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

AMENDED
08/27/2024

Elma Homecare, Inc
Elma Home Care
PO Box 759
Elma, WA 98541

RE: Elma Home Care License # 2383

Dear Administrator:

This letter addresses Compliance Determination(s) 45152 (Completion Date 08/07/2024) and 41198 (Completion Date 05/30/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/07/2024 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-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3100-2, WAC 388-78A-3100-4, WAC 388-78A-3100-1, WAC 388-78A-2400-2, WAC 388-78A-2060, WAC 388-78A-2060-1, WAC 388-78A-2060-2, WAC 388-78A-2060-3, WAC 388-78A-2060-4, WAC 388-78A-2060-5, WAC 388-78A-2060-6, WAC 388-78A-2060-7, WAC 388-78A-2060-8, WAC 388-78A-2600-1-d, WAC 388-78A-2600-2-n, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-1, WAC 388-78A-2130-1, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-3-a, WAC 388-78A-2462-3-a, WAC 388-78A-2160, WAC 388-78A-2640-1-a, WAC 388-78A-2640-3, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2510, WAC 388-78A-2500-2, WAC 388-78A-2500-2-a, WAC 388-78A-2500-2-b, WAC 388-78A-2500-2-c, WAC 388-78A-2500-2-d, WAC 388-78A-2500-1, WAC 388-78A-2500, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-c, WAC 388-78A-2100-2-b-iii, WAC 388-78A-2100-2-a, WAC 388-78A-2480, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2483-2, WAC 388-78A-2483, WAC 388-78A-2483-1, WAC 388-78A-2484-2, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2305-1, WAC 388-78A-2300-1-f, WAC 388-78A-2300-1-c-iii, WAC 388-78A-2300-1-g, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-3, WAC 388-78A-2140-5, WAC 388-78A-2450-2-h-v

The Department staff who did the on-site verification:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

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

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

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

The department completed data collection for the unannounced on-site full inspection on 05/14/2024, 05/15/2024, 05/16/2024 and 05/30/2024 of:
Elma Home Care
901 West Young St
Elma, WA 98541

The following sample was selected for review during the unannounced on-site visit: 6 of 20 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

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

Residential Care Services

06/05/2024
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) 6-7-2024 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 5 of 5 areas within the building (TV Room, outside areas, kitchen, guest bathroom, and Resident 4 Bedroom). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean for 1 of 1 facility reviewed. These failures placed 20 of 20 residents at risk for to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included..

Record review of the facility's "Building Maintenance and Upkeep Policy", effective date 05/15/2024, showed the facility ensured a safe, clean, and comfortable living enforcement for residents. The facility was to maintain the building, equipment, and grounds as needed. They were to inspect the grounds quarterly and notate any concerns. They were to fix any maintenance issues in a timely manner.

Outside areas
In an observation on 05/14/2024 at 8:50 AM, the outside of the buildings fence showed there was a ladder standing up right. Half the ladder was on one the outside of the fence while the other half of the ladder was on the inside of the fence.

In an observation on 05/14/2024 at 8:52 AM, the outside of the buildings side door entrance porch patio showed cobwebs, spiders, and dirt particles that covered the white ceiling.

In an observation on 05/14/2024 at 9:20 AM, the outside entrance to the facility showed the black railings for the ramp and stairs were covered in orange and red rusted spots.

In an observation on 05/14/2024 at 9:23 AM, on the back side of the building one of the

Administrator (or Representative) Date

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In an observation on 05/14/2024 at 9:20 AM, the outside entrance to the facility showed the black railings for the ramp and stairs were covered in orange and red rusted spots.

In an observation on 05/14/2024 at 9:23 AM, on the back side of the building one of the

two window screens had a large rip and hole.

In an observation on 05/14/2024 at 9:24 AM, the outside fenced in area showed an empty carton of cigarettes had been left on the top of the wood that covered the crawl space.

In an observation on 05/14/2024 at 9:28 AM, on the left side of the facility closest to the neighboring house, five of the seven windows did not have screens on them. There were two windows that were propped open with a pick of wood, [redacted]

In an observation on 05/14/2024 at 9:32 AM, in the covered smoking section showed a wood structure that was propped against the fence and was partially behind the garbage can. Multiple unknown residents were observed to sit on top of the wood structure. One resident sat to the right side of the garbage can. There were a total of 4 chairs in the uncovered and covered smoking section that were available for use. There were observed to be more residents who smoked then there were chairs available.
In an observation on 05/14/2024 at 9:34 AM, on the right side of the building closet to the street showed straw and grass laid on top of the green drain catcher.

TV Room
In an observation on 05/14/2024 at 9:12 AM, the TV room showed one of two opened windows did not have a screen. The window without a screen was opened 1.10 feet. There was a wooden plank of wood on the outside of the window.

In an observation on 05/14/2024 at 9:16 AM, the TV room showed on the left wall to the right of the door there was a thermostat that had tape over the temperature dial. Below the taped thermostat was a couch that covered a heater that was attached to the wall. On the other side of the room showed a door that was covered by a free-standing entertainment center.

In an observation on 05/14/2024 at 10:23 AM, the TV room showed on the entertainment center there was a black binder labeled "Inspection Report" that had a silver chain attached to it. The chain was not anchored to anything, and the binder was able to be moved.

In an interview on 05/14/2024 at 10:41 AM, Staff A, Administrator, said the black binder labeled "Inspection Report" used to be anchored to the wall because the residents would move it. Staff A said the residents got used to the binder being in the TV room because when it was unchained the residents did not touch it.

Kitchen
In an observation on 05/14/2024 at 3:42 PM, the kitchen storage area showed when you entered there were missing floor tiles that caused an uneven walking surface

In an observation on 05/14/2024 at 11:28 AM, the kitchen drawer next to the

two window screens had a large rip and hole.

In an observation on 05/14/2024 at 9:24 AM, the outside fenced in area showed an empty carton of cigarettes had been left on the top of the wood that covered the crawl space.

In an observation on 05/14/2024 at 9:28 AM, on the left side of the facility closest to the neighboring house, five of the seven windows did not have screens on them. There were two windows that were propped open with a pick of wood, and a black round object.

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In an observation on 05/14/2024 at 9:16 AM, the TV room showed on the left wall to the right of the door there was a thermostat that had tape over the temperature dial. Below the taped thermostat was a couch that covered a heater that was attached to the wall. On the other side of the room showed a door that was covered by a free-standing entertainment center.

In an observation on 05/14/2024 at 10:23 AM, the TV room showed on the entertainment center there was a black binder labeled "Inspection Report" that had a silver chain attached to it. The chain was not anchored to anything, and the binder was able to be moved.

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Kitchen
In an observation on 05/14/2024 at 3:42 PM, the kitchen storage area showed when you entered there were missing floor tiles that caused an uneven walking surface.

In an observation on 05/14/2024 at 11:28 AM, the kitchen drawer next to the

handwashing sink showed face masks mixed between kitchen utensils such as a rolling pin, potato masher, and spatula.

In an interview on 05/14/2024 at 11:25 AM, Staff B, Cook, said they wished they organized their kitchen drawers. Staff B said they did not have enough time to go through the kitchen.

In an observation and interview on 05/14/2024 at 4:00 PM, the kitchen pantry showed individually packaged bags of cereal were stored inside a clear zip lock bag. Inside the zip lock bag was a black live moving insect. Staff B confirmed the insect was alive and retrieved it out of the zip lock bag. After the insect was moved Staff B repacked the zip lock bag with the individually wrapped cereal and placed the bag on the pantry shelf.

In an observation on 05/15/2024 at 12:36 PM, the kitchen showed 1 of 3 kitchen doors did not have a frame on the inside of the kitchen. Two pieces of frame were propped up in the corner of the kitchen behind the trash can.

Guest Bathroom
In an observation on 05/14/2024 at 9:55 AM, the public bathroom showed upon entering there were three stripes of duct tape on the silver floor trim taped to the ground. One of two round lights on the ceiling did not have a protective cover. The bottom of the mirror attached to the wall had chipped and was peeling upwards. The bottom of the sinks silver drain had a brown spot that covered the silver surface. The right and left sink knobs had white and blue substances imbedded into the base of the faucet. The toilet paper dispenser attached to the wall was missing the piece that held the toilet paper. The silver hose attached to the toilet and wall had a white substance that covered the base of the hose. The circular attachment to the hose had separated and had come off the wall. Behind the shower curtain showed the top portion of the shower tile had been stripped back and a gap had formed.

Resident 4's Bedroom
In an observation on 05/16/2024 at 9:49 AM, behind R4's bedroom door was a hole in the wall. When the door was open R4's bedroom door handle went through the wall and was the shape of the hole in the wall.

In an interview on 05/16/2024 at 9:43 AM, Staff A, Administrator, said they were considered to be the maintenance staff for the building. Staff A said they had received multiple quotes in regard to replacing the facility windows. Staff A said after they received the quote the contractor did not follow up with them. Staff A said they did not have a current plan in place to fix the facility windows. Staff A said there was tape on the thermostat in the TV room because the heater did not work. Staff A said the heater had not worked since the 1990's. Staff A said the couch in front of the heater and the free-standing entertainment center in front of the door would be a safety concern. Staff A said the kitchen did not have trim on the inside of one of the doors because they took it off to fit a commercial fridge through. Staff A said they had not put the trim back on after the project had been completed. Staff A said the owners had intentions to remodel the guest

bathroom but there were no current plans to review.

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024.

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

Administrator (or Representative) 6-10-2024 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;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies for assisted living resident for 5 of 5 locations (hallway, Laundry room, television (TV) room, guest bathroom, and kitchen). This failure placed 20 of 20 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's "Chemical Handling and Storage Policy", effective date 05/15/2024, showed all chemicals in the facility must be labeled with the product name and safety information. Chemicals were not to be stored in unmarked or plain containers. All chemicals were to be stored out of reach or locked away from resident access.

Hallway

In an observation on 05/14/2024 at 9:18 AM, the front entrance door showed a filing cabinet. Inside the unlocked top drawer there was a bottle of Clorox disinfecting wipes.

Laundry Room

bathroom but there were no current plans to review.

Plan/Attestation Statement

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Hallway
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Laundry Room

In an observation on 05/15/2024 at 9:10 AM, the door to the laundry room handle was locked but unlatched. The door was able to be pushed open and inside the laundry room was two large bottles of arm and hammer oxi clean detergent, a red plastic container labeled, "ultra clean tough stain fighting power laundry detergent pacs", and multiple other chemical bottles all unlocked.

TV Room
In an observation on 05/14/2024 at 10:17 AM, the TV room showed on the shelf in the puzzle area there was a "shark carpet xpert deep clean pro for stain striker". In a box on the bottom of the shelving unit showed a bottle of shark stain striker oxy multiplier.

In an observation on 05/14/2024 at 10:20 AM, the TV room showed on the DVD shelf the unlocked cabinet showed three boxes of "terro multi surface liquid ant's baits". There was one box of "terry and killer liquid ant baits". There was one opened box of four ounces of "terro outdoor liquid ant baits".

Guest Bathroom
In an observation on 05/14/2024 at 9:55 AM, the unlocked public bathroom showed on top of the paper towel dispenser had a bottle of Clorox disinfecting mist and one all purpose cleaner.

In an observation on 05/15/2024 at 12:47 PM, the unlocked public bathroom showed the two bottles of chemicals remained on top of the paper towel dispenser.

Kitchen
In an observation on 05/14/2024 at 11:22 AM, three of three doors in the kitchen were unlocked. Two of three doors in the kitchen were opened. One door led to the dining room and the other opened door led to a communal hallway where residents rooms were located. At 11:25 AM, next to the hand washing sink showed a clear bottle with a clear liquid inside of it. There was not a label on the bottle to review.

In an interview on 05/14/2024 at 11:25 AM, Staff B, Cook, said the clear bottle with the clear liquid was a rubbing alcohol like a sanitizer.

In an observation on 05/14/2024 at 11:26 AM, under the hand washing sink in an unlocked cabinet showed two multipurpose cleaner lemon scent, one Lysol kitchen pro anti-bacterial cleanser, one green works all-purpose cleaner, ECOS plant powdered all-purpose cleaner, one seventh generation disinfecting multi surface cleaner, one stronger than dirt ajax with bleach, one Lysol disinfectant spray, and one honest disinfecting spray that has hand written letters written over the bottle that says "Murphey".
In an observation on 05/14/2024 at 12:05 PM, under the dishwashing sink open area showed one simple green heavy duty bbq cleaner, one multipurpose cleaner, one Lysol quaternary disinfectant cleaner, one bottle of Clorox, and one clear bottle with a blue liquid inside that was not labeled.

In an interview and observation on 05/14/2024 at 4:06 PM, Staff B, Cook, said chemicals were supposed to be put up and away. Staff B acknowledged even though the residents were not supposed to be in the kitchen they had access to the chemicals that were left out through the three kitchen doors and open kitchen window. Staff A, Administrator said chemicals were supposed to be labeled. Staff B said they saw an unlabeled chemical with a blue liquid under the dishwashing sink. Staff B said they did not know what was inside the container.

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 6.14.2024

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

Administrator (or Representative) 6/10/24 Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure confidentiality of resident records, for 1 of 1 inspection binders reviewed. This failure placed 20 of 20 residents at risk for exposure of confidential records.

Findings included...

Record review of "Resident/Staff List Confidential Information Do Not Disclose to Public" dated, 03/20/2019 and 03/21/2019, showed seven resident's first and last names that were available to review. There was a handwritten smiley face on the document.

Record review of an untitled document, dated 05/09/2018, showed two resident's first and last names that were available to review.

Record review of "Confidential Do Not Post" dated, 12/21/2011 and 12/22/2011, showed five resident's first and last names that were available to review.

In an observation on 05/14/2024 at 10:23 AM, the black binder labeled "Inspection Report" that had a silver chain attached to it had three documents with residents' confidential information that was available to review.

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In an interview on 05/14/2024 at 10:41 AM, Staff A, Administrator, said the three pages of

information with residents' confidential information that were in the survey binder should not have been in there to review.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 6-10-24

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the facility failed to perform a preadmission assessment for 1 of 5 sampled residents (Resident 1 [R1]). This failure placed Resident 1 at risk for not having an assessment to identify and meet the resident's healthcare needs.

Findings included...

Record review of the facility's policy titled, "5.01 Assessments, Ongoing, and Change in Condition Assessments", dated 02/29/2024, showed to ensure that each resident's needs

information with residents' confidential information that were in the survey binder should not have been in there to review.

Plan/Attestation Statement

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Administrator (or Representative) Date

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Based on record reviews and interviews, the facility failed to perform a preadmission assessment for 1 of 5 sampled residents (Resident 1 [R1]). This failure placed Resident 1 at risk for not having an assessment to identify and meet the resident's healthcare needs.

Findings included...

Record review of the facility's policy titled, "5.01 Assessments, Ongoing, and Change in Condition Assessments", dated 02/29/2024, showed to ensure that each resident's needs

and preferences were identified in a timely manner and incorporated into the Negotiated Service Agreement (NSA) providing directions for caregivers in delivering care that meets these needs. The assessment identifieds services that promote the highest level of function and support the residents right to dignity and choice, while the NSA will identify care and service needs to be provided. The licensed nurse or other qualified assessor would complete a preadmission assessment as soon as possible for prospective residents.

Record review of R1's "Resident Information Sheet", undated, showed R1 moved into the facility on [redacted]2023.

Record review of R1's records as of 05/15/2024 showed there was no preadmission assessment to review.

In an interview on 05/16/2024 at 2:14 PM, Staff A, Administrator, stated R1 did not have a preadmission assessment for the Department to review.

The facility was unable to provide a record as evidence that a preadmission assessment had been completed for R1.

Plan/Attestation Statement

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

Administrator (or Representative) 6-10-24 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:

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 68.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(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:

and preferences were identified in a timely manner and incorporated into the Negotiated Service Agreement (NSA) providing directions for caregivers in delivering care that meets these needs. The assessment identifieds services that promote the highest level of function and support the residents right to dignity and choice, while the NSA will identify care and service needs to be provided. The licensed nurse or other qualified assessor would complete a preadmission assessment as soon as possible for prospective residents.

Record review of R1's "Resident Information Sheet", undated, showed R1 moved into the facility on [redacted]2023.

Record review of R1's records as of 05/15/2024 showed there was no preadmission assessment to review.

In an interview on 05/16/2024 at 2:14 PM, Staff A, Administrator, stated R1 did not have a preadmission assessment for the Department to review.

The facility was unable to provide a record as evidence that a preadmission assessment had been completed for R1.

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, Elma Home Care 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-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:

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(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 interview and record review, the facility failed to update and implement their policy for respiratory protection for 1 of 1 facility reviewed. This failure placed 20 of 20 residents and all staff members at risk of not having the proper guidance and training for respiratory protection.

Findings included...

Respiratory Protection Policies

Record review of the dear provider letter number 2023-014, dated 03/30/2023, showed that the Secretary of Health announced the order that required wearing a face covering in long term care facilities had ended on 04/03/2023. Despite that the order had ended the individuals in long-term care facilities, including residents, staff, and visitors, were required to continue to follow the Department of Health (DOH) and Centers of Disease Control and Prevention (CDC) guidance. Facilities were asked to revise their policies to reflect the updated guidance by 05/01/2023. Facilities may create their own policies that require staff and ask residents and visitors to wear a face covering, as long as they were at least as stringent as DOH and CDC guidance. Respiratory Protection Program (RPP) requirements were not changed by the ending of the Secretary of Health's order, nor would they change when the federal public health emergency ended on 05/11/2023. Staff would still be required to wear N95 respirators around individuals with suspected or confirmed COVID-19 (Corona Virus Disease 2019- an infectious communicable disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, 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) , and an RPP was required anytime a respirator was used in a long-term care facility. An RPP must include medical clearance, fit testing, training, written policies, and documentation.

Record review of CDC's document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", dated 05/08/2023, showed with the end of the federal COVID-19 Public Health Emergency (PHE) on 05/11/2023, CDC was no longer receiving data needed to publish Community Transmission levels for SARS-CoV-2. This metric informed CDC's recommendations for broader use of source control in healthcare facilities to allow for earlier intervention, to avoid strain on a healthcare system, and to better protect individuals seeking care in these settings. Source control was recommended more broadly as described in CDC's core infection prevention control by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high). Under the section titled, "Assisted Living, Group Homes and Other Residential Care Settings (excluding nursing homes)", showed follow community prevention strategies based on COVID-19 hospital admission levels, similar to independent living, retirement communities or other non-healthcare congregate settings.

Record review of the Centers for Disease Control and Prevention (CDC) document titled, "Healthcare Respiratory Protection Resources", undated, showed the toolkit was developed to assist the healthcare setting to develop and implement effective respiratory protection programs with an emphasis on preventing the transmission of aerosol transmissible diseases (ATD [micro sized infectious particles that are spread through air or by contact through inhaling or by direct contact to eyes, nose, or mouth]) to healthcare personnel. Healthcare personnel were paid and unpaid persons who provide patient care in a healthcare setting or support the delivery of healthcare by providing clerical, dietary,

housekeeping, engineering, security, or maintenance services. Healthcare personnel may potentially be exposed to ATD pathogens. Aerosols are particles or droplets suspended in air. ATDs are diseases transmitted when infectious agents, which were suspended or present in particles or droplets, contact the mucous membranes or were inhaled. Healthcare settings had an important role to protect their workers from exposure to all types of respiratory hazards and implement their respiratory protection programs (RPP). The RPP were to help implement and protect health care workers from job-related risks of exposure to infectious respiratory illnesses. When an outbreak of infectious disease occurred in a health care setting, the healthcare professionals were relied on to care for those affected, by putting themselves at increased risk of exposure to the pathogen causing disease.

Record review of the Washington State Department of Health document titled, "Respiratory Protection Program for Long-Term Care Facilities", undated, showed "employers have an obligation to protect their employees from hazards in the workplace. Providing your workforce with respiratory protection against respiratory hazards regulated and enforced by the Washington Department of Labor and Industries. Healthcare facilities commonly use the tight-fitting disposable N95 respirator for worker respiratory protection. Keep your workers safe by establishing your respirator program so they are ready to use a respirator at any given time". Under the section titled, "written program", showed "the written respiratory protection program describes your facility's procedures for respiratory protection. It serves as a reference for the facility workers and helps them understand how to protect themselves from exposure to respiratory hazards while at work. A Respiratory Protection Program template for COVID-19 in Long-Term Care Facilities. This template was designed by L&I (Labor and Industries- government department that regulates and enforces labor standards) for Long Term Care Facilities. The required elements of your written respirator program should include:
How your worker's can select a N95
How the medical evaluation for respirator use will be done
Who will provide the fit testing and what type of fit testing
How the training will be done to learn how to properly use the N95 and who will provide the training
When the N95 will be used
Where the N95s supply will be kept and any exceptions for storing them
How you will evaluate your program for effectiveness".

Record review of the facility's "Respiratory Protection Program for use by Healthcare Facilities during the COVID-19 Pandemic", dated March 2021, showed according to state and federal regulations, workplaces with workers that are required to wear fit tested respirators must have an established "Respiratory Protection Program". The respiratory protection program showed use of the respirators at the facility was to protect against transmission of the SARS COV-2 virus and other airborne diseases. The program showed CDC guidance was consistent with DOSH's PPE guidelines for those workers in its "extremely high-risk category", which was for workers at a higher risk than those in the "high risk category", workers were directed to wear FDA-approved FFR's or surgical masks with face shields. The RPP only identified SARS COV-1 virus as a healthcare respiratory hazard.

In an interview on 05/17/2024 at 10:53 AM, Staff A, Administrator stated the RPP that was provided to the Department was the most updated RPP the facility followed.

Statement of Deficiencies	License #: 2363	Compliance Determination # 41156
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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024

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

Administrator (or Representative) — Date: 6-10-2024

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 has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action,

(a) The changes identified in the resident per subsection (2) of this section, and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor the resident's well-being after a fall, a change in residents' condition, and after resident sustained injuries at the facility for 4 of 5 sampled residents (Resident 2, Resident 4, Resident 3, and Resident 6). This failure placed all residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy and procedure titled, "Alert Charting", undated, showed alert charting would be implemented for each resident as specified in the procedure that follows. The policy was to establish standards of practice for documenting and monitoring a resident with a change of condition or a temporary medical problem or behavioral concern. Resident conditions or events that would require charting include but not limited to or directed by the licensed nurse included falls, new medications, infections or illnesses, changes in level of consciousness, behavioral changes, change in appetite or fluid intake, and change in ability to complete or preform activities of daily living. The

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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 has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor the resident's well-being after a fall, a change in residents' condition, and after resident sustained injuries at the facility for 4 of 5 sampled residents (Resident 2, Resident 4, Resident 3, and Resident 6). This failure placed all residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy and procedure titled, "Alert Charting", undated, showed alert charting would be implemented for each resident as specified in the procedure that follows. The policy was to establish standards of practice for documenting and monitoring a resident with a change of condition or a temporary medical problem or behavioral concern. Resident conditions or events that would require charting include but not limited to or directed by the licensed nurse included falls, new medications, infections or illnesses, changes in level of consciousness, behavioral changes, change in appetite or fluid intake, and change in ability to complete or preform activities of daily living. The

document showed that each med tech (medication technician) was responsible for initiating alert charting.

Record review of the facility's document titled, "Alert Charting Guidelines", undated, showed alert charting was to be completed for most changes, once each shift, and for a minimum of 72 hours.

Resident 2 (R2)

Record review of R2's "resident log", dated 02/18/2024 at 4:14 AM, showed the caregiver heard a loud noise and found R2 on the floor on their knees next to their bed in their room. R2 told the caregiver that they were trying to get up on the bed. There was no other documentation completed for dates 02/19/2024 through 02/22/2024 for review.

Record review of R2's "resident log", dated 03/04/2023 at 8:00 PM, showed R2 was found covered up with a blanket laying on the floor. R2 stated they had fallen while getting into bed and hurt their back on the dresser on their way down. R2 had a scratch on her back that was two inches long on the right side. There was no further documentation about how R2 was doing after the fall and if the scratch on R2's back was healing. The next entry for R2 that was documented was dated 03/06/2024 that showed "removed resident from alert".

Record review of R2's "Notes", dated 04/13/2024 at 3:44 PM, showed R2 had a fall that afternoon in their room that required two staff members to assist R2 up off the ground. R2 complained of knee pain. The caregiver documented that R2 had some redness to their knees. The caregiver placed R2 on alert charting for 24 hours.

Record review of R2's "Notes", dated 04/14/2024 at 2:46 PM, showed R2 was taken off alert. R2 was feeling better with no complaints of any pain from yesterday's fall. There was no documentation about R2's redness on their knees or any other documentation about how R2 was doing from the fall.

Record review of R2's "Notes", dated 04/23/2024 at 4:18 PM, showed R2's brief had rubbed the skin on the crease of their leg causing it to hurt. The caregiver looked at R2's leg and documented they observed skin break down on the left leg near the groin area. Desitin (a medicated ointment used to moisturize the skin) was applied and R2 was told to keep the area dry. There was no further documentation until 05/02/2024 at 2:48 PM that was about appointments.

Record review of R2's "Notes", dated 05/10/2024 at 12:32 AM, showed R2 returned from the hospital at 11:50 PM. R2 had new orders to wear a sling for comfort for 5 to 7 days, but would need to remove it for the times their walker was used. R2 was to use cold compressions 2 to 3 times and Tylenol. There was no further documentation as to what injury R2 had or any other details.

R4

Record review of R4's "resident log", dated 01/31/2024 (no time documented), showed R4 had dropped weight. The note showed R4 had bought diet pills from the local store. The next documented note was dated 02/21/2024 about R4 having an appointment. There was no further documentation about R4's weight.

R3

Record review of R3's "notes", dated 04/01/2024 at 3:44 AM, showed R3 was sitting at the dining room table with the administrator when R3 began making sexual gestures at another resident. R3 denied behaving that way. The administrator saw R3 continue to make sexual gestures at the other resident. The administrator and R3 had to leave to R3's room to stop the behavior. The next documented note was on 04/16/2024 at 3:19 PM that was about R3 having a visitor. There was no further documentation about the residents change in behavior.

In an interview on 04/15/2024 at 11:26 AM, Staff A, Administrator, stated alert charting was to be completed each shift. Staff A stated alert charting was not always completed for the residents.

In an interview on 04/15/2024 at 11:51 AM, Staff H, Certified Nursing Assistant/Coverage, stated all caregivers were responsible to chart on all the residents that were on alert for anything. Staff H stated the caregivers worked 10-hour days. Staff H stated for all medication changes, the resident would be on alert charting for seven days, fall without any injuries for 24 hours and with an injury would be seven days.

R6

Record review of R6's "Notes", dated 04/16/2024 at 1:13 PM, showed R6 reported to Staff A, Administrator, that the sound devices in their eyes were telling them to hurt themselves.

Record review of R6's "Notes" dated 04/16/2024 at 9:19 PM, showed R6 stated they felt better today.
There were no further notes to review regarding R6's statement that the sound devices told them to hurt themselves.

In an interview on 03/15/2024 at 3:40 PM, Staff A, Administrator, said when R6 reported they wanted to hurt themselves Staff A should have initiated alert charting and had facility staff check on R6

Plan/Attestation Statement

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

Administrator (or Representative) — 6-10-2024 Date

R3

Record review of R3's "notes", dated 04/01/2024 at 3:44 AM, showed R3 was sitting at the dining room table with the administrator when R3 began making sexual gestures at another resident. R3 denied behaving that way. The administrator saw R3 continue to make sexual gestures at the other resident. The administrator and R3 had to leave to R3's room to stop the behavior. The next documented note was on 04/16/2024 at 3:18 PM that was about R3 having a visitor. There was no further documentation about the residents change in behavior.

In an interview on 04/15/2024 at 11:25 AM, Staff A, Administrator, stated alert charting was to be completed each shift. Staff A stated alert charting was not always completed for the residents.

In an interview on 04/15/2024 at 11:51 AM, Staff H, Certified Nursing Assistant/Coverage, stated all caregivers were responsible to chart on all the residents that were on alert for anything. Staff H stated the caregivers worked 10-hour days. Staff H stated for all medication changes, the resident would be on alert charting for seven days, fall without any injuries for 24 hours and with an injury would be seven days.

R6

Record review of R6's "Notes", dated 04/15/2024 at 1:13 PM, showed R6 reported to Staff A, Administrator, that the sound devices in their eyes were telling them to hurt themselves.

Record review of R6's "Notes" dated 04/16/2024 at 9:19 PM, showed R6 stated they felt better today.
There were no further notes to review regarding R6's statement that the sound devices told them to hurt themselves.

In an interview on 03/15/2024 at 3:40 PM, Staff A, Administrator, said when R6 reported they wanted to hurt themselves Staff A should have initiated alert charting and had facility staff check on R6.

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) Date

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

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop an initial Negotiated Service Agreement (NSA) following admission to the facility for 2 of 2 newly admitted residents (Resident 1 [R1] and Resident 2[R2]). The facility failed to update the residents NSA when there was a change in physical and mental changes for 2 of 5 residents (R2, Resident 3 [R3]). These failures placed both residents at risk of unmet care needs and decreased quality of life.

Findings included...

Initial NSA

R1

Record review of R1's "Resident Information Sheet", undated, showed R1 moved into the facility on [redacted]2023 with multiple medical diagnoses that included [redacted].

Record review of R1's Negotiated Service Agreement (NSA), undated showed under the section "plan of care/negotiated service agreement signatures" showed, "initial full negotiated service agreement (completed within 30 days of move-in) was signed by the resident on 01/16/2024 and by Staff A, Administrator on 12/19/2023. The NSA was completed 20 days after R1 moved into the facility.

Record review of R1's medical chart on 05/15/2024, showed there were no other negotiated service agreements that had been completed for R1 for review.

R2

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and

Sample Selection", undated, showed R2 moved into the facility on [redacted]2023.

Record review of R2's "pre-admission assessment", dated 10/08/2023, showed R2's estimated admission to the facility was on 11/01/2023. The assessment showed R2 was legally blind and required extra help with their television. R2 had poor hearing that required people to talk loud and clearly. R2 required reminders to clean their dentures and denture cup. R2 needed reminders for meals, assistance with bathing tasks, and assistance with getting mediations that required R2 to take them with yogurt. R2 had multiple medical diagnoses that included [redacted] and [redacted].

Record review of R2's Negotiated Service Agreement (NSA), undated, showed under the section "plan of care/negotiated service agreement signatures" showed, "initial full negotiated service agreement (completed within 30 days of move-in) was signed by the resident on 11/20/2023 and by Staff A on 11/20/2023. The NSA was completed 16 days after R2 moved into the facility.

In an interview on 05/14/2024 at 2:56 PM, Staff A stated all the residents NSA's were filed in their hard medical chart for review. Staff A stated the NSA for R2 dated 11/20/2023 was the only completed NSA for R2.

Update NSA

R2

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [redacted]2023.

Record review of R2's NSA, dated 11/20/2023, under the section titled, "mobility-ambulation" showed R2 had unsteady gait and used a walker. R2 had history of falls that recently occurred in their bedroom on 11/06/2023 and 11/16/2023. The section showed R2 was legally blind and staff were to make sure pathways were clear for R2 to walk safely. R2's balance was unsteady and if staff noticed R2 to have troubles they were to assist R2 with walking. The NSA showed there were no updated information documented since 11/20/2024 for review.

Record review of the facility's "Incident and Abuse Investigation Log, undated showed R2 had a fall on 02/18/2024 and 03/04/2024.

Record review of R2's "incident report", dated 02/18/2024 at 4:14 AM, showed R2 was found on the floor on their knees next to their bed in their room. The incident showed R2's bathroom was occupied by the roommate and attempted to use the trash can to go to the bathroom and fell. Staff educated R2 to use the hallway bathroom.

Record review of R2's "incident report", dated 03/04/2024 (no documented time), showed R2 was found by their roommate lying on the ground next to their
bed covered with a blanket. R2 told the staff member that she had slipped and fell. R2 was unable to get up by themselves and covered up with a blanket and waited for help. Under

the section titled, "summary of assessment of contributing factors", showed R2's walker had gotten caught on the nightstand. The staff moved the night stand out more for prevention. The incident report showed the NSA was not revised due to the incident.

Record review of R2's "incident report", dated 04/13/2024 at 3:18 PM, showed R2 was found on the floor next to their bathroom door. R2 told the staff member that they "were coming out of the bathroom and just fell". The incident report showed there was no updates made to the NSA.

Record review of R2's "Notes", dated 05/10/2024 at 12:32 AM, showed R2 returned from the hospital at 11:50 PM. R2 had new orders to wear a sling for comfort for 5 to 7 days, but would need to remove it for times walker was used. R2 was to use cold compressions 2 the 3 times and Tylenol. There was no further documentation as to what injury R2 had or any other details.

Record review of R2's hospital after visit summary dated 05/09/2024, showed R2 had a strain of their left shoulder and had new orders for R2 to use a sling for comfort for the next 5 to 7 days but to remove it for the times their walker was used, a cold compression for 2 to 3 days, and use of Tylenol for discomfort. This information was not included in R2's NSA.

R3

Record review of R3's NSA, dated 04/17/2024, under the section titled, "mobility- ambulation", showed R3 required limited assistance. R3 had an unsteady gait and used a manual wheelchair. R3 had a history of falls with the last one occurring on 03/23/2023. Staff were to encourage R3 to use their walker all the time. R3 had a history of leaving their walker in places and that the walker was resting. Staff were to bring the walker to R3 for use. Under the section titled, "skin integrity", showed R3's skin bruised easily with the slightest bump. Under the section titled "pain", showed R3 experiences occasional shoulder pain. There were no other updates made on the service plan in the areas stated above.

Record review of the facility's "Incident and Abuse Investigation Log, undated, showed R3 had a fall with a skin tear on 01/03/2024. Record review of R3's "incident report and investigation", dated 01/03/2024 at 6:00 PM, showed R3 was found lying on the ground on their stomach. The report showed R3 had a fallen putting their milkshake in the refrigerator. The investigation review showed R3's incident was avoidable and that R3's services plan was not revised.

Record review of R3's "Resident Log", dated 11/23/2023 at 9:30 PM, showed R3 had a non injury fall that afternoon when they were walked into the dining room. R3 lost their balance, fell backwards onto their bottom and then on their back. R3 complained that R3's arm was sore and painful.

Record review of R3's "Resident Log", dated 11/24/2023 at 9:00 AM, showed R3's right hand and pinky finger was swollen. R3's pinky finger was purple and black in color and caused R3 pain when they tried to move it.

Record review of R3's "Resident Log", dated 11/24/2023 at 2:00 PM, showed R3 returned to the facility from the hospital with their right pinky finger being fractured (broken bone). R3 required their right-hand pinky finger to be buddy taped (finger was taped to another finger to stabilize the finger that was broken) in place until they were seen by a bone

specialist.

In an interview on 05/15/2024 at 11:25 AM, Staff A, Administrator, stated not all resident's incidents were documented on the residents NSA. Staff A stated the facility did fill out temporary service plan (TSP) for changes for the resident for the staff to know. Staff A stated they had not made a TSP for R3's fall with a fractured finger or R2's hospital visit that resulted in a shoulder sprain.

In an interview on 05/15/2024 at 11:51 AM, Staff H, Certified Nursing Assistant/Coverage, stated the facility was to complete a TSP for residents that required a change in care, mobility, or physically needs. Staff H stated they would make a TSP for a resident if they had a fracture, or required a use of a sling that was prescribed for an injury a resident endured.

Plan/Attestation Statement

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

Administrator (or Representative) 6-10-2024 Date

WAC 388-76A-2462 Background checks Who is required to have.

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(a) Volunteers who are not residents, and students who may have unsupervised access to residents;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 student (Collateral Contact 1 [CC1]) completed a Washington State Name and Date of Birth Background Check. This failure to ensure a Washington State Background Check was conducted placed 20 of 20 residents at risk of CC1 having unsupervised access to residents.

Findings included...

Record review of the Assisted Living Facility Guidebook, Partners in Protection, dated

specialist.

In an interview on 05/15/2024 at 11:25 AM, Staff A, Administrator, stated not all resident's incidents were documented on the residents NSA. Staff A stated the facility did fill out temporary service plan (TSP) for changes for the resident for the staff to know. Staff A stated they had not made a TSP for R3's fall with a fractured finger or R2's hospital visit that resulted in a shoulder sprain.

In an interview on 05/15/2024 at 11:51 AM, Staff H, Certified Nursing Assistant/Coverage, stated the facility was to complete a TSP for residents that required a change in care, mobility, or physically needs. Staff H stated they would make a TSP for a resident if they had a fracture, or required a use of a sling that was prescribed for an injury a resident endured.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

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

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(a) Volunteers who are not residents, and students who may have unsupervised access to residents;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 student (Collateral Contact 1 [CC1]) completed a Washington State Name and Date of Birth Background Check. This failure to ensure a Washington State Background Check was conducted placed 20 of 20 residents at risk of CC1 having unsupervised access to residents.

Findings included...

Record review of the Assisted Living Facility Guidebook, Partners in Protection, dated

Statement of Deficiencies	License #: 2363	Compliance Determination # 41196
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February 2019, under the section titled, "introduction", showed it was the responsibility of the assisted living facility to conduct criminal history background checks on all staff, volunteers, and students who have unsupervised access to vulnerable adults, within one business day of starting work and to ensure that all staff, volunteers, and students were free of any disqualifying criminal history per regulation.

In an observation and interview on 05/15/2024 at 11:47 AM, CC1 entered the kitchen. Staff B, Cook, said CC1 was their 14-year-old child who was homeschooled and sometimes hung out at the facility while they worked.

In an observation on 05/15/2024 at 9:20 AM, CC1 was observed to be at the facility until the Department licensors left at 4:00 PM.

In an observation on 05/16/2024 at 10:48 AM, CC1 exited the door from the kitchen into the television and living room area. Resident 1 saw CC1 and stated "hi [CC1's name]". There were no facility employee's in the area at the time of the observation.

In an observation on 05/16/2024 at 10:53 AM, CC1 was observed to arrive to the facility.

In an interview on 05/16/2024 at 10:53 AM, Staff A, Administrator, stated they were unaware CC1 needed a completed Washington State Name and Date of Birth Background Check.

There were no records provided that indicated CC1 completed a Washington State Name and Date of Birth Background Check.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024.

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

Administrator (or Representative) — 6-10-2024 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

February 2018, under the section titled, "introduction", showed it was the responsibility of the assisted living facility to conduct criminal history background checks on all staff, volunteers, and students who have unsupervised access to vulnerable adults, within one business day of starting work and to ensure that all staff, volunteers, and students were free of any disqualifying criminal history per regulation.

In an observation and interview on 05/15/2024 at 11:47 AM, CC1 entered the kitchen. Staff B, Cook, said CC1 was their 14-year-old child who was homeschooled and sometimes hung out at the facility while they worked.

In an observation on 05/15/2024 at 9:20 AM, CC1 was observed to be at the facility until the Department licensors left at 4:00 PM.

In an observation on 05/15/2024 at 10:46 AM, CC1 exited the door from the kitchen into the television and living room area. Resident 1 saw CC1 and stated "hi [CC1's name]". There were no facility employee's in the area at the time of the observation.

In an observation on 05/16/2024 at 10:53 AM, CC1 was observed to arrive to the facility.

In an interview on 05/16/2024 at 10:53 AM, Staff A, Administrator, stated they were unaware CC1 needed a completed Washington State Name and Date of Birth Background Check.

There were no records provided that indicated CC1 completed a Washington State Name and Date of Birth Background Check.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Elma Home Care 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-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 2363	Compliance Determination # 41136
Plan of Correction	Elma Home Care	Completion Date
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Based on observation, interview, and record review the facility failed to provide care agreed upon in the negotiated service agreement (NSA) for 1 of 4 sampled residents (Resident 5 [R5]). This failure impacted R5's quality of life by not having their care needs provided.

Findings included...

Record review of R5's NSA, dated 03/07/2023, bathing section showed resident was supervision/set up with bathing. Concerns related to bathing included R5 resisted bathing and they were unable to adequately bathe themselves. Equipment used during bathing showed staff washed R5's hair in the sink when R5 allowed it. Staff were to try and encourage R5 to wash their hair once weekly.

Record review of R5's "Resident Log", dated 02/19/2024, showed R5 refused hair washing and R5 looked unkept. "This is not new but usually certain care staff can talk [R5] into washing it but are not having any luck now. Staff will continue to encourage [R5] to let them wash it."

Record review of R5's "Resident Log" and "Notes" dated, 02/19/2024 – 05/08/2024, did not have any other notes to review regarding R5 showering and hair washing schedule.

In an observation on 05/14/2024 at 8:55 AM, R5 was observed to have their hair unkept. R5 wore a purple shirt and purple pants.

In an observation on 05/15/2024 at 11:19 AM, R5 was observed to have their hair unkept. R5 wore the same purple shirt and purple pants they had on the day previously.

In an interview on 05/16/2024 at 9:32 AM, Staff A, Administrator said the facility staff kept documentation on when they offered R5 a shower and when they encouraged R5 to shower. Staff A momentarily left to obtain the documentation. Staff A returned and said they could not provide documentation regarding when the facility staff encouraged and showered R5.

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-24

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

Administrator (or Representative) 6-10-2024 Date

Based on observation, interview, and record review the facility failed to provide care agreed upon in the negotiated service agreement (NSA) for 1 of 4 sampled residents (Resident 5 [R5]). This failure impacted R5's quality of life by not having their care needs provided.

Findings included...

Record review of R5's NSA, dated 03/07/2023, bathing section showed resident was supervision/set up with bathing. Concerns related to bathing included R5 resisted bathing and they were unable to adequately bathe themselves. Equipment used during bathing showed staff washed R5's hair in the sink when R5 allowed it. Staff were to try and encourage R5 to wash their hair once weekly.

Record review of R5's "Resident Log", dated 02/19/2024, showed R5 refused hair washing and R5 looked unkept. "This is not new but usually certain care staff can talk [R5] into washing it but are not having any luck now. Staff will continue to encourage [R5] to let them wash it."

Record review of R5's "Resident Log" and "Notes" dated, 02/19/2024 – 05/08/2024, did not have any other notes to review regarding R5 showering and hair washing schedule.

In an observation on 05/14/2024 at 8:55 AM, R5 was observed to have their hair unkept. R5 wore a purple shirt and purple pants.

In an observation on 05/15/2024 at 11:19 AM, R5 was observed to have their hair unkept. R5 wore the same purple shirt and purple pants they had on the day previously.

In an interview on 05/16/2024 at 9:32 AM, Staff A, Administrator said the facility staff kept documentation on when they offered R5 a shower and when they encouraged R5 to shower. Staff A momentarily left to obtain the documentation. Staff A returned and said they could not provide documentation regarding when the facility staff encouraged and showered R5.

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, Elma Home Care 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-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify a resident's physician after an incident occurred for 1 of 2 residents (Resident 2 [R2]). This failure placed Resident 2 at risk for delay in treatment or further evaluation by the physician.

Findings included...

Record review of the facility's policy titled, "5.04 Physician Notification", dated 02/29/2024, showed the assisted living facility must consult with the resident's physician whenever there was a significant change in the resident's condition. The assisted living facility must document in the resident's records the date and time each individual was contacted.

R2

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [redacted]2023.

Record review of R2's "incident report", dated 02/18/2024 at 4:14 AM, showed R2 was found on the floor on their knees next to their bed in their room. The incident showed R2's bathroom was occupied by the roommate and attempted to use the trash can to go to the bathroom and fell. Under the section titled, "response to injury/incident Description (name of where sent if applicable) for primary care provider (PCP) notified, showed there was nothing documented for the PCP.

Record review of R2's "incident report", dated 03/04/2024 (no documented time), showed R2 was found by their roommate lying on the ground next to their bed covered with a blanket. R2 told the staff member that she had slipped and fell. R2 was unable to get up by themselves and covered up with a blanket and waited for help. Under the section titled, "summary of assessment of contributing factors", showed R2's walker had gotten caught on the nightstand. The staff moved the night stand out more for prevention. Under the section titled, "response to injury/incident Description (name of where sent if applicable) for PCP notified, showed there was nothing documented for the PCP.

In an interview on 05/16/2024 at 9:55 AM, Staff A, Administrator, stated they did not have documentation to show that R2's PCP was notified of their falls that occurred on 02/18/2024 and 03/04/2024 for the department to review.

Statement of Deficiencies	License #: 2383	Compliance Determination # 41196
Plan of Correction	Elma Home Care	Completion Date
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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024 .

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

Administrator (or Representative) 6-10-24 Date

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 4 sampled staff (Staff C) had the dementia specialty training certificate as required. This failure placed all residents with dementia at risk of unmet care needs by untrained staff.

Findings included...

WAC 388-112A-0495 "What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities?.. Assisted living facilities.(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training. (5) Until a long-term care worker completes the specialty training and demonstrates competency as required under subsection (4) of this section, the home must not allow the long-term care worker to provide personal care to a resident with special needs without direct supervision, unless indirect supervision is allowed under subsection (6) of this section. (6) The long-term care worker may provide personal care with indirect supervision if one or more of the following requirements are met:
(a) The long-term care worker is a nursing assistant certified (NA-C) under chapter 18.88A RCW;
(b) The long-term care worker is a certified home care aide (HCA) under chapter 18.88B RCW;
(c) The long-term care worker is a licensed practical nurse (LPN) under chapter 18.79 RCW;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 4 sampled staff (Staff C) had the dementia specialty training certificate as required. This failure placed all residents with dementia at risk of unmet care needs by untrained staff.

Findings included...

WAC 388-112A-0495 "What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities.(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training. (5) Until a long-term care worker completes the specialty training and demonstrates competency as required under subsection (4) of this section, the home must not allow the long-term care worker to provide personal care to a resident with special needs without direct supervision, unless indirect supervision is allowed under subsection (6) of this section. (6) The long-term care worker may provide personal care with indirect supervision if one or more of the following requirements are met:
(a) The long-term care worker is a nursing assistant certified (NA-C) under chapter 18.88A RCW;
(b) The long-term care worker is a certified home care aide (HCA) under chapter 18.88B RCW;
(c) The long-term care worker is a licensed practical nurse (LPN) under chapter 18.79 RCW;

(d) The long-term care worker is a registered nurse (RN) under chapter 18.79 RCW; or
(e) The long-term care worker is exempt from the seventy-hour basic training under WAC 388-112A-0090...."

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed Resident 2 had dementia.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff C, Home Care Aide, was hired at the facility on 06/08/2023.

Record review on 05/15/2024 of Staff C's employee file showed there was no completed certificate for the specialty training for Dementia

In an interview on 05/15/2024 at 3:20 PM, Staff A, Administrator, stated Staff C did not have the completed dementia specialty certificate for the Department to review.

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-24

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

Administrator (or Representative) — Date: 6-10-2024

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

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

(d) The long-term care worker is a registered nurse (RN) under chapter 18.79 RCW; or
(e) The long-term care worker is exempt from the seventy-hour basic training under WAC 388-112A-0090... ."

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed Resident 2 had dementia.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff C, Home Care Aide, was hired at the facility on 06/08/2023.

Record review on 05/15/2024 of Staff C's employee file showed there was no completed certificate for the specialty training for Dementia.

In an interview on 05/15/2024 at 3:20 PM, Staff A, Administrator, stated Staff C did not have the completed dementia specialty certificate for the Department to review.

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

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure that 1 of 4 sampled staff (Staff C) had the mental health specialty training certificate as required. This failure placed all residents with mental health illnesses at risk of unmet care needs by untrained staff.

Findings included...

WAC 388-112A-0495 "What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities.(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training. (5) Until a long-term care worker completes the specialty training and demonstrates competency as required under subsection (4) of this section, the home must not allow the long-term care worker to provide personal care to a resident with special needs without direct supervision, unless indirect supervision is allowed under subsection (6) of this section. (6) The long-term care worker may provide personal care with indirect supervision if one or more of the following requirements are met:
(a) The long-term care worker is a nursing assistant certified (NA-C) under chapter 18.88A RCW;
(b) The long-term care worker is a certified home care aide (HCA) under chapter 18.88B RCW;
(c) The long-term care worker is a licensed practical nurse (LPN) under chapter 18.79 RCW;
(d) The long-term care worker is a registered nurse (RN) under chapter 18.79 RCW; or
(e) The long-term care worker is exempt from the seventy-hour basic training under WAC 388-112A-0090... ."

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed the facility had 18 of 20 listed resident that had [redacted] diagnosis.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff C, Home Care Aide, was hired at the facility on 06/08/2023. Record review on 05/15/2024 of Staff C's employee file showed there was no completed certificate for the specialty training for mental health.

In an interview on 05/15/2024 at 3:20 PM, Staff A, Administrator, stated Staff C did not have the completed mental health specialty certificate for the Department to review.

Statement of Deficiencies	License #: 2363	Compliance Determination # 41196
Plan of Correction	Elma Home Care	Completion Date
Page of 46	Licensee: Elma Homecare, Inc	05/30/2024

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024

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

Administrator (or Representative) 6-10-2024 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident has an injury requiring the intervention of a practitioner.

(c) Ensure the staff person performing the ongoing assessments is qualified to perform them.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that clinical assessments were completed by a qualified assessor for 2 of 5 sampled residents (Resident 2 and Resident 6) annually. The facility failed to complete a change of condition assessment for 2 of 5 sampled residents (Resident 3 and Resident 4) when they had a change that required provider guidance. The facility failed to complete an assessment annually for 1 of 4 sampled residents (Resident 5) that smoked cigarettes. These failures placed the residents at risk of unmet care needs and staff not having the most updated and accurate care and services the resident required.

Findings included...

"WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident: (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC, or (4) is a physician with a valid state license to practice medicine; or (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and

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, Elma Home Care 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-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(iii) When the resident has an injury requiring the intervention of a practitioner.

(c) Ensure the staff person performing the ongoing assessments is qualified to perform them.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that clinical assessments were completed by a qualified assessor for 2 of 5 sampled residents (Resident 2 and Resident 6) annually. The facility failed to complete a change of condition assessment for 2 of 5 sampled residents (Resident 3 and Resident 4) when they had a change that required provider guidance. The facility failed to complete an assessment annually for 1 of 4 sampled residents (Resident 5) that smoked cigarettes. These failures placed the residents at risk of unmet care needs and staff not having the most updated and accurate care and services the resident required.

Findings included...

"WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident: (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or (4) Is a physician with a valid state license to practice medicine; or (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and

current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living".

"WAC 246-980-140 Scope of practice for long-term care workers. (1) A long-term care worker performs activities of daily living or activities of daily living and instrumental activities of daily living. A person performing only instrumental activities of daily living is not acting under the long-term care worker scope of practice. (a) "Activities of daily living" means self-care abilities related to personal care such as bathing, eating, medication assistance, using the toilet, dressing, and transfer. This may include fall prevention, skin and body care. (b) "Instrumental activities of daily living" means activities in the home and community including cooking, shopping, house cleaning, doing laundry, working, and managing personal finances. (2) A long-term care worker documents observations and tasks completed, as well as communicates observations. (3) A long-term care worker may perform medication assistance as described in chapter 246-888 WAC. (4) A long-term care worker may perform nurse delegated tasks, to include medication administration, if he or she meets and follows the requirements in WAC 246-980-130. (5) A long-term care worker may provide skills acquisition training on instrumental activities of daily living and the following activities of daily living tasks: Dressing, application of deodorant, washing hands and face, hair washing, hair combing and styling, application of makeup, menses care, shaving with an electric razor, tooth brushing or denture care, and bathing tasks excluding any transfers in or out of the bathing area. (6) This section applies to all long-term care workers, whether required to be certified or exempt."

"WAC 246-840-700 Standards of nursing conduct or practice.
(2) The nursing process is defined as a systematic problem solving approach to nursing care which has the goal of facilitating an optimal level of functioning and health for the client, recognizing diversity. It consists of a series of phases: Assessment and planning, intervention and evaluation with each phase building upon the preceding phases. (a) Registered Nurse: (b) Licensed Practical Nurse: Minimum standards for registered nurses include the following: Minimum standards for licensed practical nurses include the following: (i) Standard I Initiating the Nursing Process: (i) Standard I - Implementing the Nursing Process: The practical nurse assists in implementing the nursing process; (A) Assessment and Analysis: The registered nurse initiates data collection and analysis that includes pertinent objective and subjective data regarding the health status of the clients. The registered nurse is responsible for ongoing client assessment, including assimilation of data gathered from licensed practical nurses and other members of the health care team; (A) Assessment: The licensed practical nurse makes basic observations, gathers data and assists in identification of needs and problems relevant to the clients, collects specific data as directed, and, communicates outcomes of the data collection process in a timely fashion to the appropriate supervising person; (B) Nursing Diagnosis/ Problem Identification: The registered nurse uses client data and nursing scientific principles to develop nursing diagnosis and to identify client problems in order to deliver effective nursing care; (B) Nursing Diagnosis/ Problem Identification: The licensed practical nurse provides data to assist in the development of nursing diagnoses which are central to the plan of care"

Record review of the Washington Health Care Association article titled, "Who Can Conduct Resident Assessments in Assisted Living?", undated, showed topics that would warrant a Registered Nurses assessment included diabetic management that may include enhanced oversight of the condition.

Record review of the facility's policy titled, "5.01 Assessments, Ongoing, and Change in Condition Assessments", dated 02/29/2024, showed "to ensure that each resident's needs and preferences are identified in a timely manner and incorporated into the Negotiated Service Agreement (NSA) providing directions for caregivers in delivering care that meets these needs. The assessment identifies services that promote the highest level of function and support the resident right to dignity and choice, while the NSA will identify care and service needs to be provided". All full re-assessments would be completed on a standardized assessment form that addresses all aspects of WAC. For an ongoing/change in condition assessment would focus solely on the resident's areas of change and may or may not be considered full assessments, depending on the scope and level of changes.

Record review of Staff A, Administrators employee file showed Staff A, Administrator, had a home care aide certification through the Washington State Department of Health.

In an interview on 05/14/2024 at 11:41 AM, Staff A stated the NSA was the resident's assessment and care plan was in one document. At 2:14 PM, Staff A stated they were not a qualified assessor for clinical or medical evaluations needed for the residents.

Clinical Annual Assessment

R2

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [redacted]2023.

Record review of R2's pre-admission assessment dated 10/08/2023 showed R2 was legally blind due to macular degeneration (an eye disease that can blur your central vision) and vascular dementia (a condition when the brain damage from impaired blood flow to the brain that causes problems with reasoning, planning, judgement, memory, and other thought processes).

Record review of R2's NSA, dated 11/20/2023, showed the assessment was completed on the same document. Under the section titled, "Assessment Signatures", showed the last assessment was dated 11/20/2023 for R2's 30-day evaluation and was completed by Staff A, Administrator. Under the section titled, "diabetic assessment", showed it was reviewed on 11/20/2023 by Staff A. The section reviewed that R2 preformed the task of checking their blood sugar testing (puncturing the skin to get blood to test sugar levels) levels once daily every morning.

Record review of R2's "Notes", dated 05/10/2024 at 12:32 AM, showed R2 returned from the hospital at 11:50 PM. R2 had new orders to wear a sling for comfort for 5 to 7 days, but would need to remove it for times their walker was used. R2 was to use cold compressions 2 to 3 times and Tylenol. There was no further documentation as to what injury R2 had or any other details.

Record review of R2's after visit summary dated 05/09/2024, showed R2 had a strain of their left shoulder and had new orders for R2 to use a sling for comfort for the next 5 to 7 days but to remove it for times their walker was used, a cold compression for 2 to 3 days, and use of Tylenol for discomfort.

In an interview on 05/15/2024 at 2:56 PM, Staff A stated R2 continued to get their blood sugar checked. Staff A stated the only assessment for R2 completed by the facility was dated 11/20/2023.

In an interview on 05/16/2024 at 9:55 AM, Staff A stated there was no assessment completed for R2 after their recent hospital visit that resulted in R2 diagnosed with [redacted] that required use of a sling and an increase in pain that R2 experienced.

R6

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R6 moved into the facility on [redacted] 2007.

Record review of R6's NSA, dated, 07/06/2022, showed the assessment was completed on the same document. The diabetic assessment section showed R6 had type two diabetes (occurred when blood sugar was too high). It showed R6 tested and reported their glucose levels to staff once daily. It indicated R6 did not need insulin (medication to treat two diabetes). The assessment was updated for the annual evaluation on 07/18/2023 and was reviewed and initialed by Staff A.

Change of Condition Assessment

R3

Record review of R3's NSA, dated 04/17/2024, showed it was updated for the annual evaluation on 04/17/2024. R3's annual assessment date was on 04/17/2024 and was assessed by Staff A.

Record review of R3's "Resident Log", dated 11/23/2023 at 9:30 PM, showed R3 had a non-injury all that afternoon when they were walked into the dining room. R3 lost their balance, fell backwards onto their bottom and then on their back. R3 complained of R3's arm was sore and painful.

Record review of R3's "Resident Log", dated 11/24/2023 at 9:00 AM, showed R3's right hand and pinky finger was swollen. R3's pinky finger was purple and black in color and caused R3 pain when they tried to move it.

Record review of R3's "Resident Log", dated 11/24/2023 at 2:00 PM, showed R3 returned to the facility from the hospital with their right pinky finger being fractured (broken bone). R3 required their right-hand pinky finger to be buddy taped (finger was taped to another finger to stabilize the finger that was broken) in place until they were seen by a bone specialist.

Record review on 05/15/2024 of R3's medical chart showed there was no assessment that had been completed from R3's hospital evaluation and newly diagnosed [redacted] to R3's pinky finger.

In an interview on 05/16/2024 at 9:55 AM, Staff A stated there was no change of condition assessment completed for R3's newly diagnosed [redacted] and [redacted].

R4

Record review of R4's NSA, showed it was annually updated on 07/18/2023. R4's last annual assessment was completed on 07/18/2023 by Staff A. Under the section "oral care", showed R4 had their own teeth, but also had severe tooth decay. Staff were to encourage R4 to eat meals.

Record review of R4's "Resident Log", dated 01/31/2024 (not time documented), showed R4 had recently dropped weight. R4 told Staff A that they had bought weight loss medication at the local store. There was no further documentation about the reason for R4's weight loss.

In an interview on 05/16/2024 at 9:55 AM, Staff A stated there was no change of condition assessment completed for R4's weight loss completed.

Annual Smoking Assessment

R5
Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R5 moved into the facility on [redacted] 2011.

Record review of R5's NSA, dated, 03/07/2023, showed the assessment was completed on the same document. The smoking safety section did not have information to review but in the comments section it said R5 did not practice safe smoking. Staff tried to monitor R5 when they smoked but other residents provided R5 cigarettes. Staff A reviewed and initialed the smoking safety section on 03/07/2023.

In an observation on 05/15/2024 at 11:15 AM, R5 took a package of cigarettes out of their bra and handed Resident 7 a cigarette.
Record review of R5's "Resident Log", dated 03/22/2024, showed R5 was getting low on their carton of cigarettes. Staff asked R5 if they wanted them to go get R5 more. R5 stated no they were going to quit smoking.

Record review of R5's "Notes", dated 04/09/2024 at 9:52 AM, showed R5 let care staff take their debit card and buy them cartons of cigarettes. R5 stopped yelling at other residents and staff since they had access to them.

Record review of R5's "Notes", dated 04/25/2024 at 4:24 PM, showed R5 asked Staff A to get their carton of cigarettes out of the closet so the other residents would leave them alone.

In an interview on 05/16/2024 at 9:32 AM, Staff A stated R5 could not make it to the store independently so R5 asked facility staff members to buy them cigarettes. Staff A said even though R5 wanted facility staff to purchase cigarettes for them, R5 would become concerned that they had not received their debit card back and would be worried about having missing funds. Staff A said that facility staff completed the errand and immediately returned R5's debit card with receipt. Staff A said they needed to follow up on incorporating the smoking information in R5's NSA because it was not currently in there to review.

In an interview on 05/30/2024 at 9:23 AM, Staff A stated the licensed nurse would only come in to evaluate a resident that checked their blood sugar independently, if the caregivers reported any concerns. Staff A stated all nursing assistance certified (NAC) and

home care aides (HCA) that took the training course know how a resident should check their blood sugar. Staff A stated they were able to the residents and know when there were changes.

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024 .

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

Administrator (or Representative) 6-10-24 Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 2 sampled Staff (Staff C and Staff F) received their Tuberculosis (infectious bacterial disease of the lungs) test within three days of employment. This failure placed 20 of 20 residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately **begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on** July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the facility's document titled, "Tuberculosis Policy and Procedure", undated, showed the facility would ensure that all staff members were tested for TB within

home care aides (HCA) that took the training course know how a resident should check their blood sugar. Staff A stated they were able to the residents and know when there were changes.

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, Elma Home Care 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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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 2 sampled Staff (Staff C and Staff F) received their Tuberculosis (infectious bacterial disease of the lungs) test within three days of employment. This failure placed 20 of 20 residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the facility's document titled, "Tuberculosis Policy and Procedure", undated, showed the facility would ensure that all staff members were tested for TB within

3 days of hire.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff C, Home Care Aide, was hired at the facility on 08/08/2023.

Record review on 05/15/2024 of Staff C's employee file showed Staff C had a QuantiFERON gold plus blood test that was completed on 07/28/2023. That was 46 days after the required time frame the TB test was required to be completed.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff F, Cook, was hired at the facility on 09/01/2022.

Record review on 05/15/2024 of Staff F's employee file showed Staff F had a QuantiFERON gold plus blood test that was completed on 07/26/2023. That was 324 days after the required time frame the TB test was required to be completed.

In an interview on 05/15/2024 at 3:30 PM, Staff A, Administrator, stated they had their staff get a QuantiFERON gold plus TB blood tested completed as the facility's nurse was only available on call.

In an interview on 05/30/2024 at 9:23 AM, Staff A stated new employed staff were to get their TB test completed within three days of employment.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 6-10-2024

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

3 days of hire.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff C, Home Care Aide, was hired at the facility on 06/08/2023.

Record review on 05/15/2024 of Staff C's employee file showed Staff C had a QuantiFERON gold plus blood test that was completed on 07/28/2023. That was 46 days after the required time frame the TB test was required to be completed.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff F,
Cook, was hired at the facility on 09/01/2022.

Record review on 05/15/2024 of Staff F's employee file showed Staff F had a QuantiFERON gold plus blood test that was completed on 07/26/2023. That was 324 days after the required time frame the TB test was required to be completed.

In an interview on 05/15/2024 at 3:30 PM, Staff A, Administrator, stated they had their staff get a QuantiFERON gold plus TB blood tested completed as the facility's nurse was only available on call.

In an interview on 05/30/2024 at 9:23 AM, Staff A stated new employed staff were to get their TB test completed within three days of employment.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 1 sampled Staff (Staff E) received one Tuberculosis (infectious bacterial disease of the lungs) test within three days of employment. This failure placed 20 of 20 residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the facility's document titled, "Tuberculosis Policy and Procedure", undated, showed the facility would ensure that all staff members were tested for TB within 3 days of hire.

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff E, Certified Nursing Assistant, was hired at the facility on 01/01/2023.

Record review on 05/15/2024 of Staff E's employee file showed Staff E had a QuantiFERON gold blood test that was completed on 06/29/2022. That was 186 days before they were hired at the facility. There were no other records provided that Staff D had a TB test completed within three days of their employment at the facility provided to the Department for review.

In an interview on 05/15/2024 at 3:30 PM, Staff A, Administrator, stated they had their staff get a QuantiFERON gold plus TB blood tested completed as the facility's nurse was only available on call.

In an interview on 05/30/2024 at 9:23 AM, Staff A stated new employed staff were to get their TB test completed within three days of employment.

Statement of Deficiencies	License #: 2383	Compliance Determination # 41196
Plan of Correction	Elma Home Care	Completion Date
Page of 46	Licensee: Elma Homecare, Inc	05/30/2024

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024

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

Administrator (or Representative) 6-10-2024 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 1 sampled Staff (Staff D) received their first and second Tuberculosis (infectious bacterial disease of the lungs) skin test within the required time. This failure placed 20 of 20 residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of the Centers for Disease Control and Prevention web site article, titled, "TB Screening and Testing of Health Care Personnel", dated 08/30/2022, under the section, "baseline testing: Two-step testing", showed "If the Mantoux tuberculin skin test (TST) is used to test health care personnel upon hire (preplacement), two-step testing should be used. This is because some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection". The second TST test was to be administered one to three weeks after the first test.

Record review of the facility's document titled, "Tuberculosis Policy and Procedure", undated, showed the facility would ensure that all staff members were tested for TB within 3 days of hire.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 1 sampled Staff (Staff D) received their first and second Tuberculosis (infectious bacterial disease of the lungs) skin test within the required time. This failure placed 20 of 20 residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of the Centers for Disease Control and Prevention web site article, titled, "TB Screening and Testing of Health Care Personnel", dated 08/30/2022, under the section, "baseline testing: Two-step testing", showed "if the Mantoux tuberculin skin test (TST) is used to test health care personnel upon hire (preplacement), two-step testing should be used. This is because some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection". The second TST test was to be administered one to three weeks after the first test.

Record review of the facility's document titled, "Tuberculosis Policy and Procedure", undated, showed the facility would ensure that all staff members were tested for TB within 3 days of hire.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the

permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff D, Caregiver, was hired at the facility on 09/11/2023.

Record review on 05/15/2024 of Staff D's employee file showed Staff D had a skin test given on 09/18/2023. The test was read negative on 09/21/2023. There was no second skin test documented, completed, or provided to the Department for review.

In an interview on 05/15/2024 at 3:30 PM, Staff A, Administrator, stated Staff D did not get a second step skin test completed.

As of 05/15/2024 the facility was unable to provide any further documentation that a second step TB testing was completed as required.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024.

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

Administrator (or Representative) — Date: 6-10-2024

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow and implement safe food handling and storing practices for 1 of 1 kitchen reviewed. These failures placed 20 of 20 residents at risk for receiving food that was at risk for exposure to food-borne illnesses.

Findings included...

permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the facility document titled, "[facility name] Employee List", undated, showed Staff D, Caregiver, was hired at the facility on 09/11/2023.

Record review on 05/15/2024 of Staff D's employee file showed Staff D had a skin test given on 09/18/2023. The test was read negative on 09/21/2023. There was no second skin test documented, completed, or provided to the Department for review.

In an interview on 05/15/2024 at 3:30 PM, Staff A, Administrator, stated Staff D did not get a second step skin test completed.

As of 05/16/2024 the facility was unable to provide any further documentation that a second step TB testing was completed as required.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Elma Home Care 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-2305 Food sanitation. The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow and implement safe food handling and storing practices for 1 of 1 kitchen reviewed. These failures placed 20 of 20 residents at risk for receiving food that was at risk for exposure to food-borne illnesses.

Findings included...

WAC 246-215-03526
"Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).
(1) Except when packaging food using a reduced oxygen packaging method as specified under WAC 246-215-03540, and except as specified in subsections (5) and (6) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than twenty-four hours must be clearly marked to indicate the date or day by which the food must be consumed on the premises, sold, or discarded when held at a temperature of 41ºF (5ºC) or less for a maximum of seven days. The day of preparation must be counted as day one.
(2) Except as specified in subsections (5) through (7) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant must be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four hours, to indicate the date or day by which the food must be consumed on the premises, sold, or discarded, based on the temperature and time requirements specified in subsection (1) of this section and:
(a) The day the original container is opened in thefood establishment is counted as day one; and
(b) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on foodsafety.
(3) A refrigerated,ready-to-eat, time/temperature control for safety food ingredient or a portion of a refrigerated,ready-to-eat, time/temperature control for safety food that is combined with additional ingredients or portions offood must retain the date marking of the earliest-prepared or first-prepared ingredient.
(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:
(a) Using a methodapproved by the regulatory authority for refrigerated,ready-to-eat, time/temperature control for safety foodthat is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;
(b) Marking the date or day of preparation, with a procedure to discard thefood on or before the last date or day by which the foodmust be consumed on the premises, sold, or discarded as specified under subsection (1) of this section;
(c) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or
(d) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authority upon request."

WAC 246-215-03351
"Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location;
(b) Where it is not exposed to splash, dust, or other contamination; and
(c) At least six inches (15 cm) above the floor.
(2) food in packages and working containers may be stored less than six inches (15 cm)

above the floor on case lot handling equipment as specified under WAC 246-215-04268.
(3) Pressurized beverage containers, cased food in waterproof containers such as bottles or cans, and milk containers in plastic crates may be stored on a floor that is clean and not exposed to floor moisture."

WAC 246-215-04555
"Equipment—Mechanical ware washing equipment, hot water sanitization temperatures (FDA Food Code 4-501.112).
(1) Except as specified in subsection (2) of this section, in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 194°F (90°C) or less than:
(a) For a stationary rack, single temperature machine, 165°F (74°C); or
(b) For all other machines, 180°F (82°C).
(2) The maximum temperature specified under subsection (1) of this section, does not apply to the high pressure and temperature systems with wand-type, hand-held, spraying devices used for the in-place cleaning and sanitizing of equipment such as meat saws."

WAC 246-215-03505
"Temperature and time control—Time/temperature control for safety food, slacking (FDA Food Code 3-501.12). Frozen Time/temperature control for safety food that is slacked to moderate the temperature must be held:(1) Under refrigeration that maintains the food temperature at 41°F (5°C) for less; or(2) At any temperature if the food remains frozen."

WAC 246-215-03510
"Temperature and time control—Thawing (FDA Food Code 3-501.13).
Except as specified in subsection (4) of this section, time/temperature control for safety food must be thawed:
(1) Under refrigeration that maintains the food temperature at 41°F (5°C) or less;"

Labeling/Expired foods/Improperly Stored Foods
Record review of the food safety website article, "Cold Food Storage Chart", last reviewed 09/19/2023, showed frozen items should be kept below zero degrees Fahrenheit. The chart showed in order to keep an item at its best quality bacon and sausage should be kept between one to two months. Cooked store wrapped slices of ham should be kept for one to two months. Chicken or poultry pieces should be kept for up to nine months.

Record review of the facility's "Storage and Labeling Policy", effective date 05/15/2024, showed all foods in the pantry, refrigerator, and freezers needed to be labeled. All opened food and repackaged food needed to be labeled with the date it was opened, the product name, and the expiration date. All perishable food needed to be labeled with the name and date it was opened. Perishable food needed to be discarded after seven days of being opened. Food must be six inches from the ground and stored in food safe containers and packaging. The kitchen would be cleaned and rotated by the foods best by date at least twice monthly. No food was to be stored in open packaging or without packaging.

In an observation on 05/14/2024 at 11:30 AM, in the cabinet drawer next to the

handwashing sink had an opened container of argo corn starch that did not have a label to review. There were two opened containers of sprinkles one without a lid, both containers did not have labels to review. There were a variety of free-standing chocolates in a basket that included 100 grand, reeses, and snickers that did not have labels to review. In the third drawer there were free standing chocolate that included twix and peanut MnM's that did not have a label to review. The chocolate was mixed in-between brown paper bags, sprinkles, and tea.

In an interview on 05/14/2024 at 11:25 AM, Staff B, Cook, said they wished they organized their kitchen drawers. Staff B said they labeled foods after the item had been opened. Staff B said they were supposed to label perishable items. Staff B said all opened perishable items would be discarded after seven days. Staff B said they did not have to label items such as sprinkles or seasonings.

In an observation on 05/14/2024 at 11:40 AM, the cupboard next to the handwashing sink showed an opened container of whole dill weed with a best by date of 03/04/2024. A container of spice supreme pure ground sage with a best by date of 12/01/2019. An opened container of wylers beef cubes with a best before date of 08/21/2022. An opened container of simply organix crushed red pepper showed best by date of September 2013. An opened container of organic curry powder with a best by date of 12/01/2018.

In an interview on 05/14/2024 at 11:45 AM, Staff B acknowledged the whole dill weed container had a best by date that had passed. Staff B said they did not use the expired spices in the cupboard. Staff B said that they should have not left the expired seasonings in the cupboard, but they were out of site and out of mind. Staff B said there was not a system in place that informed them when they needed to go through and dispose of expired foods. Staff B said they would not use the expired spices to make residents food.

In an observation on 05/14/2024 at 11:50 AM, the kitchen cupboard showed a container labeled "brown sugar" with no other information to review. There was a white container with lid that had an unknown white powder inside. There was not a label to review. A container of quick oats had been opened and did not have a label to review.

In an observation on 05/14/2024 at 11:57 AM, showed inside the refrigerator "tuna salad" in a plastic zip lock bag that did not have a label to review. There was a container of extra heavy mayo that did not have a label of when it was opened. There was an opened bag of iceberg lettuce that had started to turn red in color, there was no label to review. There was a black container with a clear plastic lid on the inside had an onion and tomatoes. There was no label to review.

In an observation on 05/14/2024 at 3:42 PM, the kitchen storage area showed a two-litter bottle of Canada dry soda that was next to a package of water bottles that were all located on the ground. There were three bottles of orange fanta on the ground. Inside the pantry closet were clear containers with blue lids labeled sugar, flour, split peas, rice/elbow macaroni, and ramen noodles that were on the ground. There was also a twenty-four pack of sans cola on the ground.

In an observation on 05/14/2024 at 3:46 PM, inside the standing full-size freezer, there was an open bag of green peas. The bag was stored inside a large clear Ziplock bag that had large amount of white ice inside. There was no documented date on the package of peas or the Ziplock bag for review. There was an open package of "Hormel pepperoni", that was not dated. There was a pink piece of meat that resembled ham that was wrapped in saran wrap that had large amounts of white ice built up inside. The wrapped food was unlabeled and undated. There were two packages labeled chicken drumsticks. One of the packages of chicken drumsticks had large amounts of ice buildup on the chicken making it difficult to see the actual chicken. The other package had orange and yellow frozen substance on the outside of the package. Both packages of chicken drumsticks showed their best by date was 04/09/2023. There was a bag of cubed chunks of frozen mangos. The bag was open and observed the mango inside had lots of white ice substance built up on the mango chunks.

In an observation on 05/14/2024 at 3:47 PM, showed inside the freezer there were 13 unlabeled white containers. There was an opened precooked package of bacon that did not have a label to review. There was a package of frozen sausage patties that were not sealed closed, and the package did not have a label to review. There were four berry blend package that did not have a label to review. There was a container of vanilla ice cream that had been opened without a label to review. In the side of the freezer there were two packages of an unknown white food item that had kernels of corn embedded into it. There were ice crystals formed inside of the package. There was not a label to review.

In an interview on 05/14/2024 at 3:56 PM, Staff B stated the bag of mango chunks were freezer burned. Staff B stated the chicken from Walmart would not be used because it was too small, and it froze too fast. Staff B stated they were responsible to take the food out of the freezer. Staff B stated all food in the freezer were good up to one year after the best by date on the package. Staff B stated they tried to review the kitchen monthly for expired items but due to staffing shortages they were unable to regularly do so. Staff B stated the unlabeled item inside the freezer that developed ice crystals was their personal cauliflower rice that they did not keep in the employee refrigerator because it needed to be inside of a freezer.

In an observation on 05/24/2024 at 4:05 PM, the freezer chest under the window showed there was an opened bag with food items that resembled fish filets. The bag was not secured closed and exposed the food item open to air. The bag of food was unlabeled and undated.

Dishwasher, Food Temperature, and Refrigerator/Freezer logs

Record review of the facility's "Fridge and Freezer Temp Policy", effective date 05/15/2024, showed "ensure proper cooling and freezer of all cold storage foods." The refrigerators were to be checked daily with a maximum temperature of 40 degrees. The freezers were to be checked daily to ensure maximum temperature of 30 degrees. The findings were supposed to be logged.

Record review of the facility's "Dishwasher Temp Policy", effective date 05/15/2024, showed check and monitor temperature gauge on equipment at least once per shift. Temperature must be in green to properly sanitize the dishes. Keep a monthly temperature log and file a minimum of three months.

Record review of the facility's "Temperature Log", dated 05/01/2024 – 05/14/2024, showed the maximum temperature should be "40" and the minimum temperature should be "32". In handwritten letters on the paper read "Freezer max 30 [degrees]". The manager signature section was signed by Staff B, Cook. On 05/06/2024 the log did not have a temperature section or initial section to review. On 05/09/2024 – 05/10/2024 the log showed the temperature section had a check mark and there were initials to review. On 05/11/2024, 05/12/2024, and 05/13/2024 the log did not have a temperature section to review but there were initials available to review. On 05/14/2024 the temperature section had a check mark and there were initials to review.

In an interview and observation on 05/15/2024 at 9:28 AM, Staff B, Cook, said the facility did not complete temperature checks for the dishwasher and did not complete dishwasher temperature logs. Staff B said an outside company came out weekly and serviced the machine. Staff B was unsure if the dish washer temperatures were on the invoice provided by the outside company. Observation of the dishwasher showed there were no temperature logs to review. Staff B said they used a thermometer to check food temperatures. Staff B said the facility did not keep food temperature logs to review. Staff B said they kept a condensed version of refrigerator and freezer temperature logs that were available to review. Staff B said they used to have an individual sheet on each of the refrigerators and freezer to where the facility staff wrote down the temperature and signed. Staff B said it took too much time and facility staff would forget to complete each sheet daily. Staff B said their current process was to check the freezer and make sure the temperature was below 30 degrees and to check all the refrigerators and if the temperatures were minimum 32 degrees and maximum 40 degrees they would write "good" and initial the document.

In an interview on 05/16/2024 at 10:51 AM, Staff A, Administrator, said they did not have any dishwasher temperature invoices to review from the outside company that provided the weekly service.

Record review of dishwasher temperature logs showed there were none provided to review.

Record review of food temperature logs showed there were none provided to review.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2383	Compliance Determination # 41196
Plan of Correction	Elma Home Care	Completion Date
Page of 48	Licensee: Elma Homecare, Inc	05/30/2024

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date) 7-14-2024

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

Administrator (or Representative) 6-10-2024 Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(iii) Include all food and snacks served that contribute to nutritional requirements;

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to substitute foods of equal nutrition when changes were made for 1 of 1 kitchen reviewed. This failure placed all 20 of 20 residents at risk of not having their nutritional needs met.

Findings included...

Menu Substitutions

Record review of the facility's "Weekly Menu", dated 04/11/2024, showed dinner was supposed to be hamburger steak and onions, steamed red potatoes, maple roasted carrots, baked roll, and cherry cheesecake. Other than the baked roll and cherry cheesecake the dinner menu items were crossed out with a line and with handwritten letters showed ravioli and mixed veggies.

Record review of the facility's "Weekly Menu", dated 05/07/2024, showed lunch was supposed to be Greek chicken pasta, assorted fruit, tomato/cucumber salad, and crusty garlic bread. Other than the assorted fruit the lunch menu items were crossed out with a line and with handwritten letters showed pancakes, sausage, and eggs.

Record review of the facility's "Weekly Menu", dated 05/12/2024 – 05/18/2024, showed on 05/15/2024 lunch was supposed to be spaghetti with marinara meat sauce, pears,

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Administrator (or Representative) Date

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Findings included...

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Record review of the facility's "Weekly Menu", dated 05/12/2024 – 05/18/2024, showed on 05/15/2024 lunch was supposed to be spaghetti with marinara meat sauce, pears,

garlic green beans, and garlic bread. Dinner was supposed to be roasted pork, baked sweet potato, grilled asparagus, baked roll, pineapple, and blueberry crumble. The Dinner menu was crossed out and an arrow indicated the lunch menu was moved to dinner. Above the lunch menu was handwritten letters that said ham and cheese, cottage cheese, pineapple, and chips. On 05/16/2024 lunch was supposed to be honey mustard deli wrap, orange cottage salad, pickled beets, and chips. Dinner was supposed to be bacon and cheese chopped steak, mushroom rice, peas and carrots, baked roll, and toll house pie. The dinner menus bacon and cheese chopped steak, baked roll, and toll house pie was crossed out. In handwritten letters showed baked chicken thighs, bread and butter, Costco cakes.

In an observation on 05/14/2024 at 11:49 AM, the menu on the wall outside of the kitchen serving window in the dining room showed it had been changed and lunch was ham and cheese sandwich with cottage cheese, pineapple and chips with the alternative as chicken noodle soup and a half a sandwich. The meal that was originally to be served was spaghetti with salad and dinner roll.

In an interview on 05/14/2024 at 3:37, Staff B, Cook, stated spaghetti with meatballs, side salad, and bread and butter were for dinner.

In an interview on 05/15/2024 at 9:35 AM, Staff B stated they were informed they could alter the menus to fit the preferences of the population that they served. Staff B stated if they followed the menu often what was supposed to be served for lunch would be too heavy and the residents would not want to eat it. Staff B stated yesterday on 05/14/2024 the residents were supposed to have spaghetti for lunch but instead they had sandwiches and had spaghetti for dinner. Staff B stated the residents do not want casseroles for lunch they want something lighter like soup or sandwiches. Staff B stated if they made a change to the menu, they wrote it down, and kept all menus for over a year.

In an interview and observation on 05/15/2024 at 12:37 PM, Staff B distributed lunch to the residents. Staff B stated the lunch menu included deli mustard wraps, cottage cheese, chips, and salad. Orange salad or pickled beets were not observed being served.

In an interview on 05/15/2024 at 2:18 PM, Staff B stated historically if they altered the menu, they would go into the Grove system and electronically input the modifications. Staff B did this, so they received calculations if the item they substituted had too little or too many calories. Staff B stated they could not electronically alter the menus because it was too time consuming. Staff B stated they served strawberry salad instead of the listed orange salad on 05/15/2024. Staff B stated they did not serve pickled beets and did not modify the paper menu as accurately as they should have to indicate the proper substitutions.

In an interview on 05/14/2024 at 4:00 PM, Staff B, stated they stored their cereal bags under shelving in the kitchen pantry, so the bags were hidden from other employees. Staff B stated they did this so facility staff would not only offer cereal to the residents at breakfast time. Staff B stated a former employee would offer residents cereal daily instead of cooking breakfast.

Statement of Deficiencies	License #: 2383	Compliance Determination # 411586
Plan of Correction	Elma Home Care	Completion Date
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 6-10-2024 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:

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(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.

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Negotiated Service Agreements (NSA) the plan to provide the care and services necessary to support the residents preferences and care needs, the plan to provide assistance with activities of daily living, and appropriate behavioral interventions for 1 of 4 sampled residents (Resident 5 [R5]). This failure impacted staff's ability to provide care and placed R5 at risk for unmet care needs.

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, Elma Home Care is or will be in compliance with this law and / or regulation on (Date)_____ .

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Administrator (or Representative) Date

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

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(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.

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Negotiated Service Agreements (NSA) the plan to provide the care and services necessary to support the residents preferences and care needs, the plan to provide assistance with activities of daily living, and appropriate behavioral interventions for 1 of 4 sampled residents (Resident 5 [R5]). This failure impacted staff's ability to provide care and placed R5 at risk for unmet care needs.

Findings included...

Record review of the website mayoclinic.org article, "Hyponatremia", dated 05/17/2022, showed Hyponatremia (condition where sodium in blood is abnormally low) can cause symptoms such as nausea, vomiting, headache, confusion, loss of energy, drowsiness, fatigue, restlessness, irritability, muscle weakness, spasms, cramps, seizures, and coma.

R5

Record review of R5's "Department of Social & Health Services Assessment Details Current Annual", dated 03/13/2024, showed R5 had been resistive to care with words and gestures. R5 refused showering and R5 had been observed showering one time in six years. Personalized interventions included continue to offer showers, monitor resident for behavioral or skin effects. Offer alternate shower times and record attempts. Unsafe smoking section showed R5 continued to smoke outside of facility doors. R5 challenged the facility policy by improperly disposing lit cigarettes. Personalized interventions included facility staff were to talk in a calm tone while explaining hazards, provide handheld ashtray for R5 to use, have staff monitor R5 when they smoked, and report any concerns to R5's provider.

Record review of R5's NSA, dated 03/07/2023, under the mobility – transfers section showed resident was independent, supervision/set up with their transfers. R5 had difficulty moving from one surface to another. "When residents sodium levels are really low [R5] needs help with transfers." There is no information to review regarding signs and symptoms for facility staff to look for when R5 had low sodium levels. Dressing section showed R5 was supervision/set up with dressing. R5 was resistive to clothing changes, slept in street clothes, and unaware their clothing was dirty. R5 would wear the same clothes for weeks, when staff tried to encourage R5 to change they became combative. R5 would yell and cuss at staff until they left the room. There was no information to review regarding when and how often facility staff were supposed to encourage resident to change and what facility staff were supposed to do if R5 became combative. Bathing section showed R5 was supervision/set up with bathing. R5 resisted bathing and they were unable to adequately bathe themselves. Equipment used during bathing showed staff washed R5's hair in the sink when R5 allowed it. The preference section that indicated if R5 preferred to shower, bathe in a tub, or sponge bath was blank. The hair washed section if R5 preferred the salon or shower was blank. The time-of-day R5 preferred to bathe section was blank. The hair care section showed R5 was supervision/set up. R5's hair was greasy and unkept. There was no information to review regarding how staff encouraged R5 to wash their hair. The other needs section showed the task bed making, laundry, arrange healthcare appointments, and arrange transportation section were marked under wellness. The tasks did not indicate if they were scheduled daily, weekly, monthly, or as needed. The smoking safety section did not have information to review, in the comments section it said R5 did not practice safe smoking. Staff tried to monitor R5 when they smoked but other residents provided R5 cigarettes. If facility staff noticed that R5 smoked in any other area, then the smoking section they would escort R5 to the designated area.

In an observation on 05/14/2024 at 8:55 AM, R5 was observed to have their hair unkept. R5 wore a purple shirt and purple pants.

In an observation on 05/15/2024 at 11:19 AM, R5 was observed to have their hair unkept. R5 wore the same purple shirt and purple pants they had on the day prior.

Statement of Deficiencies	License #: 2363	Compliance Determination # 41196
Plan of Correction	Elma Home Care	Completion Date
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In an observation on 05/15/2024 at 11:15 AM, R5 took a package of cigarettes out of their bra and handed Resident 7 a cigarette.

Record review of R5's "Resident Log", dated 03/22/2024, showed R5 was getting low on their carton of cigarettes. Staff asked R5 if they wanted them to go get R5 more. R5 stated no they were going to quit smoking.

Record review of R5's "Notes", dated 04/09/2024 at 9:52 AM, showed R5 let care staff take their debit card and buy them cartons of cigarettes. R5 stopped yelling at other residents and staff since they had access to them.

Record review of R5's "Notes", dated 04/25/2024 at 4:24 PM, showed R5 asked Staff A, Administrator, to get their carton of cigarettes out of the closet so the other residents would leave them alone.

In an interview on 05/16/2024 at 9:32 AM, Staff A said the facility staff kept documentation on when they offered R5 a shower and when they encouraged R5 to shower. Staff A momentarily left to obtain the documentation. Staff A returned and said they could not provide documentation regarding when the facility staff encouraged and showered R5. Staff A stated R5 could not make it to the store independently so R5 asked facility staff members to buy them cigarettes. Staff A said even though R5 wanted facility staff to purchase cigarettes for them, R5 would become concerned that they had not received their debit card back and would be worried about having missing funds. Staff A said that facility staff completed the errand and immediately returned R5's debit card with receipt. Staff A said they needed to follow up on incorporating the smoking information in R5's NSA because it was not currently in there to review.

Plan/Attestation Statement

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

Administrator (or Representative) 6-10-2024 Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(v) Policies, procedures, and equipment necessary to perform duties;

In an observation on 05/15/2024 at 11:15 AM, R5 took a package of cigarettes out of their bra and handed Resident 7 a cigarette.

Record review of R5's "Resident Log", dated 03/22/2024, showed R5 was getting low on their carton of cigarettes. Staff asked R5 if they wanted them to go get R5 more. R5 stated no they were going to quit smoking.

Record review of R5's "Notes", dated 04/09/2024 at 9:52 AM, showed R5 let care staff take their debit card and buy them cartons of cigarettes. R5 stopped yelling at other residents and staff since they had access to them.

Record review of R5's "Notes", dated 04/25/2024 at 4:24 PM, showed R5 asked Staff A, Administrator, to get their carton of cigarettes out of the closet so the other residents would leave them alone.

In an interview on 05/16/2024 at 9:32 AM, Staff A said the facility staff kept documentation on when they offered R5 a shower and when they encouraged R5 to shower. Staff A momentarily left to obtain the documentation. Staff A returned and said they could not provide documentation regarding when the facility staff encouraged and showered R5. Staff A stated R5 could not make it to the store independently so R5 asked facility staff members to buy them cigarettes. Staff A said even though R5 wanted facility staff to purchase cigarettes for them, R5 would become concerned that they had not received their debit card back and would be worried about having missing funds. Staff A said that facility staff completed the errand and immediately returned R5's debit card with receipt. Staff A said they needed to follow up on incorporating the smoking information in R5's NSA because it was not currently in there to review.

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(v) Policies, procedures, and equipment necessary to perform duties;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have all staff trained on policies and procedures needed to perform their job duties for 1 of 1 kitchen reviewed. This failure placed all 20 of 20 residents at risk for exposure to food borne illnesses.

Findings included...

Record review of the facility's "7.08 Hand Washing", effective/revised 02/29/2024, showed under the hand hygiene and gloves section, when conducting a procedure that required gloves proper hand hygiene should be completed before donning (putting on) and doffing (taking off) the gloves.

Record review of the facility's "[facility name] Employee List", undated, showed Staff B, Cook, date of hire was 07/11/2022.

In an observation on 05/14/2024 at 11:40 AM, the cupboard next to the handwashing sink showed an opened container of whole dill weed with a best by date of 03/04/2024. A container of spice supreme pure ground sage with a best by date of 12/01/2019. An opened container of wylers beef cubes with a best before date of 08/21/2022. An opened container of simply organix crushed red pepper showed best by date of September 2013. An opened container of organic curry powder with a best by date of 12/01/2018.

In an interview on 05/14/2024 at 11:45 AM, Staff B said they wished they had organized their kitchen cabinets and drawers. Staff B said they did not have enough time to go through the kitchen. Staff B said they did not have a task sheet or any other information to reference that informed them when they were supposed to go through items in the pantry and discard expired items such as spices and seasonings.

In an observation on 05/14/2024 at 3:46 PM, inside the standing full-size freezer, there were two packages labeled chicken drumsticks. One of the packages of chicken drumsticks had large amounts of ice buildup on the chicken making it difficult to see the actual chicken. The other package had orange and yellow frozen substance on the outside of the package. Both packages of chicken drumsticks showed their best by date was 04/09/2023.

In an interview on 05/14/2024 at 3:56 PM, Staff B said there was chicken in the freezer from Walmart that the facility did not use because it was too small and froze fast. Staff B said they transitioned from shopping at Walmart to Fred Meyer. Staff B said they tried to go through the kitchen refrigerators and freezers monthly but due to staffing shortages the task had slipped through the cracks.

In an interview on 05/15/2024 at 9:35 AM, Staff B inquired with the Department licensor if they needed to complete hand hygiene after they changed their gloves if they were not changing tasks in the kitchen. Staff B said they were sure the facility had a hand washing policy they could review. Staff B said they wanted to clarify the correct way they should perform the procedure because their facility's policy could be wrong. Staff B said they had been working on developing kitchen policies because there were not systems in place for them to reference to know what to do and when. Staff B said they were unsure how to create policies for the kitchen as there were not policies readily available to review.

In an interview on 05/15/2024 at 9:18 AM, Staff A, Administrator, said they did not have a

Statement of Deficiencies	License #: 2363	Compliance Determination # 411136
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policy binder to review. Staff A said they had been in the process of re-doing a lot of the facility policies. Staff A said some policies were electronic whereas others were hard copies.

Plan/Attestation Statement

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Administrator (or Representative) 6-10-2024 Date

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Administrator (or Representative) Date

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

06/05/2024

Elma Homecare, Inc
Elma Home Care
PO Box 759
Elma, WA 98541

RE: Elma Home Care # 2383

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/30/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

Manfay Chan, Field Manager
Residential Care Services
Region 3, Unit E
800 NE 136th Ave Ste 200

Vancouver, WA 98684

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

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

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

Facility has the residents smoking across from resident windows and door entry to the facility less than 25 ft per Washington State law. There were no concerns expressed from the residents in regards to the smoking smells from the rooms that their windows face the smoking area. The Fire Marshall did not have any expressed concerns.

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

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

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

after review of 2 of 2 staff members they had a background checked after 2 years of employment, but one staff member was 6 months late and the other staff member had it done 4 years late. The ED identified that they weren't done and completed them. The facility has a tracking system in place to ensure staff get the required Washington state Name and Date of Birth background check every 2 years.

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

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

In Addition, You May:

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

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

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

Sincerely,

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

Enclosure