.

<R1>
Record review of the facility's undated characteristic roster showed R1 moved into the facility on [redacted]/2021 and was diagnosed with [redacted].

Record review of R1's signed NSA, dated 03/22/2024, showed R1 required frequent staff rounding for safety.

In an observation on 01/15/2025 at 7:45 PM, R1's bathroom cabinet was observed unlocked. Inside the cabinet, it was observed to be full of body wash, body lotions, soap bars, hair shampoo and conditioner, face wash and moisturizer, and shaving cream. Observed on the top shelf was Efferdent-brand denture cleaner, 6 tubes of partially used toothpaste, arm and hammer-brand deodorant, and 7 bars of soap. On top of the cabinet was more soap and deodorant.

On 01/15/2025 at 7:52 PM, vanilla lotion, dove body wash, body scrub, hand cream, and six boxes of Efferdent denture cleaner were observed in R1's closet outside the bathroom.

In an interview on 01/15/2025 at 7:55 PM, Staff C, Medication Aide, stated that residents were supposed to have their cabinets locked, but that there were many residents, including R1's room, whose cabinets did not lock.

In an observation on 01/17/2025 at 12:58 PM, vanilla lotion, dove body wash, body scrub, hand cream, and six boxes of Efferdent denture cleaner were observed in R1's closet outside the bathroom.

<R3>
Record review of the facility's undated characteristic roster showed R3 moved into the facility on [redacted]/2024 and had a diagnosis of [redacted].

On 01/17/2025 at 5:27 PM, polygrip denture cleaner, moisturizing shaving cream, Everyman Jack brand shampoo, Dermavera brand skin and hair cleanser, Kenra brand

shampoo, a shaver, and scissors were observed inside R3's unlocked bathroom cabinet.

In an interview on 01/17/2025 at 5:30 PM, Staff P stated all resident soap, shampoo, and personal hygiene items should be in their cabinets and the cabinets should be locked. Staff P stated that they did not know R3's cabinet was unlocked.

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: 2.14.25

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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to maintain 1 of 1 on-site food service facilities in compliance with the Washington Administrative Food Service Code 246-15 and failed to ensure 1 of 5 sampled staff (Staff D) obtained a food worker card according to Washington Administrative Food Service Code 246-217 WAC. This failure placed 22 of 22 residents at risk for food-borne illnesses.

Findings include...

<Food Worker Cards>

In an interview on 01/14/2024 at 12:18 PM, Staff V, Life Enrichment Coordinator, stated, any caregiver would usually serve the residents, there is not a separate dietary staff in the facility.

shampoo, a shaver, and scissors were observed inside R3's unlocked bathroom cabinet.

In an interview on 01/17/2025 at 5:30 PM, Staff P stated all resident soap, shampoo, and personal hygiene items should be in their cabinets and the cabinets should be locked. Staff P stated that they did not know R3's cabinet was unlocked.

Plan/Attestation Statement

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Administrator (or Representative) 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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to maintain 1 of 1 on-site food service facilities in compliance with the Washington Administrative Food Service Code 246-15 and failed to ensure 1 of 5 sampled staff (Staff D) obtained a food worker card according to Washington Administrative Food Service Code 246-217 WAC. This failure placed 22 of 22 residents at risk for food-borne illnesses.

Findings include...

<Food Worker Cards>

In an interview on 01/14/2024 at 12:16 PM, Staff V, Life Enrichment Coordinator, stated, any caregiver would usually serve the residents, there is not a separate dietary staff in the facility.

Record review of Staff D's, Caregiver, food worker's certificate dated 11/02/2023, showed that the certificate was issued by the Food Handler Solutions LLC. The certificate did not show that it was issued by a Washington state jurisdictional health department.

Record review of Food Handlers Solution's website stated, "The Food Handlers Solutions Program is currently not approved in the state of Washington." The website then goes on to state that the program is "intended to be used for personal development and preparation."

In an interview on 01/15/2024 at 6:19 PM with Staff S, stated that they do not know why Staff D's food workers card looked different from all the others.

In an interview on 01/17/2025 at 8:00 PM, Staff A, Administrator, stated that Staff D's food handler's permit was not an acceptable certification, and that Staff D required a Washington State issued food handlers permit, instead.

<Certified Food Protection Manager>

Record review of the facility's food worker's certificate binder on 01/17/2025 at 6:14 PM, showed that there was not a certified food manager's certificate available for review.

In an interview on 01/15/2025 at 4:19 PM, with Staff S, they stated that they did not know who their food protection manager was, and they did not have a certificate. Staff S stated that Staff A, Administrator, would know.

In an interview on 01/17/2025 at 8:35 PM, with Staff A, stated they weren't sure who the certified food protection manager was and that there was not a certificate.

In an interview on 01/17/2025 at 8:35 PM, with Staff Q, Region Director Operations, stated, they agreed that they did not know who the certified food protection manager is.

<Temperature Holding>

Record review of the kitchen temperature log dated November 2024, December 2024 and January 2024, showed refrigerator temperatures exceeding 41 degrees Fahrenheit (F) on the following dates.
11/8/2024 at 1:30 PM - 43.1 degrees F
11/21/2024 at 4:30 PM - 42 degrees F
11/22/2024 at 1:30 PM - 43.3 degrees F
11/28/2024 at 6:30 PM - 42.6 degrees F
12/20/2024 at 5:30 PM - 44.7 degrees F
12/27/2024 at 5:30 PM – 46.9 degrees F
12/29/2024 at 10:30 AM – 45 degrees F
12/30/2024, no time logged – 45 degrees F
12/31/2024 at 5:00 PM – 44.4 degrees
No temp logged on 01/02/2025
01/03/2025 at 6:30 PM – 45.6 degrees F
1/8/2025 at 6:00 PM – 46.9 degrees F
1/9/2025 at 9:30 AM – 45.6 degrees F
1/10/2025 at 6:30 PM – 44.4 degrees F

In an interview on 1/15/2025 at 6:21 PM, Staff S, stated that the refrigerator had broken a few weeks ago, but it's fixed now and that the temperatures recorded was not accurate.

In an observation on 01/17/2025 at 12:50 PM, the outside thermometer on the refrigerator read 44 degrees F. The inside thermometer read 40.0 degrees F.

In an interview on 01/17/2025 at 12:42 PM, Staff S stated that the outside thermometer on the refrigerator was broken, and they have instructed staff to log the reading from the inside thermometer.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 2·14·25

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to implement their facility's fall policy for 1 of 1 resident (Resident 6 [R6]). This failure placed the residents at risk for unidentified injuries.

Findings include...

Record review of the facility's fall policy, undated, stated that staff must call 911 if resident complains of any pain in their legs, arms or back. The document also instructs staff to take vital signs.

<Resident 6>

In an interview on 1/15/2025 at 6:21 PM, Staff S, stated that the refrigerator had broken a few weeks ago, but it's fixed now and that the temperatures recorded was not accurate.

In an observation on 01/17/2025 at 12:50 PM, the outside thermometer on the refrigerator read 44 degrees F. The inside thermometer read 40.0 degrees F.

In an interview on 01/17/2025 at 12:42 PM, Staff S stated that the outside thermometer on the refrigerator was broken, and they have instructed staff to log the reading from the inside thermometer.

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Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to implement their facility's fall policy for 1 of 1 resident [Resident 6 [R6]). This failure placed the residents at risk for unidentified injuries.

Findings include...

Record review of the facility's fall policy, undated, stated that staff must call 911 if resident complains of any pain in their legs, arms or back. The document also instructs staff to take vital signs.

<Resident 6>

Record review of R6's "Resident Info Sheet", undated, showed that R6 was admitted to the facility on [redacted]/2024. and had been diagnosed with [redacted] and had a pacemaker.

Record review of R6's January 2025 MAR showed R6 took aspirin (medication for pain and prevents clotting) daily.

Record review of R6's "service plan", dated 11/20/2024, showed that R6 required a walker for ambulation and stability when standing. The plan also showed R6 needed frequent reminders from staff to use their walker, even for short distances and experienced episodes of dizziness when standing.

In an observation on 01/15/2024 at 6:05 PM, R6 was heard yelling out for help. Staff K and Staff M were observed running into R6's room. Upon arrival, R6 was observed lying on their left side, face down. R6 told Staff K and Staff M that their left hip hurt. R6 stated that they had been standing at the kitchenette when his vision " started going black". R6 restated their left hip hurt. At 6:10 PM, Staff C, medication aide, and Staff H, Lead Medication Aide, arrived and assessed took R6's blood pressure. No other vital signs were taken. Resident told staff that his hip hurts multiple times. R6's walker was against the wall in their bedroom. Staff K, M, C, and H assisted R6 to a seated position in a chair next to the kitchenette. The walker was still against the wall in the bedroom. The department staff asked if R6 would have their skin assessed since they took aspirin and were complaining of left hip pain. Staff C stated they would assess it in private, however, did not and left the room with Staff H at 6:16 PM. At 6:24 PM, Staff K and Staff M were observed in the hallway. Staff K stated that R6 was in their room.

In an interview on 01/15/2024 at 6:27 PM Staff K, medication aide, stated that after a fall staff ask the resident if they are in pain and then they call the medication aide who then checks the vital signs. They then stated that they don't call 911 unless the resident hit their head. Staff K did not know when it was required to have the facility nurse assess the resident and stated that it was at the discretion of the medication aide who responds to the resident incident.

In an observation on 01/15/2025 at 6:30 PM, R6 was observed alone in their apartment sitting on a chair near the kitchenette. R6's walker was against the wall. R6 got up and walked into the bathroom without their walker. Staff K then reminded R6 to use their walker and retrieved the walker from R6's bedroom wall.

In an interview on 01/17/2025 at 8:14 PM, Staff E stated that they were not notified of R6's fall and therefore did not evaluate R6 as per the facility policy. Staff E stated that staff should have taken a full set of vitals, not only R6’s blood pressure, after a fall.

Statement of Deficiencies	License # 2363	Compliance Determination # 53068
Plan of Correction	Riverside Place	Completion Date
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Plan/Attestation Statement

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Administrator (or Representative) — Date: 2.14.25

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 14-day assessments were completed in a timely manner for 2 of 2 sampled residents (Resident 2 [R2] and Resident 3 [R3]). This failure placed R2 and R3 at risk for unmet care needs due to unidentified needs and services.

Findings include...

In an interview on 01/14/2025 at 11:15 AM, Staff A, Administrator stated Staff E, Resident Care Nurse and Staff G, Resident Care Coordinator, complete all pre-admission, 14-day, and on-going assessments for residents. Staff A clarified that Staff E and Staff G are also responsible for creating and updating all Negotiated Service Agreement (NSA)'s for residents.

In an interview on 01/21/2025 at 11:30 AM, Staff A stated that the facility uses the NSA as resident assessments, therefore NSA content and assessment information are in the same document.

<Resident 2>

Record review of the facility's undated characteristic roster showed R2 admitted to the facility on [redacted]2024 and was diagnosed with [redacted].

Record review of R2's 14-day NSA showed it was completed on 04/16/2024. R2's 14-day assessment was completed 7 days late.

Plan/Attestation Statement

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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 14-day assessments were completed in a timely manner for 2 of 2 sampled residents (Resident 2 [R2] and Resident 3 [R3]). This failure placed R2 and R3 at risk for unmet care needs due to unidentified needs and services.

Findings include...

In an interview on 01/14/2025 at 11:15 AM, Staff A, Administrator stated Staff E, Resident Care Nurse and Staff G, Resident Care Coordinator, complete all pre-admission, 14-day, and on-going assessments for residents. Staff A clarified that Staff E and Staff G are also responsible for creating and updating all Negotiated Service Agreement (NSA)'s for residents.

In an interview on 01/21/2025 at 11:30 AM, Staff A stated that the facility uses the NSA as resident assessments, therefore NSA content and assessment information are in the same document.

<Resident 2>

Record review of the facility's undated characteristic roster showed R2 admitted to the facility on [redacted]/2024 and was diagnosed with [redacted].

Record review of R2's 14-day NSA showed it was completed on 04/15/2024. R2's 14-day assessment was completed 7 days late.

<Resident 3>

Record review of R3's undated "resident info sheet" showed that R3 moved in on [redacted]/2024. The document also shows R3 has a diagnosis of [redacted].

Record review of R3's preadmission assessment showed that it was completed on 07/14/2022.

Record review of R3's NSA shows that R3's 14-day assessment was completed on 08/26/2024, 21 days late.

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: 2.14.25

<Resident 3>

Record review of R3's undated "resident info sheet" showed that R3 moved in on [redacted]/2024. The document also shows R3 has a diagnosis of [redacted].

Record review of R3's preadmission assessment showed that it was completed on 07/14/2022.

Record review of R3's NSA shows that R3's 14-day assessment was completed on 08/26/2024, 21 days late.

Plan/Attestation Statement

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Administrator (or Representative) Date