



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

10/24/2024

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

RE: The Meridian at Stone Creek # 2365

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 49380 (Completion Date 10/24/2024) and 44313 (Completion Date 08/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/24/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

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.

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

(2) Assisted living facilities.

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

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

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

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

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

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;

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

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

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

- (1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:
 - (a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;
 - (b) Identifies the resident's immediate needs; and
 - (c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (4) Take appropriate action in response to each resident's changing needs.

The Department staff who did the On Site verification:

Kathy Heinz, Long Term Care Surveyor
Shirley Grew, LTC Surveyor
Woodetta Maulana,

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

Sincerely,



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



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert.#: 2365

Intake ID: 133687

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

House keeping and maintenance services are not being provided

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 12 Closed records sample size: 1
Observations:	Resident rooms Resident to resident interactions Staff to resident interactions Food preparation
Interviews:	Maintenance staff Kitchen staff caregivers Executive Director Administrative Staff
Record Reviews:	Incident investigation Personnel files Staff training records Staff patterns care plans progress notes medication administration records

Investigation Summary:

Based on observation, and interview a citation was written under WAC 388-78A -3090 for failure to maintain a safe and sanitary environment.

Conclusion / Action:

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

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert.#: 2365

Intake ID: 136844

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

Financial exploitation

Care and services were not provided

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 12 Closed records sample size: 1
Observations:	Residents Dining Resident rooms Staff to resident interactions Activities Identified resident
Interviews:	complainant Executive Director Resident Services Director
Record Reviews:	care plans progress notes task sheets

Investigation Summary:

1. There was not enough evidence to support the allegation of financial exploitation
2. Based on interview and record review failed practice was identified and a citation was written under 388- 78A - 2130 (1) (a) (b) (c) when the facility failed to develop an initial service plan.

Conclusion / Action:

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

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert. #: 2365

Intake ID: 136776

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

1. Residents admitted with out a proper documents
 2. Care and services not provided/ pendant call times are over fifteen minutes
 3. Staff are not following policies and procedures for medication administration
 4. Residents wait for long periods of time in the dining room
 5. Housekeeping Services are not provided.
 6. Staff lack training.
-

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 12 Closed records sample size: 1
Observations:	Residents Dining Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Executive Director Family members Residents Staff
Record Reviews:	Medical records Incident investigation Personnel files care plans

Investigation Summary:

1. There was no evidence to support the allegation
2. A citation was written for failing to develop a care plan and failing to have to care plans signed by the resident or their representative
3. A consultation was written for failing to secure an order prior to the administration of a topical.

4. Dining observations failed to show Resident's waited for long periods of time.
 5. A citation was written for failing to provide a safe and sanitary environment. The citation was written under a separate intake.
 6. Citations were written for staff who failed to have required training documents.
-

Conclusion / Action:

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



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert. #: 2365

Intake ID: 137436

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

Food safety

Investigation Methods:

Sample: Total residents: 60
Resident sample size: 12
Closed records sample size: 1

Observations: Kitchen

Interviews: Food Services Director
Executive Director

Record Reviews: None

Investigation Summary:

Investigation Summary: Based on observations and interviews a citation was written under WAC 388-78A-2305 (1) for failure to maintain a sanitary environment in the kitchen.

Conclusion / Action:

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



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert.#: 2365

Intake ID: 139797

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

Care and services not being provided for Identified Resident 1 and Identified resident 2.

Investigation Methods:

Sample:

Total residents: 60
Resident sample size: 12
Closed records sample size: 1

Observations:

Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions

Interviews:

Nursing staff
Residents
Family members
complainant

Record Reviews:

investigation of incident involving the identified resident 2

Investigation Summary:

Based on observation and interview, failed practice was identified and a citation was written under 388-78A-3090 (1) (a, c and d) maintenance and housekeeping. The facility conducted an investigation of the incident involving identified resident 2.

Conclusion / Action:

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



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert. #: 2365

Intake ID: 127335

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

- 1) Resident 10 had Norovirus while living in the facility
- 2) Resident 10 sustained an open wound while living in the facility

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 12 Closed records sample size: 1
Observations:	staff to resident interaction residents general observation of the facility
Interviews:	staff others not associated with the facility
Record Reviews:	resident records

Investigation Summary:

- 1) Unable to substantiate failed facility practice
- 2) Based on interview and record review the Assisted Living Facility failed to take appropriate action when Resident 10 sustained an open area to their buttocks. Citation was written under 388-78A-2120-4

Conclusion / Action:

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



Residential Care Services Investigation Summary Report

Provider/Facility: The Meridian at Stone Creek **Provider Type:** Assisted Living Facility

License/Cert.#: 2365

Intake ID: 125269

Compliance Determination #: 44313

Region/Unit #: RCS Region 3 / Unit D

Investigator: Kathy Heinz

Investigation Date(s): 07/17/2024 through 08/09/2024

Complainant Contact Date(s):

Allegation(s):

1) Resident 10 sustained an open area while living in the facility

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 12 Closed records sample size: 1
Observations:	staff to resident interaction residents general observation of the facility
Interviews:	Staff others not associated with the facility
Record Reviews:	Resident records

Investigation Summary:

1) Based on interview and record review the Assisted Living Facility failed to take appropriate action when Resident 10 sustained an open area to their buttocks. Citation was written under 388-78A-2120-4

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

AMENDED
08/22/2024

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

RE: The Meridian at Stone Creek # 2365

Dear Administrator:

This document references the following complaint numbers 133687, 134368, 136844, 136776, 137436, 139797, 127335, 125269.

The Department completed a full inspection of your Assisted Living Facility on 08/09/2024 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:

Cory Cisneros, Field Manager

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

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 not listed on the enclosed report.

WAC 388-78A-2220 Prescribed medication authorizations.

(1) Before the assisted living facility may provide medication assistance or medication administration to a resident for prescribed medications, the assisted living facility must have one of the following:

(b) A written order from the prescriber;

The facility failed to ensure a topical medication for a resident with a skin condition was ordered by their physician. Staff purchased an over-the-counter topical medication and applied the medication. The resident's physician wrote an order for a similar topical medication to be applied to the resident's skin.

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

The Meridian at Stone Creek # 2365

08/09/2024

Page 3 of 3

Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit D
Residential Care Services

Enclosure

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



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

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 4 of 19	Licensee: Milton Meridian LLC	08/09/2024

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 07/17/2024, 07/18/2024, 07/19/2024, 07/22/2024, 07/25/2024 and 07/25/2024 of:

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

This document references the following complaint numbers: 133687, 134368, 136844, 136776, 137436, 139797, 127335, 125269.

The following sample was selected for review during the unannounced on-site visit: 12 of 60 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Shirley Grew, LTC Surveyor
Kathy Heinz, Long Term Care Surveyor
Woodetta Maulana,

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.

Cory Cisneros
Residential Care Services

08/22/2024
Date

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



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

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 4 of 19	Licensee: Milton Meridian LLC	08/09/2024

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

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

This document references the following complaint numbers: 133687, 134368, 136844, 136776, 137436, 139797, 127335, 125269.

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The department staff that inspected the Assisted Living Facility:

Shirley Grew, LTC Surveyor
Kathy Heinz, Long Term Care Surveyor
Woodetta Maulana,

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

Date

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

Statement of Deficiencies	License #: 2385	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 5 of 19	Licensee: Milton Meridian LLC	08/09/2024

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)

8/20/2024
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 record reviews and interview, the facility failed to ensure 3 of 4 sampled staff (Staff A, C and D) were screened for tuberculosis (TB, a communicable disease), within three days of hire. This failure placed all 59 of 59 residents at risk for potential exposure to a communicable disease.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed:

Staff A (Executive Director) was hired on 05/13/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had been screened for TB.

Staff C (Memory Care Director) was hired on 03/25/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had been screened for TB.

Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had been screened for TB.

During an interview on 07/25/2024 at 3:00 PM, Staff A said that she, and Staff C and D, had not been screened for TB within three days of hire.

This is a recurring deficiency previously cited on 09/08/2022.

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-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 record reviews and interview, the facility failed to ensure 3 of 4 sampled staff (Staff A, C and D) were screened for tuberculosis (TB, a communicable disease), within three days of hire. This failure placed all 59 of 59 residents at risk for potential exposure to a communicable disease.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed:

Staff A (Executive Director) was hired on 05/13/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had been screened for TB.

Staff C (Memory Care Director) was hired on 03/25/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had been screened for TB.

Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had been screened for TB.

During an interview on 07/25/2024 at 3:00 PM, Staff A said that she, and Staff C and D, had not been screened for TB within three days of hire.

This is a recurring deficiency previously cited on 09/08/2022.

Statement of Deficiencies

License #: 2365

Compliance Determination # 44313

Plan of Correction

The Meridian at Stone Creek

Completion Date

Page 6 of 19

Licensee: Milton Meridian LLC

08/09/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 7/16/2024
9/23/2024

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


 Administrator (or Representative)

8/28/2024
 Date

WAC 368-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 3 of 3 sampled staff (Staff B, C and D) obtained a CPR (Cardiopulmonary Resuscitation)/first-aid card within thirty days of hire. This failure placed all 59 of 59 residents at risk of potential decline of their health status during a medical emergency.

Findings included..

Review of the facility staff roster, dated 07/16/2024, showed:

Staff B (Medication Technician) was hired on 06/16/2023. Review of her personnel file on 07/22/2024 failed to show she had obtained a CPR/first-aid card within thirty days of hire.

Staff C (Memory Care Director) was hired on 03/25/2024. Review of her personnel file on 07/22/2024 failed to show she had obtained a CPR/first-aid card within thirty days of hire.

Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of her personnel file on 07/22/2024, failed to show she had obtained a CPR/first-aid card within thirty days of hire.

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)_____.

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

Administrator (or Representative)

Date

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

(2) Assisted living facilities.

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This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 3 of 3 sampled staff (Staff B, C and D) obtained a CPR (Cardiopulmonary Resuscitation)/first-aid card within thirty days of hire. This failure placed all 59 of 59 residents at risk of potential decline of their health status during a medical emergency.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed:

Staff B (Medication Technician) was hired on 06/16/2023. Review of her personnel file on 07/22/2024 failed to show she had obtained a CPR/first-aid card within thirty days of hire.

Staff C (Memory Care Director) was hired on 03/25/2024. Review of her personnel file on 07/22/2024 failed to show she had obtained a CPR/first-aid card within thirty days of hire.

Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of her personnel file on 07/22/2024, failed to show she had obtained a CPR/first-aid card within thirty days of hire.

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 7 of 19	Licensee: Milton Meridian LLC	08/09/2024

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff B, C and D, did not possess CPR/first-aid cards.

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) <u>~~10/6/2024~~</u> <u>9/23/2024</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>8/28/2024</u> Date

WAC 388-79A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

- (a) A Washington state name and date of birth background check; and
- (b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on record reviews and interview, the facility failed to ensure 1 of 4 sampled staff (Staff D) completed a Washington state name and date of birth criminal background check. This failure may have resulted in staff with a criminal history providing care to 59 of 59 residents.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed a Washington state name and date of birth criminal background check.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff D had not completed a Washington state name and date of birth criminal background check.

Plan/Attestation Statement

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff B, C and D, did not possess CPR/first-aid cards.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

- (a) A Washington state name and date of birth background check; and
- (b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on record reviews and interview, the facility failed to ensure 1 of 4 sampled staff (Staff D) completed a Washington state name and date of birth criminal background check. This failure may have resulted in staff with a criminal history providing care to 59 of 59 residents.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed a Washington state name and date of birth criminal background check.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff D had not completed a Washington state name and date of birth criminal background check.

Plan/Attestation Statement

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

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 8 of 19	Licensee: Millon Meridian LLC	08/09/2024

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) 10/6/2024
9/23/2024

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



Administrator (or Representative)

8/28/2024

Date

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

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on record reviews and interview, the facility failed to ensure 1 of 4 sampled staff (Staff D) had completed a national fingerprint criminal print background check. This failure placed 59 of 59 residents at risk of receiving care from a staff with a criminal background.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed a national fingerprint criminal background check within 120 days of hire.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said that Staff D had not completed a national fingerprint criminal 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) 10/6/2024
9/23/2024

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Administrator (or Representative)

Date

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

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on record reviews and interview, the facility failed to ensure 1 of 4 sampled staff (Staff D) had completed a national fingerprint criminal print background check. This failure placed 59 of 59 residents at risk of receiving care from a staff with a criminal background.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed a national fingerprint criminal background check within 120 days of hire.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said that Staff D had not completed a national fingerprint criminal background check.

Plan/Attestation Statement

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Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 9 of 19	Licensee: Milton Meridian LLC	08/09/2024



Administrator (or Representative)

8/28/2024

Date

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 4 staff (Staff D) had completed mental health specialty training. This failure placed residents at risk of receiving care and services from untrained staff and at risk of a decreased quality of life.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed mental health specialty training within 120 days of hire.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff D had not provided verification she had completed the training.

Plan/Attestation Statement

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9/23/2024

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



Administrator (or Representative)

8/28/2024

Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least

_____ Administrator (or Representative)	_____ Date
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WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 4 staff (Staff D) had completed mental health specialty training. This failure placed residents at risk of receiving care and services from untrained staff and at risk of a decreased quality of life.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed mental health specialty training within 120 days of hire.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff D had not provided verification she had completed the training.

Plan/Attestation Statement	
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Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 10 of 19	Licensee: Milton Meridian LLC	08/09/2024

one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 4 staff (Staff D) had completed dementia specialty training. This failure placed residents at risk of receiving care and services from untrained staff and at risk for decreased quality of life.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed dementia specialty training.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff D had not provided documentation that she had completed dementia specialty training.

Plan/Attestation Statement	
I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) <u>~~10/6/2024~~</u> <u>9/23/2024</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
	<u>8/28/2024</u>
Administrator (or Representative)	Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

This requirement was not met as evidenced by:

one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 4 staff (Staff D) had completed dementia specialty training. This failure placed residents at risk of receiving care and services from untrained staff and at risk for decreased quality of life.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file failed to show she had completed dementia specialty training.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff D had not provided documentation that she had completed dementia specialty training.

Plan/Attestation Statement

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Date

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(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 11 of 19	Licensee: Million Meridian LLC	08/09/2024

Based on record review and interview, the facility failed to ensure 2 of 2 sampled staff (Staff B and C) had taken continuing education classes as required. This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Review of the facility staff roster dated 07/16/2024 showed:

Staff B (Medication Technician) was hired on 06/16/2023 and her date of birth was 04/20. Review of her personnel file on 07/22/2024 failed to show documentation of continuing education classes taken between 04/20/2023 and 04/20/2024.

Staff C (Memory Care Director) was hired on 03/25/2024 and her date of birth was 08/31. Review of her personnel file on 07/22/2024 failed to show documentation of continuing education classes taken between 08/31/2022 and 08/31/2023.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director), said Staff C had not provided documentation of approved continuing education curriculum.

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) <u>10/6/2024</u> <u>9/23/2024</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
	<u>8/28/2024</u>
Administrator (or Representative)	Date

WAC 288-72A-2450 Staff.

(2) The assisted living facility must:

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

This requirement was not met as evidenced by:

Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff (Staff D) had a credential in good standing. This failure placed all 59 residents at risk of receiving care from inadequately trained staff.

Based on record review and interview, the facility failed to ensure 2 of 2 sampled staff (Staff B and C) had taken continuing education classes as required. This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Review of the facility staff roster dated 07/16/2024 showed:

Staff B (Medication Technician) was hired on 06/16/2023 and her date of birth was 04/20. Review of her personnel file on 07/22/2024 failed to show documentation of continuing education classes taken between 04/20/2023 and 04/20/2024.

Staff C (Memory Care Director) was hired on 03/25/2024 and her date of birth was 08/31. Review of her personnel file on 07/22/2024 failed to show documentation of continuing education classes taken between 08/31/2022 and 08/31/2023.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director), said Staff C had not provided documentation of approved continuing education curriculum.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2450 Staff.

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This requirement was not met as evidenced by:

Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff (Staff D) had a credential in good standing. This failure placed all 59 residents at risk of receiving care from inadequately trained staff.

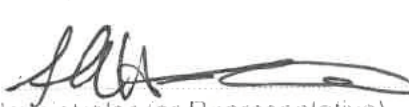
Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 12 of 19	Licensee: Milton Meridian LLC	08/09/2024

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file showed they completed 75 hours of Department of Social and Health Services Long Term Care worker training on 05/24/2017. Staff D's personnel file failed to show she had been certified as a long-term care worker following her training in 2017.

During an interview on 07/24/2024 at 2:00 PM, Staff A (Executive Director), said Staff D told her she was "grandfathered in" (not required to obtain certification).

Record review of the online Washington State Department of Health (DOH) credential verification website on 08/06/2024 showed no active credential by the department for Staff D.

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) <u>7/16/2024</u> <u>9/23/2024</u>	
In addition, I will <u>implement</u> a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>8/28/2024</u> Date

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 3 of 3 sampled staff (Staff B, C, and D) completed facility orientation. This failure placed 59 of 59 residents at risk of receiving care and services from untrained staff.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of Staff D's personnel file showed they completed 75 hours of Department of Social and Health Services Long Term Care worker training on 05/24/2017. Staff D's personnel file failed to show she had been certified as a long-term care worker following her training in 2017.

During an interview on 07/24/2024 at 2:00 PM, Staff A (Executive Director), said Staff D told her she was "grandfathered in" (not required to obtain certification).

Record review of the online Washington State Department of Health (DOH) credential verification website on 08/06/2024 showed no active credential by the department for Staff D.

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Administrator (or Representative)	Date

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

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This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 3 of 3 sampled staff (Staff B, C, and D) completed facility orientation. This failure placed 59 of 59 residents at risk of receiving care and services from untrained staff.

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 13 of 19	Licensee: Milton Meridian LLC	08/09/2024

Findings included...

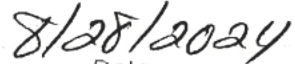
Review of the facility staff roster, dated 07/16/2024, showed:

Staff B (Medication Technician) was hired on 06/16/2023. Review of her personnel file on 07/22/2024 failed to show documentation she had completed facility orientation.

Staff C (Memory Care Director) was hired on 03/25/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had completed facility orientation.

Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of her personnel file failed to show she had completed facility orientation.

During an interview on 07/25/2024 at 3:00 PM, Staff A (Executive Director) said Staff B, C, and D had not completed facility orientation.

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 358-78A-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 observations and interviews, the Assisted Living Facility (ALF) failed to ensure food was stored properly and failed to maintain cleanliness for 2 of 2 kitchen areas reviewed (main ALF kitchen and memory care kitchenette). The ALF also failed to date mark food properly for 1 of 2 kitchen areas (memory care kitchenette) and failed to control insects in 1 of 2 kitchen areas (main ALF kitchen). These failures placed all 59 residents at risk for exposure to food-borne illnesses.

Findings included...

Review of the facility staff roster, dated 07/16/2024, showed:

Staff B (Medication Technician) was hired on 06/16/2023. Review of her personnel file on 07/22/2024 failed to show documentation she had completed facility orientation.

Staff C (Memory Care Director) was hired on 03/25/2024. Review of her personnel file on 07/22/2024 failed to show documentation she had completed facility orientation.

Staff D (Resident Services Coordinator) was hired on 02/21/2024. Review of her personnel file failed to show she had completed facility orientation.

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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;

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure food was stored properly and failed to maintain cleanliness for 2 of 2 kitchen areas reviewed (main ALF kitchen and memory care kitchenette). The ALF also failed to date mark food properly for 1 of 2 kitchen areas (memory care kitchenette) and failed to control insects in 1 of 2 kitchen areas (main ALF kitchen). These failures placed all 59 residents at risk for exposure to food-borne illnesses.

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 14 of 19	Licensee: Millon Meridian LLC	08/09/2024

Findings included...

WAC 246-215-03351

Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food: (a) In a clean, dry location; (b) Where it is not exposed to splash, dust, or other contamination; and (c) At least six inches (15 cm) above the floor.

WAC 246-215-03526

Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).

(1) Except when packaging food using a reduced oxygen packaging method as specified under WAC 246-215-03540, and except as specified in subsections (5) and (6) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than twenty-four hours must be clearly marked to indicate the date or day by which the food must be consumed on the premises, sold, or discarded when held at a temperature of 41°F (5°C) or less for a maximum of seven days. The day of preparation must be counted as day one.

WAC 246-215-06550

Methods—Controlling pests (FDA Food Code 6-501.111).

The premises must be maintained free of infestations of insects, rodents, and other pests such that there is not a breeding population of pests in the facility. The presence of insects, rodents, and other pests must be controlled to minimize their presence on the premises by: (1) Routinely inspecting incoming shipments of food and supplies; (2) Routinely inspecting the premises for evidence of pests; (3) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under WAC 246-215-07210, 246-215-07250, and 246-215-07255; and (4) Eliminating harborage conditions.

WAC 246-215-06505

Methods—Cleaning, frequency and restrictions (FDA Food Code 6-501.12).

(1) physical facilities must be cleaned as often as necessary to keep them clean.

(2) Except for cleaning that is necessary due to a spill or other accident, cleaning must be done during periods when the least amount of food is exposed such as after closing.

Memory Care (MC) Kitchenette

In an observation and interview on 07/17/2024 at 12:30 PM, in the MC kitchenette, Staff G, Server, pulled plates out of a plate holder and coffee cups off a shelf and examined them. Staff G wiped multiple plates, flatware, and coffee cups with a cloth napkin and vinegar. Staff G said pieces of food settle on the dishes when they were being cleaned in the dishwasher. He said the dishes never appeared clean and vinegar will clean them. Observation of the MC kitchenette refrigerator showed the vents in the front of the refrigerator were splattered with matter. Matter covered the refrigerator shelves and

Findings included...

WAC 246-215-03351

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WAC 246-215-06505

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Memory Care (MC) Kitchenette

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Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 15 of 19	Licensee: Milton Meridian LLC	08/09/2024

walls. The refrigerator contained undated macaroni salad.

During an interview on 07/25/2024 at 1:00 PM, Staff A, Executive Director, said the "main kitchen" staff was responsible for cleaning the refrigerator in the MC unit.

Main ALF Kitchen

An observation on 07/18/2024 at 11:35 AM, and an observation on 07/19/2024 at 1:20 PM, showed one large cardboard box of graham crumbs open to air on a low shelf in the dry storage area of the kitchen. Graham crumbs were visible on the top flaps of the cardboard box as well as on the inner plastic.

An observation on 07/18/2024 at 11:39 AM, and an observation on 07/19/2024 at 1:20 PM, showed four winged insects flying in a continuous circular pattern in the dry storage area. On both dates, licenser observed kitchen staff walking in and out of the dry storage area multiple times.

An observation on 07/18/2024 at 1:13 PM, and an observation on 07/19/2024 at 1:25 PM, showed multiple boxes of frozen food products sitting directly on the floor of the walk-in freezer.

During an interview on 07/19/2024 at 1:15 PM, Staff E, Food Services Director, said she was unaware that the box with graham crumbs was open. Staff E acknowledged the presence of flies in the dry storage room and said they thought the facility's maintenance department was responsible for addressing this concern.

Staff E stated that on 07/18/2024 and 07/19/2024 they received large deliveries of frozen food items. They said that the kitchen staff had been too busy to move the boxed frozen items off the floor of the walk-in freezer.

In an observation and interview on 07/25/2024 at 1:15 PM, licensers showed the flying insects in the dry storage area to Staff A. The insects had multiplied in number since the previous observation, and several insects were observed flying through the main kitchen. Staff A said she had not been aware of the insects.

In an observation and interview on 07/25/2024 at 1:20 PM, a thick black substance showed covering multiple ceiling tiles and vents directly above the main cooking area. Staff A acknowledged that the dirty ceiling tiles and vents in the kitchen were an issue.

This is a recurring deficiency previously cited on 09/08/2022.

walls. The refrigerator contained undated macaroni salad.

During an interview on 07/25/2024 at 1:00 PM, Staff A, Executive Director, said the “main kitchen” staff was responsible for cleaning the refrigerator in the MC unit.

Main ALF Kitchen

An observation on 07/18/2024 at 11:35 AM, and an observation on 07/19/2024 at 1:20 PM, showed one large cardboard box of graham crumbs open to air on a low shelf in the dry storage area of the kitchen. Graham crumbs were visible on the top flaps of the cardboard box as well as on the inner plastic.

An observation on 07/18/2024 at 11:39 AM, and an observation on 07/19/2024 at 1:20 PM, showed four winged insects flying in a continuous circular pattern in the dry storage area. On both dates, licenser observed kitchen staff walking in and out of the dry storage area multiple times.

An observation on 07/18/2024 at 1:13 PM, and an observation on 07/19/2024 at 1:25 PM, showed multiple boxes of frozen food products sitting directly on the floor of the walk-in freezer.

During an interview on 07/19/2024 at 1:15 PM, Staff E, Food Services Director, said she was unaware that the box with graham crumbs was open. Staff E acknowledged the presence of flies in the dry storage room and said they thought the facility’s maintenance department was responsible for addressing this concern.

Staff E stated that on 07/18/2024 and 07/19/2024 they received large deliveries of frozen food items. They said that the kitchen staff had been too busy to move the boxed frozen items off the floor of the walk-in freezer.

In an observation and interview on 07/25/2024 at 1:15 PM, licensors showed the flying insects in the dry storage area to Staff A. The insects had multiplied in number since the previous observation, and several insects were observed flying through the main kitchen. Staff A said she had not been aware of the insects.

In an observation and interview on 07/25/2024 at 1:20 PM, a thick black substance showed covering multiple ceiling tiles and vents directly above the main cooking area. Staff A acknowledged that the dirty ceiling tiles and vents in the kitchen were an issue.

This is a recurring deficiency previously cited on 09/08/2022.

Statement of Deficiencies

License #: 2365

Compliance Determination # 44313

Plan of Correction

The Meridian at Stone Creek

Completion Date

Page 16 of 19

Licensee: Milton Meridian LLC

08/09/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 10/6/2024
9/23/2024

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



Administrator (or Representative)

8/28/2024

Date

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

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to ensure that the negotiated service agreement (NSA) for 4 of 8 sampled residents (Residents 3, 5, 6, and 7 [R3, R5, R6, and R7]) was signed annually by the resident or their representative, and a representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included ...

Resident 3 (R3)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Assisted Living)," undated, showed that R3 was admitted to the ALF on [REDACTED]/2024. Review of R3's NSA, dated 04/03/2024, showed no signature from R3 or R3's representative, and no facility representative signature.

Resident 5 (R5)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Memory Care)," undated, showed that R5 was admitted to the ALF on [REDACTED]/2023. Review of R5's NSA, dated [REDACTED]/2023, showed no signature from R5 or R5's representative, and no facility representative signature.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to ensure that the negotiated service agreement (NSA) for 4 of 8 sampled residents (Residents 3, 5, 6, and 7 [R3, R5, R6, and R7]) was signed annually by the resident or their representative, and a representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included...**Resident 3 (R3)**

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Assisted Living)," undated, showed that R3 was admitted to the ALF on [REDACTED]/2024. Review of R3's NSA, dated 04/03/2024, showed no signature from R3 or R3's representative, and no facility representative signature.

Resident 5 (R5)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Memory Care)," undated, showed that R5 was admitted to the ALF on [REDACTED]/2023. Review of R5's NSA, dated [REDACTED]/2023, showed no signature from R5 or R5's representative, and no facility representative signature.

Statement of Deficiencies	License #: 2365	Compliance Determination #: 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 17 of 19	Licensee: Milton Meridian LLC	08/09/2024

Resident 6 (R6)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Memory Care)," undated, showed that R6 was admitted to the ALF on [REDACTED]/2019. Review of R6's NSA, dated 10/02/2020, showed no signature from R6 or R6's representative, and no facility representative signature.

Resident 7 (R7)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Memory Care)," undated, showed that R7 was admitted to the ALF on [REDACTED]/2020. Review of R7's NSA, dated 10/22/2020, showed no signature from R7 or R7's representative, and no facility representative signature.

During an interview on 07/22/2024 at 3:00 PM, Staff F, Resident Care Director, said the NSAs for R5, R6, and R7 were not signed. During an interview on 07/23/2024 at 9:30 AM, Staff A, Executive Director, said the NSA for R3 was not signed.

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)	<u>8/28/2024</u> Date

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

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

- (a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;
- (b) Identifies the resident's immediate needs; and
- (c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Resident 6 (R6)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Memory Care)," undated, showed that R6 was admitted to the ALF on [REDACTED]/2019.

Review of R6's NSA, dated 10/02/2020, showed no signature from R6 or R6's representative, and no facility representative signature.

Resident 7 (R7)

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection (Memory Care)," undated, showed that R7 was admitted to the ALF on [REDACTED]/2020.

Review of R7's NSA, dated 10/22/2020, showed no signature from R7 or R7's representative, and no facility representative signature.

During an interview on 07/22/2024 at 3:00 PM, Staff F, Resident Care Director, said the NSAs for R5, R6, and R7 were not signed. During an interview on 07/23/2024 at 9:30 AM, Staff A, Executive Director, said the NSA for R3 was not signed.

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

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 18 of 19	Licensee: Millon Meridian LLC	08/09/2024

Based on interview and record reviews, the facility failed to develop an initial service plan for 1 of 1 newly admitted sampled residents (Resident 8 [R8]). This failure place residents at risk of having their care needs go unmet and a diminished quality of life.

Findings included...

Review of the facility's Characteristic Roster (undated) showed R8 admitted to the facility on [REDACTED] 7/2023.

During interviews on 07/18/2024 at 9:00 AM and on 07/26/2024 at 2:30 PM, Collateral Contact 1 (CC1) said the facility conducted an assessment of R8's care needs immediately following a tour of the facility prior to moving in. CC1 told the staff present at the assessment, he wanted staff to assist R8 with dressing every morning and standby assistance with showers a few days a week. CC1 said he never saw, or signed a care plan until [REDACTED] 2024. CC1 said on multiple occasions staff did not come and assist R8 with dressing in the morning and he had to help R8 get dressed.

Review of R8's Needs and Services Plan (care plan) showed an initial care plan was developed on [REDACTED] 2024, 29 days after R8 admitted. The plan was signed by CC1 on [REDACTED] 2024, 125 days after the plan developed.

During an interview on 07/23/2024 at 9:30 AM, Staff A, Executive Director, said she cannot explain why care plans were not developed.

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) <u>10/6/2024</u> <u>9/23/2024</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement	
 Administrator (or Representative)	<u>8/28/2024</u> <u>10/6/20</u> Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record reviews, the facility failed to develop an initial service plan for 1 of 1 newly admitted sampled residents (Resident 8 [R8]). This failure place residents at risk of having their care needs go unmet and a diminished quality of life.

Findings included...

Review of the facility's Characteristic Roster (undated) showed R8 admitted to the facility on [REDACTED]/2023.

During interviews on 07/18/2024 at 9:00 AM and on 07/26/2024 at 2:30 PM, Collateral Contact 1 (CC1) said the facility conducted an assessment of R8's care needs immediately following a tour of the facility prior to moving in. CC1 told the staff present at the assessment, he wanted staff to assist R8 with dressing every morning and standby assistance with showers a few days a week. CC1 said he never saw, or signed a care plan until [REDACTED] 2024. CC1 said on multiple occasions staff did not come and assist R8 with dressing in the morning and he had to help R8 get dressed.

Review of R8's Needs and Services Plan (care plan) showed an initial care plan was developed on [REDACTED]/2024, 29 days after R8 admitted. The plan was signed by CC1 on [REDACTED]/2024, 125 days after the plan developed.

During an interview on 07/23/2024 at 9:30 AM, Staff A, Executive Director, said she cannot explain why care plans were not developed.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

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

Statement of Deficiencies	License #: 2365	Compliance Determination # 44313
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 19 of 19	Licensee: Milton Meridian LLC	08/09/2024

Based on interview and record review the Assisted Living Facility (ALF) failed to take appropriate action when one sample resident (Resident 10 [R10]) sustained an open area to their buttocks. This failure placed the resident at risk for further harm.

Findings included...

Review of R10's progress notes, dated 06/07/2023, showed the facility first identified R10 to have a wound to their buttocks on 06/07/2023, and the first entry of wound care by a nurse was noted on 06/23/2023, sixteen days after the wound was first identified.

Review of R10's progress notes documented the following:

06/07/2023- "CS noted an open wound on residents' buttocks. She also complained of pain."
 06/19/2023- "... Staff also charted that her bottom is getting worse."
 06/20/2023- "Staff noted the time resident was changed, that she received peri-care and barrier cream, and that her sore is getting worse."
 06/20/2023- Care staff reported that resident's open area on her coccyx is getting bigger, notified LN [licensed nurse] who is supposed to follow up on it."
 06/23/2023- "The RN [Registered Nurse] from home health came and applied a bandage on the buttocks wound."
 08/01/2023- "The nurse had called 911 for the resident to be taken to the hospital for wound care."

In an interview on 08/09/2024 at 10:18 AM, Staff A, Executive Director, stated she had no documentation to show that R10's wound was evaluated and treated prior to 06/23/2023.

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, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 10/6/2024
9/23/2024

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



Administrator (or Representative)

8/28/2024
 Date

Based on interview and record review the Assisted Living Facility (ALF) failed to take appropriate action when one sample resident (Resident 10 [R10]) sustained an open area to their buttocks. This failure placed the resident at risk for further harm.

Findings included...

Review of R10's progress notes, dated 06/07/2023, showed the facility first identified R10 to have a wound to their buttocks on 06/07/2023, and the first entry of wound care by a nurse was noted on 06/23/2023, sixteen days after the wound was first identified.

Review of R10's progress notes documented the following:

06/07/2023- "CS noted an open wound on residents' buttocks. She also complained of pain."
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 06/20/2023- "Staff noted the time resident was changed, that she received peri-care and barrier cream, and that her sore is getting worse."
 06/20/2023- Care staff reported that resident's open area on her coccyx is getting bigger, notified LN [licensed nurse] who is supposed to follow up on it."
 06/23/2023- "The RN [Registered Nurse] from home health came and applied a bandage on the buttocks wound."
 08/01/2023- "The nurse had called 911 for the resident to be taken to the hospital for wound care."

In an interview on 08/09/2024 at 10:18 AM, Staff A, Executive Director, stated she had no documentation to show that R10's wound was evaluated and treated prior to 06/23/2023.

Plan/Attestation Statement

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