STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Aegis Senior Communities LLC
Aegis of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

RE: Aegis of Queen Anne at Rodgers Park License # 2381

Dear Administrator:

This letter addresses Compliance Determination(s) 51688 (Completion Date 12/16/2024) and 47206 (Completion Date 10/14/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/16/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2100-2-b-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-2, WAC 388-78A-2140-5, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-2, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2230-1-c, WAC 388-78A-2230-2-b, WAC 388-78A-2230-2-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-3-c, WAC 388-78A-2320-2-b, WAC 388-78A-2600-1-b, WAC 388-78A-2600-1-a, WAC 388-78A-2600-2-n, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-2, WAC 388-78A-2240, WAC 388-78A-2305-1

The Department staff who did the on-site verification:
Keiko Kitano, Licensor
Alma Duran, Licensor

If you have any questions, please contact me at (253)312-1446.

Sincerely,
Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Aegis of Queen Anne at Rodgers Park
License/Cert.#: 2381
Compliance Determination #: 47206
Investigator: Keiko Kitano
Provider Type: Assisted Living Facility
Intake ID: 145151
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 09/10/2024 through 10/14/2024
Complainant Contact Date(s):

Allegation(s):
The named resident (NR) developed a pressure wound. The NR's pressure wound went from being Stage 2 to Stage 3 which led to hospitalization.

Investigation Methods:

Sample:	Total residents: 100 Resident sample size: 10 Closed records sample size:
Observations:	The Assisted Living Facility's (ALF) environment, staff and residents' interaction
Interviews:	Administrative staff members, a licensed nurse, caregivers
Record Reviews:	Incident investigative document, resident's records, the ALF's policies

Investigation Summary:
This investigation was conducted during the ALF's licensing inspection.
The Administrative staff members stated that a caregiver discovered an open wound on the NR's buttocks. Licensed nurses assessed and monitored the NR's wound. LNs had contacted the NR's physician for treatment. The ALF followed the physician's order for wound care, but the NR's wound went from Stage 2 to Stage 3. The ALF sent the NR to the hospital for further treatment. The ALF reported the NR's skin conditions to the NR's representative. However, staff interview and records review showed that non-licensed staff members had applied prescribed ointment to the NR's open wound. The ALF did not follow their policy of wound care being done only by licensed staff. See citation 388-78A-2600 (1). (a).(b).

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Licensee: Aegis Senior Communities LLC
Aegis of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

RE: Aegis of Queen Anne at Rodgers Park License # 2381

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 10/14/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

• Wrote the enclosed Statement of Deficiencies (SOD) report; and
• May take licensing enforcement action based on any deficiency listed on the enclosed report; and
• May inspect the facility to determine if you have corrected all deficiencies.

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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• 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.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

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

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

If You Have Any Questions:

• Please contact me at (253)312-1446.

Sincerely,

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2381	Compliance Determination # 47206
Plan of Correction	Aegis of Queen Anne at Rodgers Park	Completion Date
Page 3 of 26	Licensee: Aegis Senior Communities LLC	10/14/2024

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 09/10/2024 and 09/13/2024 of:
Aegis of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

This document references the following complaint numbers: 145151, 146843.

The following sample was selected for review during the unannounced on-site visit: 10 of 100 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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

Jamie Singer
Residential Care Services

10/18/2024
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.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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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Aegis of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

This document references the following complaint numbers: 145151, 146843.

The following sample was selected for review during the unannounced on-site visit: 10 of 100 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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

Residential Care Services _____ Date _____

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

Lina White
Administrator (or Representative)

10/28/24
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that an Assessment for 1 of 1 sampled resident (Resident 5) was updated to include safety considerations and the ability to safely use a mobility device. This failure placed Resident 5 at risk of harm or injury from a mobility device.

Findings included...

NOTE: Washington Administrative Code 388-78A-2090 Full assessment topics.
The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:
(8) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:
(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

Records review showed the ALF admitted Resident 5 on [redacted]/2017 with multiple disabling diagnoses. Review of Resident 5's Individual Service Plan (ISP - equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/26/2024, showed that Resident 5 would utilize a transfer/positioning device to assist with mobility and/or position but did not identify what kind of mobility device Resident 5 had been using.

Record review of a Physical Therapist's (PT) note, dated 08/08/2024, showed that the PT instructed the ALF's maintenance staff to install one transfer pole (TP) next to the bed and a second TP in front of the couch.

Observation and interview, on 09/13/2024 at 11:10 AM, showed a TP installed at the left

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

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Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that an Assessment for 1 of 1 sampled resident (Resident 5) was updated to include safety considerations and the ability to safely use a mobility device. This failure placed Resident 5 at risk of harm or injury from a mobility device.

Findings included…

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(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:
(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

Records review showed the ALF admitted Resident 5 on [redacted]/2017 with multiple disabling diagnoses. Review of Resident 5's Individual Service Plan (ISP - equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/25/2024, showed that Resident 5 would utilize a transfer/positioning device to assist with mobility and/or position but did not identify what kind of mobility device Resident 5 had been using.

Record review of a Physical Therapist's (PT) note, dated 08/08/2024, showed that the PT instructed the ALF's maintenance staff to install one transfer pole (TP) next to the bed and a second TP in front of the couch.

Observation and interview, on 09/13/2024 at 11:10 AM, showed a TP installed at the left

side of the couch in the living room in Resident 5's apartment. Observation also showed another TP with a curved grab bar installed on the left side of the bed from ceiling to floor. Resident 5 stated that the TPs helped them to get in and out of bed and from the couch.

Records review showed the ALF did not updated Resident 5's Assessment after the TP order of 08/08/2024 with information including ability to use the TPs unsupervised, safety considerations, risks and benefits; or ensuring the proper and safe installation of the TPs.

In an interview, on 09/13/2024 at 2:40 PM, Staff A (Health Services Director) stated that they had not completed an assessment for Resident 5's TPs.

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, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 11/28/24.

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

Dina White — Administrator (or Representative)

10/28/24 — Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

side of the couch in the living room in Resident 5's apartment. Observation also showed another TP with a curved grab bar installed on the left side of the bed from ceiling to floor. Resident 5 stated that the TPs helped them to get in and out of bed and from the couch.

Records review showed the ALF did not updated Resident 5's Assessment after the TP order of 08/08/2024 with information including ability to use the TPs unsupervised, safety considerations, risks and benefits, or ensuring the proper and safe installation of the TPs.

In an interview, on 09/13/2024 at 2:40 PM, Staff A (Health Services Director) stated that they had not completed an assessment for Resident 5's TPs.

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, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

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

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) included all required contents for 2 of 2 sampled residents (Residents 5 and 10). This placed Resident 5 at risk for not having their care and services needs met and placed Resident 10 at risk for not receiving the appropriate care to meet their mental health needs.

Findings included…

RESIDENT 5
Records review showed the ALF admitted Resident 5 on [redacted]/2017 with multiple disabling diagnoses. Review of the undated ALF Residents Characteristics Roster showed Resident 5 had a private caregiver (PCG).

In an interview, on 09/12/2024 at 10:30 AM, Staff H (Resident Care Director) stated that Resident 5's family had hired a PCG for them. Staff H stated that the ALF staff were still providing direct care for Resident 5 and the PCG was more like a companion.

Observation and interview, on 09/13/2024 at 10:45 AM, showed a PCG standing at the counter in the main dining room. The PCG stated that they would deliver breakfast for Resident 5. The PCG stated they had been visiting Resident 5 three days a week for one year and assisting with a shower twice a week.

Review of an Occupational Therapist's (OT) Visit Note, dated 07/25/2024, showed that the OT instructed Resident 5 to take showers only with a caregiver's assistance for safety.

Review of Resident 5's Individual Service Plan (ISP - equivalent to a Full Assessment and an NSA), dated 07/25/2024, showed Resident 5 as being independent for bathing. The ISP did not address Resident 5's need for shower assistance. There was no information about Resident 5 having a PCG. The ISP did not clearly define roles and responsibilities of the PCG, and there was no back-up plan for when the PCG was not available.

In an interview, on 09/13/2024 at 2:40 PM, Staff A (Community Health Director) acknowledged that Resident 5's ISP did not include information about the PCG and a back-up plan.

RESIDENT 10
Record review showed the ALF admitted Resident 10 on [redacted]/2024 with multiple diagnoses including [redacted], and [redacted].

Review of the Preadmission Assessment (PA), dated 01/31/2024, showed Resident 10 required staff assistance and intervention when Resident 10 experienced behaviors such as anxiousness, mood changes, restlessness, delusions (false beliefs) or hallucinations (sensing things that do not exist). The PA showed staff were to provide redirection, intervention, and/or coordination with healthcare resources, and to intervene with validation and/or redirection techniques to calm resident.

Review of a Consultation Notes from an Advanced Registered Nurse Practitioner, dated 06/10/2024, showed Resident 10 had a diagnosis of [redacted], and an extensive psychiatric history that may be contributing to Resident 10's cognitive status.

Review of Physician's Orders, dated 02/14/2024, showed Resident 10 was prescribed apiprazole (used to treat schizophrenia, bipolar, and depression), clonazepam (used to treat anxiety), and Cymbalta (used to treat depression and anxiety).

Review of Resident 10's combined Assessment/Individual Service Plan (A/ISP – ISP is equivalent to NSA), dated 09/06/2024, showed no behavior issues related to their [redacted] diagnosis and history, what intervention would be needed should Resident 10 experience behavior issues, and no instructions to staff should Resident 10 exhibit or demonstrate mental decompensation (worsening condition of mental illness) issues requiring staff interventions.

In an interview, on 09/13/2024 at 1:20 PM, Staff A (Health Services Director and Staff I (Director of Operation) stated acknowledged that lack of a behavior plan for Resident 10.

This is a deficiency previously cited on 01/27/2023.

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, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 11/28/24.

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

Anna White — Administrator (or Representative)

10/28/24 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2260:

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement a system that supported and promoted safe medication services for 2 of 2 sampled residents (Residents 1 and 5) who required staff to administer or assist with medications. This failure resulted in Residents 1 and 5 not receiving medications as prescribed and placed Residents 1 and 5 at risk for compromised health conditions.

Findings included...

Review of the ALF's policy titled Documentation Standards of Medication, revised 04/12/2021, under the section of New Orders and Medication Order Changes, showed, "New order and medication order changes are faxed to the pharmacy for processing and entry into the computer system."

Review of the ALF's policy titled Documentation Standard Medication, revised 04/12/2024, under the section of Omitted Medication showed, "It is not acceptable to omit a medication because it is not available."

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, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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(b) Develop and implement systems that support and promote safe medication service for each resident.

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

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement a system that supported and promoted safe medication services for 2 of 2 sampled residents (Residents 1 and 5) who required staff to administer or assist with medications. This failure resulted in Residents 1 and 5 not receiving medications as prescribed and placed Residents 1 and 5 at risk for compromised health conditions.

Findings included…

Review of the ALF's policy titled Documentation Standards of Medication, revised 04/12/2021, under the section of New Orders and Medication Order Changes, showed, "New order and medication order changes are faxed to the pharmacy for processing and entry into the computer system."

Review of the ALF's policy titled Documentation Standard Medication, revised 04/12/2024, under the section of Omitted Medication showed, "It is not acceptable to omit a medication because it is not available."

Review of the ALF's policy titled Limited Supply Ordering Back Up Medication Supply, revised 03/27/2015, under the section of Obtaining Medications showed "that the Medication Care Manager (MCM) will call the ALF's preferred pharmacy and determine why the medication has not arrived and determine if it will arrive on time." "Convey this information to the next shift and the Licensed Nurse so that they can continue to follow up."

RESIDENT 1
Record review showed that the ALF admitted Resident 1 on [redacted]/2021 with multiple diagnoses including [redacted]. Review of Resident 1's Individual Service Plan (ISP - equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/18/2024, showed that trained staff would manages skin irritations, including application of creams as ordered.

Records review showed that Resident 1 developed an open skin wound on their buttock on 06/11/2024.

Review of a Progress Note (PN), dated 08/15/2024, showed that Resident 1's physician, ordered silver sulfate cream (used to skin issues) to be applied to Resident 1's wound twice a day for seven days. Review of the August 2024 electronic Medication Administration Records (eMARs) showed that Medication Care Managers (MCM) put their initials in a column for applying the silver sulfate cream to Resident 1's wound from 08/16/2024 until 08/29/2024. Resident 1 received applications of the silver sulfate cream for 13 days, not seven days as ordered.

RESIDENT 5
Record review showed that the ALF admitted Resident 5 on [redacted]/2017 with multiple diagnoses, including [redacted] Review of Resident 5's ISP, dated 07/25/2024, showed that Resident 5 required staff assistance with medication services. The ISP showed that Resident 5 had been using the ALF's preferred pharmacy, and that staff had been responsible for the timely reordering of all medications.

Review of the July, August, and September 2024 eMARs showed that Resident 5 had been prescribed multiple medications, including ferrous sulfate (iron supplement). Review of the eMARs showed that a physician had ordered Resident 5 to take ferrous sulfate once every three days. The eMARs showed that the ALF was giving Resident 5 ferrous sulfate three times a week on Sundays, Mondays, and Thursdays instead every three days as prescribed.

In an interview, on 09/13/2024 at 2:30 PM, Staff J (Regional Registered Nurse) confirmed the ferrous sulfate had been given incorrectly.

In an interview, on 09/13/2024 at 2:40 PM, Staff A (Health Services Director) acknowledged that MCMs had not given ferrous sulfate to Resident 5 as prescribed.

Records review showed that Resident 5 had been prescribed Jantoven (an anticoagulant used to prevent blood clots from forming or growing larger in a person's blood and blood vessels) for their A-Fib. Record review showed that the dosage of the Jantoven was controlled by an anticoagulation clinic (a clinic to manage anticoagulation therapy).

Review of a Progress Note (PN), dated 08/02/2024, showed that the anticoagulation clinic called the ALF and instructed Resident 5 to take Jantoven 1.5 milligrams (mg) on that day. Review of the August 2024 eMARs showed that on 08/02/2024, a MCM put their initials in a column for Jantoven 2.0 mg, indicating Resident 5 received 2.0 mg instead 1.5 mg.

Review of an order from the anticoagulation clinic, dated 08/03/2024, showed that the anticoagulation clinic instructed Resident 5 to take Jantoven 3.0 mg on 08/03/2024. This order was faxed to the ALF on 08/03/2024 at 10:17 AM. Review of the August 2024 eMARs showed the 08/03/2024 the order was not transcribed into the eMARs, and Resident 5 did not receive any dose of Jantoven on 08/03/2024.

Review of a PN, dated 08/05/2024, showed that the anticoagulation clinic called the ALF and instructed Resident 5 to take Jantoven 1.5 mg that evening. The August 2024 eMARs showed that a MCM put their initials in a column for the 2.0 mg of Jantoven, indicating Resident 5 received 2.0 mg instead of 1.5 mg.

Review of a PN, dated 08/30/2024, showed that the anticoagulation clinic instructed Resident 5 to take 1.5 mg of Jantoven on 08/30/2024. However, review of the August 2024 eMARs showed that on 08/30/2024, Resident 5 did not receive any dose of Jantoven.

Review of PNs, dated 07/28/2024 and 08/27/2024, showed that an anticoagulation clinic instructed Resident 5 to take Jantoven on those days. Review of the July and August 2024 eMARs showed that on 07/28/2024 at 8:00 PM and 08/27/2024 at 5:00 PM, the MCMs documented in the eMARs that Jantoven was unavailable, and waiting for the pharmacy to deliver, indicating Resident 5 did not received Jantoven on those days.

In an interview, on 09/13/2024 at 2:30 PM, Staff J (Regional Registered Nurse) stated that the ALF's preferred pharmacy could deliver a medication at around 10:00 PM if necessary. Staff J stated that even with a late delivery, a MCM should have given the medication to Resident 5.

On 10/07/2024, the Department received additional documents from Staff H, including

the pharmacy's medication delivery records. Review of the pharmacy's records, dated 07/28/2024 and 08/27/2024, showed that the ALF had received Resident 5's Jantoven on those days. However, records review showed no documentation to indicate that Resident 5 received Jantoven on those days. There was also no documentation to show that nursing staff had reported the omission of Jantoven on those days to Resident 5's physician.

Review of an email document from Staff A, dated 10/08/2024, showed that Resident 5 did not like to be disturbed during late hours and would not take their medication late. The email document showed a statement from Resident 5's representative confirming that. However, review of Resident 5's ISP did not address this information about late refusal of medication.

Records review showed that Resident 5 was admitted to the hospital for an acute medical condition, and returned to the ALF on [redacted]/2024. Review of a discharge medication order from the hospital, dated [redacted]2024, showed that Resident 5 was instructed to take 12.5 mg of quetiapine (used to treat the symptoms of schizophrenia ((a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions)) at bedtime.

Review of the July 2024 eMARs showed that the quetiapine order was not transcribed into the eMARs. Records review showed no documentation indicating the ALF had faxed the new order to the pharmacy for processing per the ALF's policy. There was also no documentation indicating that the ALF had contacted Resident 5's physician about the hospital quetiapine order.

In a telephone interview, date 10/07/2024 at 1:37 PM, Staff H stated that nurses were responsible for reviewing physicians' orders or discharge instruction from the hospital.

Plan/Attestation Statement

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Dina White — 10/28/24

Administrator (or Representative) — Date

the pharmacy's medication delivery records. Review of the pharmacy's records, dated 07/28/2024 and 08/27/2024, showed that the ALF had received Resident 5's Jantoven on those days. However, records review showed no documentation to indicate that Resident 5 received Jantoven on those days. There was also no documentation to show that nursing staff had reported the omission of Jantoven on those days to Resident 5's physician.

Review of an email document from Staff A, dated 10/08/2024, showed that Resident 5 did not like to be disturbed during late hours and would not take their medication late. The email document showed a statement from Resident 5's representative confirming that. However, review of Resident 5's ISP did not address this information about late refusal of medication.

Records review showed that Resident 5 was admitted to the hospital for an acute medical condition, and returned to the ALF on [redacted]/2024. Review of a discharge medication order from the hospital, dated [redacted]/2024, showed that Resident 5 was instructed to take 12.5 mg of quetiapine (used to treat the symptoms of schizophrenia ((a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions)) at bedtime.

Review of the July 2024 eMARs showed that the quetiapine order was not transcribed into the eMARs. Records review showed no documentation indicating the ALF had faxed the new order to the pharmacy for processing per the ALF's policy. There was also no documentation indicating that the ALF had contacted Resident 5's physician about the hospital quetiapine order.

In a telephone interview, date 10/07/2024 at 1:37 PM, Staff H stated that nurses were responsible for reviewing physicians' orders or discharge instruction from the hospital.

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Administrator (or Representative) Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate for any negative outcomes when 3 of 3 sampled residents (Resident 5, 8, and 10) refused their medication. This placed Residents 5, 8, and 10 at risk for a compromised health condition.

Findings included...

Review of the ALF's policy titled Resident Refusal of Medication, dated 04/12/2021, showed, "The Health Services Director (HSD) or Wellness Nurse will follow-up on the refusal of a medication, particularly if this is a pattern of refusal." "The HSD or Wellness Nurse will contact the resident's prescribing practitioner if the medication refusal is repetitive. This conversation will be documented in the Health Record."

RESIDENT 5
Records review showed that the ALF admitted Resident 5 on [redacted]/2017 with multiple diagnoses. Review of Resident 5's Individual Service Plan (ISP - equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/25/2024, showed Resident 5 required staff assistance with medications.

Review of the July and August 2024 electronic Medication Administration Records (eMARs) showed that on 06/22/2024, Resident 5's physician had ordered Resident 5 to apply an Aspercreme patch (lidocaine patch, used to relieve minor pain in shoulders, arms, neck and legs) to their left leg and back daily. Review of the eMARs showed that

in July 2024, Resident 5 had refused the Aspercreme patch for three days and in August 2024 Resident 5 refused the Aspercreme patch for seven days.

Review of Resident 5's active records showed no documentation as to whether a Medication Care Manager (a non-licensed caregiver) had notified the HSD or Wellness nurse about Resident 5's Aspercreme patch refusal. There was no documentation to indicate that the HSD or Wellness nurse evaluated Resident 5's condition for negative outcomes. There was no documentation showing the ALF had notified the physician about Resident 5's continued pattern of refusing Aspercreme per the ALF's policy.

In an interview, on 09/13/2024 at 2:40 PM, Staff A (Health Services Director) acknowledged that there was no documentation to show the ALF notified the physician or evaluated Resident 5 for negative outcomes following the Resident 5's medication refusal.

RESIDENT 8
Record review showed the ALF admitted Resident 8 on [redacted]/2024 with multiple medically disabling diagnoses. Review of Resident 8's combined Assessment/Individual Service Plan (A/ISP – ISP is equivalent to Negotiated Service Agreement), dated 08/28/2024, showed Resident 8 required assistance with medication services.

Review of the September 2024 electronic Medication Administration Records (eMAR) showed Resident 8 refused to take the 10:00 AM dose ordered medications on 09/03/2024 and 09/04/2024 for polyethylene glycol powder (prevents and treats occasional constipation).

Record review showed no documentation as to whether the ALF notified the physician about Resident 8's refusing her medication.

RESIDENT 10
Record review showed the ALF admitted Resident 10 on [redacted]/2024 with multiple medically disabling diagnoses. Review of Resident 10's A/ISP, dated 09/04/2024, showed Resident 10 required assistance with medication services.

Review of a Progress Note (PN), dated 08/15/2024, showed Resident 10 tested positive for COVID 19 (is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death).

Review of the August 2024 eMAR, showed Resident 10 was prescribed Paxlovid (a medication used to treat mild-to-moderate COVID-19) for five days. The eMAR showed Resident 10 refused to take two morning doses and three evening doses of Paxlovid, because it made her feel worse.

Review of the June 2024 eMAR, showed Resident 10 refused to take Refresh Tears eye drops (used to treat dry eyes) on 06/12/2024, 06/13/2024, and 06/14/2024.

Review of a PN, showed no documentation as to whether the ALF notified the physician about Resident 10's refusing her Paxlovid [COVID 19] or Refresh Tears eye drops, and had evaluated the significance of Resident 10's medication refusals. And there was no documentation that staff notified Resident 10's physician the reason why she refused the medication or that the Paxlovid made her feel worse.

In interview, on 09/13/2024 at 2:05 PM, Staff I (Director of Operations) and Staff A (Health Services Director) acknowledged the residents' physicians were to be notified and medication refusals were documented according to ALF's policy.

This is a deficiency previously cited on 01/27/2023.

Plan/Attestation Statement

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Anna White — Administrator (or Representative)

10/28/24 — Date

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

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

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

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

(b) Nurse delegation, if provided;

(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:

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

Review of the June 2024 eMAR, showed Resident 10 refused to take Refresh Tears eye drops (used to treat dry eyes) on 06/12/2024, 06/13/2024, and 06/14/2024.

Review of a PN, showed no documentation as to whether the ALF notified the physician about Resident 10's refusing her Paxlovid [COVID 19] or Refresh Tears eye drops, and had evaluated the significance of Resident 10's medication refusals. And there was no documentation that staff notified Resident 10's physician the reason why she refused the medication or that the Paxlovid made her feel worse.

In interview, on 09/13/2024 at 2:05 PM, Staff I (Director of Operations) and Staff A (Health Services Director) acknowledged the residents' physicians were to be notified and medication refusals were documented according to ALF's policy.

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(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:

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow the criteria for nurse delegation (ND) for 1 of 1 sampled resident (Resident 1). This resulted in non-licensed staff members administering medications without receiving ND training and placed Resident 1 at risk for compromised health conditions.

Findings included…

NOTE: Washington Administrative Code (WAC) 246-840-930 Criteria for delegation,
(1) In community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE.
ASSESS
(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.

Review of the ALF's policy titled Nurse Delegation, revised 11/14/2018, under the section for Medication Administration showed, "Determine if a resident's needs administration of medication. If the resident is NOT functionally (physically) able to take medications and cognitively aware he/she is receiving medications, the medication must be administered by a person authorized to do so."

Records review showed the ALF admitted Resident 1 on [redacted]/2021 with multiple disabling diagnoses, including [redacted]. Review of Resident 1's Individual Service Plan (ISP - equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/17/2024, showed that Resident 1 required staff assistance with medication services.

Review of the June, July, and August 2024 electronic Medication Administration Records (eMARs) showed that Resident 1 had multiple prescribed medications. The eMARs showed oral medications might need to be crushed.

In an interview, on 09/13/2024 at 12:45 PM, Staff L (Medication Care Manager - MCM) stated that MCMs had been crushing oral medications and mixing them with pudding. When asked whether Resident 1 had been able to put the mixed medication in their mouth, Staff L said, "No", and stated that MCM had been administering the medications.

Review of an ND document binder showed no documentation to indicate the ALF properly delegated MCMs for administering medications to Resident 1.

In an interview, on 09/13/2024 at 2:30 PM, Staff A (Health Services Director) acknowledged they had not delegated MCMs to administer medications to Resident 1.

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Anna White — Administrator (or Representative)

10/28/24 — Date

WAC 388-78A-2600 Policies and procedures.

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

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

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

(n) Related to food services consistent with chapter 246-215 WAC and WAC 388-78A-2300;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement their policies regarding skin management for 1 of 1 sampled resident (Resident 1) who developed a pressure sore, and also failed to implement their policies and procedures to consistently monitor and document food temperatures (FTs) at required hot and cold FT control prior to serving potentially hazardous food to 12 of 12 residents in the Memory Care Unit (MCU). This resulted in Medication Care Managers (non-licensed staff members) applying prescribed medications to Resident 1's wound and placed Resident 1 at risk for a deteriorated health condition, and 12 residents in MCU at risk for acquiring food borne illness.

Findings included...

Review of an ND document binder showed no documentation to indicate the ALF properly delegated MCMs for administering medications to Resident 1.

In an interview, on 09/13/2024 at 2:30 PM, Staff A (Health Services Director) acknowledged they had not delegated MCMs to administer medications to Resident 1.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(n) Related to food services consistent with chapter 246-215 WAC and WAC 388-78A-2300 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement their policies regarding skin management for 1 of 1 sampled resident (Resident 1) who developed a pressure sore, and also failed to implement their policies and procedures to consistently monitor and document food temperatures (FTs) at required hot and cold FT control prior to serving potentially hazardous food to 12 of 12 residents in the Memory Care Unit (MCU). This resulted in Medication Care Managers (non-licensed staff members) applying prescribed medications to Resident 1's wound and placed Resident 1 at risk for a deteriorated health condition, and 12 residents in MCU at risk for acquiring food borne illness.

Findings included….

SKIN ISSUE
Review of the ALF's policy titled Skin Management Protocol, revised 08/10/2016, under the section on Skin Observation/Wound Observation Record, showed that wound care other than first aid may not be provided in the ALF by anyone other than a licensed nurse or other licensed health care professional.

Records review showed the ALF admitted Resident 1 on [redacted]/2021 with a diagnosis of [redacted]. Review of Resident 1's Individualized Service Plan (ISP - equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/18/2024, showed that nursing staff would complete the "skin irritation treatments" ordered by a physician. The ISP showed that Resident 1 had skin breakdown on their bottom, and trained staff would manage "skin irritation", including the application of creams as ordered.

Review of a Progress Note (PN), dated 06/11/2024, showed that a caregiver reported to nursing about an open area on Resident 1's buttocks. The PN showed a Wellness nurse assessed the wound and found a 1.5 centimeter (cm) x 1 cm open area.

Review of a PN, dated 06/13/2024, showed that the wound had grown to 4.5 cm x 2.5 cm with redness around the edges with broken skin. Review of a PN, dated 06/19/2024, showed that the physician prescribed Silvadene (used to skin breakdown) cream to apply to the pressure sore on buttocks twice a day for seven days.

Review of the June 2024 electronic Medication Administration Records (eMARs) showed that starting on 06/21/2024, MCMs, not nurses, documented they applied Silvadene to Resident 1's open wound twice a day.

Review of a faxed note to the physician, dated 07/04/2024, showed that Resident 1 had a wound that had been treated with Silvadene, but had not improved. Records review showed that on 07/05/2024, the physician had ordered Calmoseptine ointment to be applied to the wound.

Review of the July 2024 eMARs showed that starting on 07/08/2024, MCMs, not nurses, documented they had applied Calmoseptine ointment to Resident 1's wound.

Review of a Current Skin Issue Observation Form (CSIOF), dated 08/05/2024, showed that a wellness nurse assessed Resident 1's wound and measured it at being 2 cm x 1.5 cm. A CSIOF, dated 08/12/2024, showed that the wound was measured at 4 cm x 2 cm, having increased its size.

Review of a PN, dated 08/15/2024, showed that the physician had ordered Silvadene cream to be applied to the wound. Review of the August 2024 eMARs showed that

starting on 08/16/2024, MCMs, not nurses, documented they had applied Silvadene cream to Resident 5's wound.

Review of a PN, dated 08/29/2024, showed that a Wellness nurse assessed the wound on Resident 1's buttock. The PN showed that the wound appeared to be stage 3 (stage 3 ulcers have progressed to breaking completely through the top two layers of the skin and into the fatty tissue below), possible stage 4 (stage 4 pressure ulcers are the most serious and extend below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments and can extend as far down as the cartilage or bone.) Another PN, dated 08/29/2024, showed that Resident 1 was sent to an emergency room for wound treatment.

In an interview, on 09/13/2024 at 12:45 PM, Staff L (MCM) stated that she had applied the prescribed creams to the wound on Resident 1's buttocks.

In an interview, on 09/13/2024 at 2:30 PM, Staff J (Regional Registered Nurse) stated that once a resident had an open skin wound, the wound care should have been conducted only by licensed nurses, as stated in the ALF's policy.

FOOD SANITATION

NOTE: Washington Administrative Code 388-78A-2305 Food sanitation. The assisted living facility must: Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

NOTE: WAC 246-215-03525 Temperature and time control—Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16). (1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained: (a) At 135°F (57°C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400(2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130°F (54°C) or above; or

NOTE: Washington Administrative Code 246-215-03515 - Temperature and time control—Cooling (FDA Food Code 3-501.14). (1) Cooked time/temperature control for safety food must be cooled, uncovered, protected from contamination, in equipment that maintains an ambient air temperature of 41°F (5°C) or less and: (a) In a shallow, uncovered, layer of two inches or less; or

Review of the ALF's Policy and Procedure (P/P), Time & Temp Guidelines for Foods Transferred from Main Kitchen, revised on 05/07/2024, showed, "The facility followed the state and federal guidelines on maintaining accurate food temperature records for potentially hazardous foods that have been transferred from the main kitchen to other

areas of a community for consumption." The P/P included "A food temperature log shall be maintained daily for all meals served to the residents (breakfast, lunch, and dinner) and kept in the main Kitchen. A second temperature/time log will travel with the food to assure the time is being monitored throughout the process… The temperature/time logs shall be kept for a period of 12 months and destroyed thereafter."

In interview, on 09/13/2024 at 9:30 AM, Staff K (Assistant Care Director) stated FT were supposed to be taken and logged for breakfast, lunch, and dinner.

Review of a FT logs, posted in Life's Neighborhood (Memory Care Unit) showed that the log would be maintained at each meal period to record appropriate FTs. The log included instructions such as, "Hot foods should be kept at an internal temperature of 135 degrees F (°F) or warmer. Cold food should be 41°F or colder. Keep cold foods refrigerated or on ice until serving time" and "Minimum Internal temperatures: Beef, Pork, Lamb steaks, chops and roasts: 145 °F; Ground meats: 160 °F; All poultry: 165 °F; Ham: 145 °F; Eggs: °F; Fish and shellfish: 145 °F; Casserole: 165 °F; Vegetables, grains and legumes: 135°F."

Review of the FT log in dining room 2 (DR2), found inconsistent documentation of food temperatures as follows:

There was no FTs from 08/26/2024 through 08/29/2024. On 08/30/2024: Only one food temperature was recorded at lunch for the soup. There were no other FTs recorded for breakfast, lunch, and dinner.

On 08/31/2024, a serving of fruit at breakfast, showed an out of range temperature recorded at 79°F (cold temperature required 41°F (5°C) or less). There were no FTs recorded at lunch and dinner, except soup.

On 09/01/2024, a serving of fruit at breakfast, showed an out-of-range temperature recorded at 80°F, the entrée recorded at 120°F. There were no food temperatures taken (except soup) at lunch and dinner.

On 09/02/2024, There were no FTs recorded at lunch and dinner.

On 09/03/2024, a serving of fish and shellfish at dinner, showed an out-of-range temperature of 90°F.

On 09/04/2024, a serving of fruit at breakfast, showed an out-of-range temperature recorded at 80°F. There were No recorded FTs at dinner.

On 09/05/2024 and 09/06/2024, there were no FTs recorded at lunch and dinner.

On 09/07/2024, there were no FTs recorder for breakfast, lunch, and dinner.

On 09/10/2024, a serving of cold salad at dinner, showed an out-of-range temperature at 54 °F.

On 09/12/2024, a serving of fish and shellfish at dinner, showed an out-of-range temperature at 128.7°F.

In an interview, on 09/13/2024 at 11:10 AM, Staff M (Interim Food Services Director) acknowledged the failure of staff to monitor food temperatures and their policy and procedures.

This is a deficiency previously cited on 02/27/2024.

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Anna White — Administrator (or Representative)

10/28/24 — Date

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to secure toxic chemicals in an area accessible to residents. This failure placed 34 of 34 residents in the ALF at risk for inadvertent ingestion of a toxic substance that

On 09/07/2024, there were no FTs recorder for breakfast, lunch, and dinner.

On 09/10/2024, a serving of cold salad at dinner, showed an out-of-range temperature at 54 °F.

On 09/12/2024, a serving of fish and shellfish at dinner, showed an out-of-range temperature at 126.7°F.

In an interview, on 09/13/2024 at 11:10 AM, Staff M (Interim Food Services Director) acknowledged the failure of staff to monitor food temperatures and their policy and procedures.

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to secure toxic chemicals in an area accessible to residents. This failure placed 34 of 34 residents in the ALF at risk for inadvertent ingestion of a toxic substance that

could cause harm and compromise health.

Findings included...

Review of the undated Resident Characteristics Roster (RCR) showed that 26 residents were identified as having dementia (a group of symptoms that affects memory, thinking and interferes with daily life) or other cognitive impairment and that eight residents were identified as receiving Mental Health services and/or having a mental health case manager.

The ALF's environment observations with Staff I (Director of Operations) and Staff N (Maintenance Director), on 09/11/2024 at 10:58 AM, showed a door to the Salon room in the basement was unlocked. Observation in the Salon room showed three bottles of chemicals, including Peroxide Multi Surface, under the sink in a bathroom. The labels on these chemical bottles showed, "Danger" and "Keep Out of Reach of Children." The basement was accessible to residents in the Assisted Living units.

In an interview, on 09/11/2024 at 11:10 AM, Staff I stated that a receptionist had unlocked the door for the Salon at around 8:00 AM for a person who would be using the Salon that afternoon. Staff I stated that the receptionist should not have opened the Salon until the person arrived.

Plan/Attestation Statement

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Nina White — Administrator (or Representative)

10/28/24 — Date

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that

could cause harm and compromise health.

Findings included…

Review of the undated Resident Characteristics Roster (RCR) showed that 26 residents were identified as having dementia (a group of symptoms that affects memory, thinking and interferes with daily life) or other cognitive Impairment and that eight residents were identified as receiving Mental Health services and/or having a mental health case manager.

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Administrator (or Representative) Date

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(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that

has previously required intervention by others.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to monitor and evaluate 1 of 1 sampled resident's (Resident 10) pain issue. This failure placed Resident 10 at risk for diminished quality of life due to experiencing pain.

Findings included...

Record review showed that the ALF admitted Resident 10 on [redacted]/2024 with multiple diagnoses. Review of Resident 10's combined Assessment/Individual Service Plan (A/ISP - equivalent to Negotiated Service Agreement), dated 09/06/2024, showed Resident 10 required assistance with medication services.

Record review, dated 02/14/2024, showed Resident 10's physician ordered ibuprofen (used to help relieve mild to moderate pain) two tablets every six hours as needed.

Review of the July, August, and September 2024 electronic Medication Administration Records (eMARs) showed Resident 10 requested the as needed ibuprofen on 23 occasions for pain. The eMARs showed that staff recorded Resident 10 had some or no relief of their pain from the ibuprofen.

Record review of the Assessment, dated 09/06/2024, showed no information related to the monitoring or evaluation of the location of the pain, what triggered the pain, what relieved the pain for Resident 10, or when to notify the prescriber for effectiveness and evaluate the need to change her pain medication.

In an interview, on 09/13/2024 at 1:20 PM, Staff A (Health Services Director) acknowledged there had been a lack of monitoring for Resident 10 for pain.

This is a recurring deficiency previously cited under 2(a)(b) on 02/27/2024, 2(a) on 01/27/2023, and 2(b) on 11/01/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 11/28/24.

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

has previously required intervention by others.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to monitor and evaluate 1 of 1 sampled resident's (Resident 10) pain issue. This failure placed Resident 10 at risk for diminished quality of life due to experiencing pain.

Findings included…

Record review showed that the ALF admitted Resident 10 on [redacted]/2024 with multiple diagnoses. Review of Resident 10's combined Assessment/Individual Service Plan (A/ISP - equivalent to Negotiated Service Agreement), dated 09/06/2024, showed Resident 10 required assistance with medication services.

Record review, dated 02/14/2024, showed Resident 10's physician ordered ibuprofen (used to help relieve mild to moderate pain) two tablets every six hours as needed.

Review of the July, August, and September 2024 electronic Medication Administration Records (eMARs) showed Resident 10 requested the as needed ibuprofen on 23 occasions for pain. The eMARs showed that staff recorded Resident 10 had some or no relief of their pain from the Ibuprofen.

Record review of the Assessment, dated 09/06/2024, showed no information related to the monitoring or evaluation of the location of the pain, what triggered the pain, what relieved the pain for Resident 10, or when to notify the prescriber for effectiveness and evaluate the need to change her pain medication.

In an interview, on 09/13/2024 at 1:20 PM, Staff A (Health Services Director) acknowledged there had been a lack of monitoring for Resident 10 for pain.

This is a recurring deficiency previously cited under 2(a)(b) on 02/27/2024, 2(a) on 01/27/2023, and 2(b) on 11/01/2022.

Plan/Attestation Statement

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

Anna White
Administrator (or Representative)

10/28/24
Date

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

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure prescribed medications were available for 3 of 10 sampled residents (Residents 3, 6, and 10), who required staff assistance with medication services. This caused Residents 3, 6, and 10 to go without prescribed medications and placed them at risk medical health complications.

Findings included...

Review of the ALF's revised policy, "Limited Supply Ordering Back-up Medications Process (All states)," dated 03/27/2015 stated, "All medications (cycled and non-cycled) are to be re-ordered when seven-day supply remains. The Medication Care Manager (MCM) is responsible for following up on a daily basis that the medication is received, implements the emergency back-up medication process when the second to last dose of a medication has been administered and there is not a replacement in-house for the last those. Medications coming from a non-preferred / mail-ordered pharmacy: The Aegis community is responsible for ordering the medication. The MCM contacts the pharmacy to identify why the medication is not available and when it arrives, an Aegis employee will pick up the medication to bring the medication to the community. If the non- preferred pharmacy is unable to provide the medication in time, the MCM will order a 7-day emergency back-up supply or enough until the medication is due to be delivered. If medication cannot be obtained, send a fax to the prescribing physician informing them that the medication is not available."

RESIDENT 3
Record review showed that the ALF admitted Resident 3 on [redacted]/2019 with multiple diagnoses including [redacted]. Review of Resident 3's combined Assessment/Individual Service Plan (A/ISP – the ISP is equivalent to Negotiated Service Agreement), dated 07/22/2024, showed that Resident 3 required a delegated staff and / or licensed nurse (LN) to administer their medications, including the special nutritional supplement Ensure every meal.

Review of the June, July, and August 2024 electronic Medication Administration Records (eMARs) showed Ensure three times daily was prescribed by a physician since

Administrator (or Representative) Date

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

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure prescribed medications were available for 3 of 10 sampled residents (Residents 3, 8, and 10), who required staff assistance with medication services. This caused Residents 3, 8, and 10 to go without prescribed medications and placed them at risk medical health complications.

Findings included...

Review of the ALF's revised policy, “Limited Supply Ordering Back-up Medications Process (All states),” dated 03/27/2015 stated, “All medications (cycled and non-cycled) are to be re-ordered when seven-day supply remains. The Medication Care Manager (MCM) is responsible for following up on a daily basis that the medication is received, implements the emergency back-up medication process when the second to last dose of a medication has been administered and there is not a replacement in-house for the last those. Medications coming from a non-preferred / mail-ordered pharmacy: The Aegis community is responsible for ordering the medication. The MCM contacts the pharmacy to identify why the medication is not available and when it arrives, an Aegis employee will pick up the medication to bring the medication to the community. If the non- preferred pharmacy is unable to provide the medication in time, the MCM will order a 7-day emergency back-up supply or enough until the medication is due to be delivered. If medication cannot be obtained, send a fax to the prescribing physician informing them that the medication is not available.”

RESIDENT 3
Record review showed that the ALF admitted Resident 3 on [redacted]/2019 with multiple diagnoses including [redacted] Review of Resident 3’s combined Assessment/Individual Service Plan (A/ISP – the ISP is equivalent to Negotiated Service Agreement), dated 07/22/2024, showed that Resident 3 required a delegated staff and / or licensed nurse (LN) to administer their medications, including the special nutritional supplement Ensure every meal.

Review of the June, July, and August 2024 electronic Medication Administration Records (eMARs) showed Ensure three times daily was prescribed by a physician since

12/11/2020. The eMARs showed that on 08/27/2024 at 6:30 PM, 07/06/2024 at 6:30 PM, 07/07/2024 at 6:30 PM, 08/02/2024 at 12:00 PM, on 08/03/2024 at 8:00 AM, 12:00 PM and 6:30 PM, and 08/04/2024 at 8:00 AM and 12:00 PM, Ensure was not given to Resident 3 because it was documented as being unavailable.

In an interview, on 09/13/2024 at 1:20 PM, Staff I (Director of Operations) and Staff A (Health Services Director) acknowledged that Resident 3 had not received Ensure supplements on the days noted in the eMARs because of supply issues.

RESIDENT 8
Record review showed that the ALF admitted Resident 8 on [redacted]/2024 with multiple diagnoses. Review of Resident 8's A/ISP, dated 08/28/2024, showed Resident 8 required assistance with medication services.

Review of the September 2024 eMARs showed that a physician prescribed Resident 8 to take minocycline (used to treat a certain type of skin condition called rosacea) every morning once daily. The September 2024 eMARs showed that the MCM documented, on 09/09/2024 and 09/10/2024 at 10:00 PM, minocycline was not administered because it was unavailable.

RESIDENT 10
Record review showed that the ALF admitted Resident 10 on [redacted]2024 with multiple diagnoses including [redacted]
Review of Resident 10's A/ISP, dated 09/06/2024, showed Resident 10 required assistance with medication services.

Review of Physician's Orders, dated 02/14/2024, showed Resident 10 was prescribed a daily dose of Aripiprazole (used to treat schizophrenia, bipolar, and depression). Review of the August 2024 eMAR showed that the Aripiprazole, on 08/26/2024, was not given because it was unavailable.

In an interview, on 09/13/2024 at 1:20 PM, Staff I (Director of Operations) and Staff A (Health Services Director) acknowledged residents should not run out of medications.

Plan/Attestation Statement

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12/11/2020. The eMARs showed that on 06/27/2024 at 6:30 PM, 07/06/2024 at 6:30 PM, 07/07/2024 at 6:30 PM, 08/02/2024 at 12:00 PM, on 08/03/2024 at 8:00 AM, 12:00 PM and 6:30 PM, and 08/04/2024 at 8:00 AM and 12:00 PM, Ensure was not given to Resident 3 because it was documented as being unavailable.

In an interview, on 09/13/2024 at 1:20 PM, Staff I (Director of Operations) and Staff A (Health Services Director) acknowledged that Resident 3 had not received Ensure supplements on the days noted in the eMARs because of supply issues.

RESIDENT 8
Record review showed that the ALF admitted Resident 8 on [redacted]/2024 with multiple diagnoses. Review of Resident 8's A/ISP, dated 08/28/2024, showed Resident 8 required assistance with medication services.

Review of the September 2024 eMARs showed that a physician prescribed Resident 8 to take minocycline (used to treat a certain type of skin condition called rosacea) every morning once daily. The September 2024 eMARs showed that the MCM documented, on 09/09/2024 and 09/10/2024 at 10:00 PM, minocycline was not administered because it was unavailable.

RESIDENT 10
Record review showed that the ALF admitted Resident 10 on [redacted]/2024 with multiple diagnoses including [redacted]. Review of Resident 10's A/ISP, dated 09/06/2024, showed Resident 10 required assistance with medication services.

Review of Physician's Orders, dated 02/14/2024, showed Resident 10 was prescribed a daily dose of Apiprazole (used to treat schizophrenia, bipolar, and depression). Review of the August 2024 eMAR showed that the Apiprazole, on 08/26/2024, was not given because it was unavailable.

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Administrator (or Representative) — 10/28/24 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 interview, the Assisted Living Facility (ALF) failed to ensure 1 of 1 staff (Staff K) properly washed their hands during food preparation and before serving meals to residents. This failure placed 12 of 12 residents in the Memory Care Unit at risk for acquiring foodborne illness.

Findings included...

NOTE: Washington Administrative Code 246-215-02305 Hands and arms—Cleaning procedure (Food and Drug Administration Food Code 2-301.12). (1) Except as specified in subsection (4) of this section, food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped as specified under WAC 246-215-05210 and Part 6, Subpart C.

During observation at breakfast, on 09/13/2024 at 8:55 AM, Staff K (Assistant Care Coordinator), rolled hot food cart from the main kitchen on the 2nd floor into the MCU dining room 2 (DR2) kitchenette. Without handwashing or donning gloves, Staff K pulled out food containers from the hot cart onto the steam table.

At 9:03 AM, without washing her hands or donning gloves, Staff K, opened a drawer, took a thermometer, pulled the thermometer cover, and without wiping or sanitizing the thermometer stem, took the temperature of a sausage from the steam table, then proceeded to take another food temperature. At that time Staff K was asked when she would wash her hands during this process or if she would sanitize the thermometer.

In interview, on 09/13/2024, at 9:05 AM, Staff K stated, "I am in a hurry, because it was already late for the residents, but usually I wash my hands." Staff K acknowledged her lack of handwashing or sanitizing the thermometer prior to handling the food for residents.

Plan/Attestation Statement

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 interview, the Assisted Living Facility (ALF) failed to ensure 1 of 1 staff (Staff K) properly washed their hands during food preparation and before serving meals to residents. This failure placed 12 of 12 residents in the Memory Care Unit at risk for acquiring foodborne illness.

Findings included…

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Statement of Deficiencies	License # 2361	Compliance Determination # 47206
Plan of Correction	Aegis of Queen Anne at Rodgers Park	Completion Date
Page 26 of 26	Licensee: Aegis Senior Communities LLC	10/14/2024

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, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 11/28/24.

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

Anna White — Administrator (or Representative)

10/28/24 — Date

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, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date)_____ .

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_____ _____

Administrator (or Representative) Date