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

Milton Meridian LLC
The Meridian at Stone Creek
1111 S 376th St
Milton, WA 98354

RE: The Meridian at Stone Creek License # 2365

Dear Administrator:

This letter addresses Compliance Determination(s) 26387 (Completion Date 08/04/2023) and 22841 (Completion Date 05/10/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/04/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2480-1

The Department staff who did the on-site verification:
Cathleen Davis, ALF Licensor
Shirley Grew, LTC Surveyor
Lisa Mason, NCI ALF Licensor
Melisa Moran, Assisted Living Facility Nursing Consultant Institutional

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

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2365	Compliance Determination # 22841
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 1 of 3	Licensee: Milton Meridian LLC	05/10/2023

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

The department completed data collection for an unannounced on-site follow-up on 04/20/2023 and 04/20/2023 of:

The Meridian at Stone Creek
1111 S 376th St
Milton, WA 98354

This document references the following SOD dated: 05/10/2023

The following sample was selected for review during the unannounced on-site visit: 0 of 74 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Lisa Mason, NCI ALF Licensor
Cathleen Davis, ALF Licensor
Shirley Grew, LTC Surveyor
Melisa Moran, Assisted Living Facility Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
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.

Residential Care Services

05/17/2023
Date

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

Representative — 6/1/2023

Administrator (or Representative) — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 4 of 5 sampled staff members (Staff A, B, C, E) were screened for tuberculosis (TB) within three days of employment as required. This failure placed all 74 residents at risk of TB infection (a communicable disease).

Findings included...

On 05/10/2023 record review showed the facility "Infection Control 14-Tuberculosis-Care Staff, Policy date: 12-14-2020" required staff to be tested within three days of hire and prior to the employee's duty assignment.

Record review showed Staff A, Resident Care Coordinator, was hired on 04/05/2023. The record showed Staff A did not complete the TB testing within the three days of employment.

Record review showed Staff B, Caregiver, was hired on 02/06/2023. The record showed Staff B did not complete the TB testing within three days of employment.

Record review showed Staff C, Caregiver, was hired on 04/05/2023. The record showed Staff C did not complete the TB testing within three days of employment.

Record review showed Staff E, Maintenance, was hired on 03/06/2023. The record showed Staff E did not complete the TB testing within three days of employment.

On 04/20/2023, an additional request for TB test results was made by secure email to the ALF. Staff A, Executive Director, responded by email stating the facility had not had staff members TB tested within 3 days of being hired.

This is a recurring and uncorrected deficiency previously cited on 02/06/2023and 09/08/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 6/10/2023 .

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

Representative — 6/1/2023

Administrator (or Representative) — Date

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

Statement of Deficiencies	License #: 2965	Compliance Determination #19305
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 1 of 3	Licensee: Milton Meridian LLC	02/06/2023

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

The department completed data collection for an unannounced on-site follow-up on 02/01/2023 and 02/01/2023 of:
The Meridian at Stone Creek
1111 S 378th St
Milton, WA 98354

This document references the following SOD dated: 02/06/2023

The following sample was selected for review during the unannounced on-site visit: 0 of 74 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cathleen Davis, ALF Licensor
Lisa Mason, NCI ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
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.

Residential Care Services — 02/13/2023 Date

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

Statement of Deficiencies	License #: 2365	Compliance Determination # 19305
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 2 of 3	Licensee: Milton Meridian LLC	02/06/2023

Administrator (or Representative) 2/17/23 Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 9 of 16 sample staff (Staff's A, E, G, H, I, J, L, O, and P) was screened for tuberculosis (TB) within three days of employment as required. This failure placed all 74 ALF residents at risk of TB infection, a communicable disease.

Findings included...

Staff A, Assistant Maintenance, was hired on 11/01/2022. Review of Staff A's provided record failed to reveal results from a TB test done within three days of employment.

Staff E, Receptionist, was hired on 12/02/2022. Review of provided record failed to reveal results from a TB test done within three days of employment.

Staff G, Receptionist, was hired 12/09/2022. Review of provided record failed to reveal results from a TB test done within three days of employment.

Staff H, Server, was hired 01/05/2023. Review of provided record failed to reveal results from a TB test done within three days of employment.

Staff I, Housekeeper, was hired 01/02/2023. Review of provided record failed to reveal results from a TB test done within three days of employment.

Staff J, Housekeeper, was hired 01/06/2023. Review of provided records failed to reveal results from a TB test done within three days of employment.

Staff L, Server, was hired 01/09/2023. Review of provided records failed to reveal results from a TB test done within three days of employment.

Staff O, Dishwasher, was hired 01/10/2023. Review of provided records failed to reveal

Statement of Deficiencies	License #: 2365	Compliance Determination # 19305
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 3 of 3	Licensee: Milton Meridian LLC	02/06/2023

results from a TB test done within three days of employment.

On 02/23/2023, an additional request for TB test results was made by secure email. Staff A, Executive Director, responded by email, stating the facility had sent over all the information they had regarding staff TB tests.

This is an uncorrected deficiency previously cited 09/08/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 3/17/23 .

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

Administrator (or Representative) 2/17/23 Date

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

09/13/2022

CERTIFIED MAIL

70201810000040942109

Milton Meridian LLC
The Meridian at Stone Creek
1111 S 376th St
Milton, WA 98354

RE: The Meridian at Stone Creek # 2365

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 09/08/2022 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

Manfay Chan, Field Manager
Residential Care Services
Region 3, Unit D
PO Box 99250

Lakewood, WA 98496

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

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

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

Observation of the Assisted Living Facility (ALF) memory care unit showed, scratches and worn surfaces on furnishings, walls, doorways, and base boards. The ALF main dining room and memory care dining room, showed chairs and tables with scratched and worn surfaces. Staff A, Executive Director, stated she was working with "corporate" to enhance the environment.

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

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

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

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:
• Please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Enclosure

RECEIVED
SEP 27 2022
DSHS RCS
REGION 3

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 on 08/23/2022, 08/23/2022, 08/24/2022, 08/29/2022 and 08/29/2022 of:
The Meridian at Stone Creek
1111 S 376th St
Milton, WA 98354

The following sample was selected for review during the unannounced on-site visit: 13 of 69 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cathleen Davis, ALF Licensor
Lisa Mason, NCI ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
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.

Residential Care Services — 9/13/2022 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.

Cindy Schafer
Administrator (or Representative)

Sept 16, 2022
Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

This requirement was not met as evidenced by:

Based on observations and interview, the Assisted Living Facility (ALF) failed to ensure the outside environment was free from hazards. This failure placed all 69 residents at risk for harm.

Findings include:

Observations on 08/23/2022 at 1:30 PM showed numerous cigarette butts scattered on the ground throughout the exterior of the building. A plastic trash can containing paper and cigarette butts and a large planter with paper and cigarette butts were observed in the parking lot. There were no cigarette butt waste receptacles present.

Observations on 08/23/2022 at 1:54 PM showed numerous cigarette butts scattered in the beauty bark throughout the memory care unit courtyard. There was a plastic trash can with paper and cigarette butts inside. There was no cigarette butt waste receptacle present.

Observation on 08/23/2022 at 1:35 PM showed greater than twenty open cans of paint stacked up against a fence near the electrical room. Located in the same area was plastic trash can containing paper and cigarette butts.

Interview on 08/23/2022 at 3:00 PM with Staff A, Executive Director, stated she was unaware of the cigarette butt debris. She said the paint cans were going to be disposed of once the facility was able to get a truck to haul them.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/16/22 .

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

C Schafer — Administrator (or Representative)

9/16/22 — Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to develop a written agreement for family assistance with medication administration. This placed 1 of 1 sample residents (2) at risk for potential medical decline if the family was unable to assist with medications.

Findings include:

Resident 2 was admitted to the ALF on [redacted]2022. Review of Needs and Service Plan for Resident 2 showed an entry under the section titled "Medications" dated 04/15/2022 revealed a family member was designated to assist with Resident 2's medications.

During an interview on 08/24/2022 at 11:00 AM, Department staff requested the Family Medication Administration Agreement for Resident 2. Staff A, Executive Director stated during the interview the facility did not have record of a Family Medication Administration Agreement.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/16/22 .

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

Administrator (or Representative) — Date: 9/23/22

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to maintain safe water temperatures in resident rooms and common areas. This failure may have placed residents at risk for injury.

Findings include:

Observation on 08/23/2022 at 2:00 PM showed water temperature was as follows:

Resident rooms E125- 133 degrees; E124- 133 degrees; E110-132 degrees; C-233b-137 degrees; C229-135 degrees; W112-136 degrees; W134-127.5. The memory care common area sink was 133 degrees.

Interview on 08/23/2022 at 3:00 PM with Staff D, Maintenance, and Staff A, Executive Director, said they were unaware of the temperatures, did not keep temperature logs and Staff D, had never been trained on the facility boiler (water heating unit) since start of his employment January 2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/16/22 .

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

Administrator (or Representative) — Date: 9/16/22

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

This requirement was not met as evidenced by:

Based on interview and record reviews, the Assisted Living Facility (ALF) failed to implement their policy and procedure to document and monitor four of six sample residents (1, 3, 6 and 10) for changes in condition. This failure placed the residents at risk for physical and mental decline.

Findings include:

Record Review of Facility Policy GP 17- Alert Charting Policy Date: 06-18-2021 showed "Alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring". "Each resident placed on alert charting will be monitored for at least 48 hours following the initiation of alert charting." Procedure for alert charting includes when a resident is new to the community, exhibits a change in condition, is returning from the hospital, ER, or urgent Care, has fallen, has eloped from the community, and is prescribed a new medication.

Resident 1

-07/03/2022 at 8:00 PM documented entry of "Unwitnessed Fall" entered late on 07/05/2022 at 5:55 PM.

-07/04/2022 at 10:55 AM documented "Dizziness" entered late on 07/15/2022 at 10:34

AM.

-07/31/2022 at 07:00 PM documented "Self-Reported Fall" entered late on 08/01/2022 at 12:22 PM.

The progress notes did not include the required 48-hour post monitoring protocol located in alert charting facility policy.

Resident 3

-05/03/2022 at 12:42 PM documented entry of "Return from ER" due to a fall.

-06/10/2022 at 10:55 AM documented entry of "Itching" entered late on 07/01/2022 at 10:53 AM.

-07/05/2022 at 10:55 AM documented entry of "Rash" entered late on 07/15/2022 at 10:53 AM.

The progress notes did not include the required 48-hour post monitoring protocol located in alert charting facility policy.

Resident 6

Resident 6 was admitted to the facility on [redacted]2022 to the memory care unit.

First noted documentation entry was on 08/01/2022 with multiple late entries for incidents that occurred on 07/23/2022 and 07/22/2022 (exit seeking), 07/21/2022 (new admission monitoring), 07/20/2022(refused to sleep in bed), [redacted]2022 (exit seeking), 07/29/2022 (Fall with injury).

- 08/03/2022 Late entry for 07/24/22 and 07/26/2022 (New admission monitoring), 07/28/2022 (elopement), 07/29/2022 (behavior).

-08/08/2022 late entry for 08/02/22 (Behavior)

-08/19/2022 late entry for 08/11/2022 (Exit Seeking)

The progress notes did not include the required 48-hour post monitoring protocol located in alert charting facility policy.

Resident 10

Noted were four documentation entries summarized as follows:

-05/05/2022 at 04:57 PM new insulin order
-07/21/2022 at 10:49 AM weight gain and PCP was faxed

-08/10 2022 at 04:34 PM Dr. faxed for medication refusals

In an interview on 08/29/2022 at 02:00 PM with Staff A, Executive Director, stated the facility did not follow their Alert Charting Policies.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/30/22 .

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

Administrator (or Representative) — Date: 9/23/22

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record reviews the Assisted Living Facility (ALF) failed to develop and implement a safe medication system to ensure medication was given as prescribed to one of two sample residents (4) with a narcotic, a controlled substance medication. This failure placed the resident at risk for potential medical decline.

Findings include:

Resident 4 was admitted to the ALF [redacted] 2020. Review of a document titled "Needs and Services Plan" showed an entry "Medications" dated 02/15/2022 which showed facility staff assisted Resident 4 with medications.

Review of Resident 4's August 2022 medication administration record (MAR) showed a medication order dated 06/08/2022 for Morphine Sulfate 20 milligrams (mg)/1.0 milliliter (ml) solution, a narcotic, with instructions to give 0.25 ml (5.0 mg) every four hours as needed for severe pain/shortness of breath. The MAR showed Resident 4 received the medication on the following dates: one time on 08/18/2022, one time on 08/21/2022, two times on 08/27/2022, and two times on 08/28/2022.

Review of a Narcotic Log dated 05/04/2022 showed ALF staff gave Morphine Sulfate solution to Resident 4 one time on 08/18/2022, one time on 08/21/2022, and one time on 08/28/2022. A Narcotic Log is a document where ALF staff include the date, the time, the dose of a controlled substance medication given to the resident, and the amount of the remaining medication in the supply as required.

Further review of the Narcotic Log showed a second page dated 04/23/2022 for a prescription order for Morphine Sulfate 15 mg tablets with instructions to give one half tablet (7.5 mg) to Resident 4 every four hours as needed for severe pain/shortness of breath. The Narcotic Log showed ALF staff gave the medication to the resident two times on 08/27/2022 and one time on 08/28/2022. Morphine Sulfate tablets were not included on Resident 4's August 2022 MAR.

Observation of Resident 4's medication supply on 08/29/2022 at 2:30 PM showed a supply of Morphine Sulfate 15 mg tablets (7.5 mg dose) and a supply of Morphine Sulfate solution 20 mg/1.0 ml (5.0 mg dose). The Morphine Sulfate tablets dose was 2.5 mg greater than the Morphine Sulfate solution dose.

During an interview on 08/29/2022 at 2:35 PM, Staff B (Resident Care Coordinator) stated the medication order for Resident 4's Morphine Sulfate tablets was discontinued by the resident's physician on 05/04/2022. Staff D, (License Practitioner Nurse / Resident Care Director) stated at 2:38 PM on 08/29/2022 they were unaware Resident 4's Morphine Sulfate tablets were discontinued.

Resident 4's Morphine Sulfate tablets were not removed from the resident's medication supply after the physician discontinued the medication on 05/04/2022. ALF staff gave the resident three - 7.5 mg doses of Morphine Sulfate tablets in August 2022 without a physician order, more than three months after the medication was discontinued by the physician. ALF staff documented in error they gave the Morphine Sulfate tablets to Resident 4 under the Morphine Sulfate solution section on the resident's August 2022 MAR.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/30/22 .

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

Administrator (or Representative) — Date: 9/23/22

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:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to conduct a risk assessment for the use of a transfer pole (device used to assist with transfers) for one of one Residents (2) . This failure placed Resident 2 at risk of harm.

Findings include:

On 08/23/2022 at 1:30 PM, Resident 2 was observed using a transfer pole to transfer herself from her wheelchair to her bed.

Staff A, Executive Director was interviewed on 08/23/2022 at 3:00 PM. During the interview, Staff A stated there was no risk assessment, for the use of the transfer pole for Resident 2.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 10/15/22 .

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

C Schafer — Administrator (or Representative)

9/23/22 — Date

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

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

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide sanitized dishes for all 27 of 27 residents in the Memory Care Unit. This failure placed all memory care residents at risk of illness from eating off of unsanitary dishes.

Findings include:

Observation on 08/23/2022 at 11:00 AM revealed a sanitizing dishwasher in the memory care unit. There were three one-gallon containers containing various chemicals to help

sanitize the dishes located under the sink next to the sanitizer. Two of the three containers were empty ("Sparkle Clean Rinse Aide" and "Eco San").

Staff C, Dining Director stated during an interview on 08/23/2022 11:30 AM, he was unaware the containers were empty and "everyone" was responsible for ensuring the sanitizing chemicals were feeding into the sanitizing dishwasher.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/16/22 .

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

Administrator (or Representative) — Date: 9/23/22

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure a Department name and date of birth background check was completed for 1 of 1 sample staff (Staff B) every two years. This failure placed residents at risk of having care and services provided by staff with a disqualifying crime.

Findings include:

Review of personnel records revealed Staff B, Resident Care Coordinator, was hired on 05/01/2020 and a department name and date of birth background check result was dated 04/29/2020 was on file. There was no

additional Department name and date of birth background checks in the records. Staff A, Executive Director stated during an interview on 08/24/2020 at 11:00 AM Staff B did not have a current Department name and date of birth background check.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/30/22 .

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

Administrator (or Representative) — Date: 9/23/22

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

WAC 388-78A-2480 (1)

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 1 of 3 sample staff (Staff F, Medication Technician) was screened for tuberculosis (TB) within three days of employment as required. This failure placed all 69 ALF residents at risk of TB infection, a communicable disease.

Findings include:

Staff F (Medication Technician) was hired by the ALF on 07/15/2022 as a medication technician. Review of the Staff F's record failed to reveal results from a TB skin test done within three days of employment.

On 09/08/2022, an additional request for TB test results was made by email. Staff A, Executive Director, responded by email, stating the facility did not have TB documentation for Staff F, Medication Technician, as required.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) ~~09/30/2022~~ 10/15/22 CS.

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

Administrator (or Representative) — Date: 9/23/22