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) 49385 (Completion Date 10/24/2024) and 42907 (Completion Date 08/07/2024).

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-2320 Intermittent nursing services systems.

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

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

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

The Department staff who did the On Site verification:

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

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: 128954
Compliance Determination #: 42907
Region/Unit #: RCS Region 3 / Unit D
Investigator: Kathy Heinz
Investigation Date(s): 06/18/2024 through 08/07/2024
Complainant Contact Date(s):

Allegation(s):

1. There is a lack of staff
2. Bathroom is always out of toilet paper or paper towels and memory care director said it is not her job to replenish
3. There was a sewage backup and staff did not sanitize
4. The environment is not clean
5. Laundry is not managed
6. Garbage not emptied
7. The facility was without hot water
8. There is a staff who treats residents disrespectfully

Investigation Methods:

Sample:	Total residents: 22 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident (IR) Residents Resident rooms Resident care equipment
Interviews:	Nursing staff Executive Director Housekeeping Complainant
Record Reviews:	Medical records Facility policies Personnel files Staff training records

Investigation Summary:

1. There was not enough evidence to substantiate
2. Observations showed a lack of toilet paper and paper towels. A citation was written under 388-78A-3090 - maintenance and housekeeping
3. Observations showed the environment was not kept sanitary and a citation was

written under 388-78A-3090/ maintenance and housekeeping
4. Observations showed the environment was not kept sanitary and a citation was written under 388-78A-3090/ maintenance and housekeeping
5. Observation of the laundry showed it was not clean and a citation was written under 388-78A-3090/ maintenance and housekeeping
6. Observations showed the environment was not kept sanitary and a citation was written under 388-78A-3090/ maintenance and housekeeping
7. This allegation was previously investigated
8. There was a criminal background completed for the named staff and there were no findings.

Conclusion / Action:

- [x] 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: 128067
Compliance Determination #: 42907
Region/Unit #: RCS Region 3 / Unit D
Investigator: Kathy Heinz
Investigation Date(s): 06/18/2024 through 08/07/2024
Complainant Contact Date(s):

Allegation(s):

1. There is a lack of paper towels and toilet paper
2. The environment is not clean
3. The Identified Resident (IR) is missing items
4. laundry is not managed
5. One staff sleeps on the job and does not treat residents well
6. Memory care director acts like she does not care
7. There was a resident to resident altercation
8. The facility was without hot water-

Investigation Methods:

Sample:	Total residents: 22 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident (IR) Residents Resident rooms
Interviews:	Nursing staff Executive Director Housekeeping Complainant
Record Reviews:	Medical records Facility policies Personnel files Staff training records

Investigation Summary:

1. A citation was written under 388-78A- 3090 under a separate report for failing to keep the environment clean and sanitary.
2. This allegation was previously investigated and a citation was written under 388-78A- 3090 under a separate report for failing to keep the environment clean and sanitary.
3. The facility was unaware IR was missing items/ unable to provide an

investigation
4. There was not enough evidence to support the allegation.
5. Staff had completed a criminal background check and there were no findings
6. Staff had completed a criminal background check and there were no findings
7. Facility unaware of the incident and unable to provide the department with a incident report/ or investigation
8. This allegation was previously investigated by the department.
Unrelated allegations were cited for failing to secure potentially hazardous items, failing to ensure staff were delegated to administer medications.

Conclusion / Action:

- [x] 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

Statement of Deficiencies	License #: 2365	Compliance Determination # 42907
Plan of Correction	The Meridian at Stone Creek	Completion Date
Page 1 of 10	Licensee: Milton Meridian LLC	08/07/2024

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 an unannounced on-site complaint investigation on 06/18/2024 and 07/25/2024 of:

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

This document references the following complaint number(s): 128954, 128067, 136923

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

The department staff that investigated the Assisted Living Facility:

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

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

08/19/2024
Date

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

Administrator (or Representative) 8/28/2024 Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 6 sampled staff (Staff C, D and E) were qualified to be delegated, or delegated by a Registered Nurse (RN), to administer oral medications, insulin injections and perform blood sugar checks for 4 of 4 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3] and Resident 4 [R4]), who required nurse delegation services. This failure may have resulted in all residents receiving delegation services at risk of receiving care from unqualified staff.

Findings included...

"WAC 246-840-930 Criteria for delegation.
...(8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has evidence as required by the Department of Social and Health Services of successful completion of nurse delegation core training; (d) Has evidence as required by the Department of Social and Health Services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task;

(e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services. (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent. (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care. (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

"WAC 246-980-130
Provision for delegation of certain tasks to a home care aide.
(1) A home care aide-certified may perform tasks delegated by a registered nurse for patients in community-based care settings or in-home care settings each as defined in RCW 18.79.260 (3)(e).
(2) Before performing any delegated task a home care aide-certified must show the certificate of completion of the core delegation training from the department of social and health services to the registered nurse delegator.
(3) A home care aide-certified who is performing nurse delegation tasks must comply with all applicable requirements of the nursing care quality assurance commission in WAC 246-840-910 through 246-840-970.
(4) A home care aide-certified, who may be performing insulin injections must show a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator.
(5) A home care aide-certified must meet any additional training requirements identified by the department of social and health services.
(6) For the purposes of this section, delegated nursing care tasks must be performed:
(a) Only for the specific patient for whom those tasks are delegated;
(b) Only with the patient's consent; and
(c) In compliance with all applicable requirements in WAC 246-840-910 through 246-840-970.
(7) A home care aide-certified may consent or refuse to consent to perform a delegated nursing care task. The home care aide-certified is responsible for his or her own actions with the decision to consent or refuse to consent and the performance of the delegated nursing care task.
(8) A home care aide-certified must not accept delegation of, or perform, the following

nursing care tasks:
(a) Administration of medication by injection, with the exception of insulin injections;
(b) Sterile procedures;
(c) Central line maintenance;
(d) Acts that require nursing judgment.
(9) A person who is working as a long-term care worker but has not received a home care aide certification must have either an active nursing assistant-certified or an active nursing assistant-registered credential issued by the department and comply with WAC 246-841-405 to perform delegated tasks."

Review of the facility Characteristic Roster, dated 06/18/2024, showed R1, R2, R3 and R4 received Nurse Delegation Services.

R1
Review of R1's Medication Administration Records (MARs) dated May 2024 and June 2024, showed a physician order to check R1's blood sugars one time a day. The MARs showed Staff D, Resident Care Coordinator, checked R1's blood sugar 18 times.

Review of R1's "Nurse Delegation: Nurse Visit form" dated 04/29/2024 failed to show Staff D was delegated by a Registered Nurse (RN) delegator to check R1's blood sugar. Review of the personnel file for Staff D on 07/24/2024 failed to show she had obtained a Nursing Assistant Registered (NAR) with the Department of Health (DOH). Staff D was not qualified to be delegated.

R2
Review of R2's MARs dated May 2024 and June 2024, showed Staff C ,Memory Care Director, and Staff D, administered multiple medications including: Acetaminophen (used to treat pain), Donepezil (used to treat dementia), Furosemide (used to treat fluid retention), Metoprolol (used to treat high blood pressure), Quetiapine (used to treat mood disorders) and Sertraline (used to treat mood disorders) during both months to R2.

Review of R2's "Nurse Delegation: Nursing Visit" form dated 04/01/2024 failed to show Staff C and D were delegated by an RN delegator to administer oral medications.

R3
Review of R3's MAR dated June 2024, showed a physician order for two types of insulin (sliding scale and routine used to treat diabetes) to be administered up to four times a day. The MAR showed a physician orders for oral medications including: Lisinopril (used to treat high blood pressure) 10, Mirtazapine (used to treat depression), Amlodipine Besylate (used to treat high blood pressure), Citalopram HBR 40 (used to treat depression), Furosemide, and Acetaminophen. The MAR showed Staff C and D administered both insulin and oral medications.

Review of R3's "Nurse Delegation: Nursing Visit" form dated 06/01/2024 failed to show Staff C and D were delegated to administer insulin and oral medications.

R4
Review of the R4's MAR dated July 2024 showed an order for the administration of insulin 3 times a day before before meal. The MAR showed Staff C administered insulin one time and Staff E, Medication Technician, administered insulin nine times between 07/01/2024 and 07/18/2024.

Review of R4's "Nurse Delegation: Nursing Visit" form dated 05/17/2024, failed to show Staff C and E were delegated to administer insulin.

In an interview on 06/20/2024 at 3:00 PM, Staff B, Resident Care Director, said she thought all staff assisting with medication administration were delegated to administer medications.

In an interview on 07/25/2024 at 3:00 PM, Staff A, Executive Director, said she thought the nurse delegator had delegated all staff during a recent visit.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) ~~10/3/2024~~ 9/20/2024.

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

Administrator (or Representative) — Date: 8/28/2024

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure common areas, bathrooms, laundry room, housekeeping room, resident sleeping rooms and equipment were kept clean, sanitary and in good repair, in the memory care unit for 1 of 1 facility reviewed. This failure resulted in 22 of 22 residents in the memory care unit, living in unsanitary, unclean and unmaintained conditions.

Findings included...

Collateral Contact 1 (CC1) said during an interview 06/18/2024 at 10:00 AM, Resident 5's (R5) room was never clean and there were never any paper towels to dry your hands on or toilet paper in the bathroom.

Collateral Contact 3 (CC3) said during an interview on 07/19/2024 at 12:00 PM, the toilet was always dirty in Resident 6's (R6) room and they had to ask for toilet paper and paper towels. CC3 added that they (CC3) cleaned the toilet for R6.

Collateral Contact 2 (CC2) said during an interview on 07/23/2024 at 11:50 AM, there was never any paper towels or toilet paper in Resident 7's (R7) room.

Observations of resident rooms and toilet rooms on 06/18/2024:

Observation at 12:00 PM of resident room [redacted], showed no paper towels or toilet paper. Debris littered the floor of the sleeping area.

Observation at 12:10 PM of R5's room, showed brown matter in front of the base of toilet bowel and bits of paper littered the floor.

Observation at 12:15 PM of resident room [redacted], showed the bathroom and living area littered with debris and bits of paper.

Observations of resident sleeping rooms and toilet rooms on 06/20/2024:

Observation at 1:00 PM of resident room [redacted], showed crumbs littered the floor by the main door, and multiple bits of paper were on the floor around the base of the toilet bowel. There were brown spots on the floor around the toilet bowl base. Brown matter was smeared on the baseboard behind the toilet base. Brown matter was observed on the rim of the toilet bowl. A side table located near the door leading to the hallway contained an empty roll of toilet paper, an empty cup, wadded up paper and four empty single-use water bottles.

Observation at 1:05 PM of resident room [redacted], showed an area approximately 7 feet by 2 feet of white streaks leading from the bathroom door to the bed. There were shoeprint tracks in the white streaks.

Observation at 1:10 PM of R5's room, showed the transition piece between the hall and the room was crusted with debris on both sides. There were bits of debris piled up in one corner of the room, the toilet bowl had a brownish ring, and debris littered the floor.

Observations of resident sleeping rooms and toilet rooms on 07/17/2024:

Observation at 9:40 AM of resident room [redacted], showed four plastic clear cups and two empty juice bottles sitting on a table when you entered the room. Bits of paper littered the rug in the bathroom. There was brown matter on the floor of bathroom. A plate containing dried food was sitting on the counter in the bathroom. There was no toilet paper, paper towels or soap in the dispensers. The floor of the living space was littered with debris.

Observation at 10:00 AM of the bathroom located in between resident rooms [redacted] and [redacted], showed no toilet paper available, a full bathroom trashcan containing used adult incontinence briefs. There was brown matter covering the toilet and the bowl was full of urine. The toilet room smelled of urine.

Observations at 10:30 AM and 12:00 PM of resident room [redacted], showed a large chunk of brown matter stuck to the wall of the toilet bowl. Brown matter covered the front area of the toilet bowl lid.

Observation at 11:55 AM of resident room [redacted] showed no toilet paper and the toilet bowl was not clean. The room had a strong smell of urine.

Observation at 2:10 PM of the common bathroom across from the laundry room, showed no toilet paper. Brown matter was observed on the base of the toilet bowl and on the wall adjacent to the toilet.

Observations of resident sleeping rooms and toilet rooms on 07/19/2024:

Observation at 11:00 AM of resident room [redacted], showed a roll of toilet paper sitting on a side table near the window. There was brown matter smeared on the top of the roll. The floor was littered with debris.

Observation at 11:10 AM of resident room [redacted] showed the first-floor room faced the main entrance of the facility. There was no screen on the window. The window was

slightly ajar, and the sill was full of dried leaves.

Observation at 11:10 AM of resident room [redacted] showed a large chunk of brown matter stuck to the wall of the toilet bowl. Brown matter covered the front area of the toilet bowl and a dried washcloth with brown matter was lying near the washbasin.

Observation at 12:00 PM of R6's room showed there was no toilet paper, and the bed sheets were soiled.

Observations of resident toilet room on 07/22/2024:

Observation at 2:00 PM of resident room [redacted], showed a chunk of brown matter stuck to the wall of the toilet bowl. Brown matter covered the front area of the toilet bowl seat.

Observation of resident rooms and toilet rooms on 07/25/2024:

Observation at 12:00 PM of resident room [redacted], showed there were no sheets on the bed. An area of the mattress measuring approximately 20 inches by 20 inches showed brown matter and yellowish-brown stains. Brown matter was located on the floor of the bathroom. There were no paper towels, and the toilet paper holder was broken. The toilet paper was placed out of reach on the bathroom counter.

Observation at 11:45 AM of resident room [redacted] showed a large chunk of brown matter stuck to the wall of the toilet bowl. Brown matter covered the front area of the toilet bowl.

Observation of R7's room at 11:50 AM showed the bed was not made. The bottom sheet showed an area of yellowish-brownish stain. There was brown matter on the faucet.

Observation at 12:00 PM of resident room [redacted] showed no paper towels.

Observation of the bathroom located between Resident rooms [redacted] and [redacted] showed the trash can was full. Several incontinence wipes were observed covered with brown matter.

During an interview on 07/25/2024 at 12:00 PM, Staff C, Memory Care Director, said staff were responsible to assist with resident care, clean the environment, pass medications, assist with eating and complete laundry. Staff C said there wasnot enough time to clean.

Observations of common area in memory care:

Observation on 07/19/2024 at 12:00 PM in the dining room showed a refrigerator, and a kitchen island that contained cupboards and drawers. Spills of matter were observed on all the drawers in the island. The refrigerator felt warm to touch and the inside compartment smelled when the door was opened. The light did not work. The freezer compartment showed a black substance covering the walls.

Observation on 07/19/2024 at 2:00 PM showed a dead yellowjacket (insect), multiple small dead insects, and debris in the windowsill located directly across from resident room [redacted].

During an interview on 07/25/2024 at 12:00 PM, Staff C said the refrigerator did not work and had been unplugged for a few months.

Observation of the memory care laundry room on 7/25/2024:

Observation at 11:00 AM showed the laundry room door propped open. Inside the unsecured room there were multiple laundry baskets full of clothes sitting on the floor. There was a pile of laundry sitting on top of the side-by-side washing machines. There were clothes on the floor. The floor was littered with debris and splotches of matter. There were broken down cardboard boxes lying on the floor. The large utility sink located next to the washing machine contained a mop head and a yellow bucket. The basin of the sink was covered with brown and grey splotches. The yellow bucket was covered with dark grey and brown splotches.

During an interview on 07/25/2024 at 1:00 PM, Staff A, Executive Director, said the laundry room was not clean.

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) ~~10/3/2024~~ 9/20/2024.

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

Administrator (or Representative) — Date: 8/28/2024