STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Legacy1864, LLC
Willow Grove
1620 E Mead St
Spokane, WA 99218

RE: Willow Grove License # 2399

Dear Administrator:

This letter addresses Compliance Determination(s) 42767 (Completion Date 06/13/2024) and 39648 (Completion Date 04/19/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/13/2024 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-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120, WAC 388-78A-2210, WAC 388-78A-2210-1, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2240, WAC 388-78A-2320, WAC 388-78A-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2730, WAC 388-78A-2730-1, WAC 388-78A-2730-1-a, WAC 388-78A-2730-1-b, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-iii, WAC 388-78A-2090, WAC 388-78A-2090-1, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-2, WAC 388-78A-2090-2-a, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3, WAC 388-78A-2090-4, WAC 388-78A-2090-4-a, WAC 388-78A-2090-4-b, WAC 388-78A-2090-5, WAC 388-78A-2090-5-a, WAC 388-78A-2090-5-b, WAC 388-78A-2090-5-c, WAC 388-78A-2090-6, WAC 388-78A-2090-6-a, WAC 388-78A-2090-6-b, WAC 388-78A-2090-6-c, WAC 388-78A-2090-6-d, WAC 388-78A-2090-6-e, WAC 388-78A-2090-7, WAC 388-78A-2090-7-a, WAC 388-78A-2090-7-b, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii, WAC 388-78A-2090-7-d, WAC 388-78A-2090-8, WAC 388-78A-2090-8-a, WAC 388-78A-2090-8-b, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-9, WAC 388-78A-2090-10, WAC 388-78A-2090-11, WAC 388-78A-2090-11-a, WAC 388-78A-2090-11-b, WAC 388-78A-2090-11-c

The Department staff who did the on-site verification:

Tethra Wales, Assisted Living Facility Licensor
Brian Zbylski, ALF Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2389	Compliance Determination # 39648
Plan of Correction	Willow Grove	Completion Date
Page 1 of 22	Licensee: Legacy1864, LLC	04/19/2024

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

The department completed data collection for the unannounced on-site full inspection on 04/12/2024, 04/16/2024, 04/17/2024, 04/18/2024 and 04/19/2024 of:
Willow Grove
1620 E Mead St
Spokane, WA 99218

The following sample was selected for review during the unannounced on-site visit: 5 of 20 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor
Carla Rose, NCI Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S.[illegible]
Residential Care Services

04/30/2024
Date

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 04/12/2024, 04/16/2024, 04/17/2024, 04/18/2024 and 04/19/2024 of:
Willow Grove
1620 E Mead St
Spokane, WA 99218

The following sample was selected for review during the unannounced on-site visit: 5 of 20 current residents and 0 former residents.

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Carla Rose, NCI Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

Residential Care Services _____ Date _____

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

Statement of Deficiencies	License #: 2399	Compliance Determination #39646
Plan of Correction	Willow Grove	Completion Date
Page 2 of 22	Licensee: Legacy1864, LLC	04/19/2024

Ashley Bennett
Administrator (or Representative)

05/09/2024
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:

(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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that fluid and dietary restrictions were monitored for 1 of 5 sampled residents (Resident 2) and failed to ensure that chronic skin conditions were monitored for 2 of 5 sampled residents (Residents 1 and 4). These failures placed Resident 2 at risk of health complications due to their diet and fluid restrictions not being monitored, and placed Resident 1 and Resident 4 at risk of worsening wound development.

Findings included...

<Fluid and Dietary Restrictions>

Review of Resident 2's Skilled Nursing Facility Transfer Orders, dated 02/02/2024, showed diagnoses of [redacted] and [redacted]. Further review showed Resident 2 had orders to restrict fluids to 1500 ml (milliliters) (equivalent to 50 ounces) per day and to restrict dietary intake to less than 1200 mg (milligrams) of phosphorus (mineral) per day.

Review of the profile in Resident 2's electronic chart showed a notation by Staff A, Administrator, dated 02/04/2024, that read, "DIET RESTRICTION: 1500 ml of fluids daily (50 fluid ounces) AND phosphorus restricted less than 1200mg per day." Dietary restrictions under key indicators in the profile listed, "Fluid and phosphorus restriction."

Review of Resident 2's Negotiated Care Plan (NSA, the facility's titled negotiated service

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;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that fluid and dietary restrictions were monitored for 1 of 5 sampled residents (Resident 2) and failed to ensure that chronic skin conditions were monitored for 2 of 5 sampled residents (Residents 1 and 4). These failures placed Resident 2 at risk of health complications due to their diet and fluid restrictions not being monitored, and placed Resident 1 and Resident 4 at risk of worsening wound development.

Findings included…

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Review of Resident 2's Skilled Nursing Facility Transfer Orders, dated 02/02/2024, showed diagnoses of [redacted] and [redacted]. Further review showed Resident 2 had orders to restrict fluids to 1500 ml (milliliters) (equivalent to 50 ounces) per day and to restrict dietary intake to less than 1200 mg (milligrams) of phosphorus (mineral) per day.

Review of the profile in Resident 2's electronic chart showed a notation by Staff A, Administrator, dated 02/04/2024, that read, "DIET RESTRICTION: 1500 ml of fluids daily (50 fluid ounces) AND phosphorus restricted less than 1200mg per day." Dietary restrictions under key indicators in the profile listed, "Fluid and phosphorus restriction."

Review of Resident 2's Negotiated Care Plan (NSA, the facility's titled negotiated service

agreement), dated 03/08/2024, showed that Resident 2 ate a normal diet and was on a fluid restriction. The NSA showed the resident's daily fluid intake needed to be 1500 ML or less (50 ounces). The NSA showed that care staff needed to measure the resident's fluid intake by ensuring the resident used a 24-ounce cup provided by the facility, and care staff were to only provide refills as needed.

Review of Resident 2's task administration records (TARs) for February 2024, March 2024, and April 2024, showed care instructions to "Log each 8oz of liquid given to resident throughout the day." Review of the February 2024 and March 2024 TARs showed a total of four fields (each represented 8 ounces) for staff to document the resident's fluid intake each day. Review of the April 2024 TARs showed a total of three fields (each represented 8 ounces) for staff to document the resident's fluid each day. Further review showed that care staff only documented the resident drank 8 ounces of liquid, six times during the month of February, 25 times during the month of March, and six times during the month of April, indicating that care staff were not documenting/monitoring the resident's complete fluid intake.

In an interview on 04/16/2024 at 11:40 AM Staff B, Director of Care, stated that Resident 2 used a measured cup (fill line) when drinking fluids. Staff B further stated that med techs were responsible to fill the cup and track the fluid intake. When asked how the med techs tracked the fluid intake, Staff B stated that it should be documented on the TARs.

In an interview on 04/16/2024 at 11:46 AM, Staff B stated that there were paper fluid trackers kept on the med cart that staff utilized to track Resident 2's fluid intake.

In an interview on 04/16/2024 at 11:52 AM, Staff B stated that staff discarded the paper fluid trackers at the end of the day. Staff B stated they would provide a copy of the fluid tracker being utilized for the week of 04/15/2024 – 04/21/2024 for review.

Review of an undated Fluid Tracker, provided by Staff B, showed Resident 2's name and fields for each day of the week covering a span of two weeks. Entries under Week 1 Monday read "20oz @ breakfast" and "20oz @ lunch". A single entry under Week 2 Monday (a date that had not yet occurred) read "20oz". A single entry under Week 1 Tuesday read "15 BF [breakfast]". All other fields on the tracker, including the dates and daily totals, were blank.

In an interview on 04/16/2024 at 11:54 AM Staff C, Caregiver/Med-tech, stated that Resident 2 had a cup they carried around during the day that had a line of measurement on it. Staff C stated that the cup used by Resident 2 at lunch that day was a regular cup and not the measured cup designated for Resident 2.

Observation of lunch service on 04/16/2024 at 11:55 AM, showed Resident 2 in the dining room drank from a large, clear, unmarked cup that was identical to the cups being used by other residents in the dining room (not the their measured cup).

agreement), dated 03/08/2024, showed that Resident 2 ate a normal diet and was on a fluid restriction. The NSA showed the resident's daily fluid intake needed to be 1500 ML or less (50 ounces). The NSA showed that care staff needed to measure the resident's fluid intake by ensuring the resident used a 24-ounce cup provided by the facility, and care staff were to only provide refills as needed.

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In an interview on 04/16/2024 at 11:54 AM Staff C, Caregiver/Med-tech, stated that Resident 2 had a cup they carried around during the day that had a line of measurement on it. Staff C stated that the cup used by Resident 2 at lunch that day was a regular cup and not the measured cup designated for Resident 2.

Observation of lunch service on 04/16/2024 at 11:55 AM, showed Resident 2 in the dining room drank from a large, clear, unmarked cup that was identical to the cups being used by other residents in the dining room (not the their measured cup).

In an interview on 04/16/2024 at 11:58 AM Staff G, Kitchen Manager, stated that kitchen staff gave Resident 2 an 8-ounce cup of the beverage being served at every meal and that no refills were permitted. Staff G stated that they would let the med tech know so they could record the fluid intake. When asked about Resident 2's personal measured cup, Staff G stated the resident did not use it at meals.

Observation in the kitchen on 04/16/2024 at 12:11 PM showed a white board noting dietary instructions for residents with Resident 2's initials followed by "NO FLUIDS (No fluids w/ any meal)".

Review of Resident 2's TARs, NSA, and assessment showed no documentation of the phosphorus restriction, or instructions and method for tracking.

In an interview on 04/17/2024 at 1:05 PM, Staff A stated that they had not received an order to discontinue the phosphorus restriction and that they had not tracked Resident 2's phosphorus intake.

<Skin Breakdown>

Review of the facility's undated policy titled, "Skin Breakdown," showed the following steps were to be completed when there was a concern of skin breakdown discovered by caregivers.

-Chart observation and complete a skin check in the Extended Care Professional (ECP, electronic charting system).

-Notify supervisor or Director of Care (DOC), supervisor to notify the DOC

-Notify residents' primary care physician and guardian if applicable.

-Continue to monitor and report changes.

-Always document changes observed

In an interview on 04/16/2024 at 2:55 PM, Staff B stated that if caregivers found skin issues, the caregivers were to document the findings and notify Staff B immediately. Staff B stated that they (Staff B) would evaluate the resident's skin, determine the next course of action, and document the assessment and actions to be taken.

In an interview on 04/16/2024 at 11:58 AM Staff G, Kitchen Manager, stated that kitchen staff gave Resident 2 an 8-ounce cup of the beverage being served at every meal and that no refills were permitted. Staff G stated that they would let the med tech know so they could record the fluid intake. When asked about Resident 2's personal measured cup, Staff G stated the resident did not use it at meals.

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In an interview on 04/17/2024 at 1:05 PM, Staff A stated that they had not received an order to discontinue the phosphorus restriction and that they had not tracked Resident 2's phosphorus intake.

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Review of the facility's undated policy titled, "Skin Breakdown," showed the following steps were to be completed when there was a concern of skin breakdown discovered by caregivers:

-Chart observation and complete a skin check in the Extended Care Professional (ECP, electronic charting system).

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-Notify residents' primary care physician and guardian if applicable.

-Continue to monitor and report changes.

-Always document changes observed.

In an interview on 04/16/2024 at 2:55 PM, Staff B stated that if caregivers found skin issues, the caregivers were to document the findings and notify Staff B immediately. Staff B stated that they (Staff B) would evaluate the resident's skin, determine the next course of action, and document the assessment and actions to be taken.

<Resident 1>

Review of Resident 1's annual assessment, dated 11/29/2023, showed the resident was wheelchair dependent and diagnosed with [redacted]. Further review showed that Resident 1 had [redacted] and [redacted].

Review of Resident 1's NSA, dated 05/10/2023, showed that Resident 1 required skin checks two times a week on the resident's scheduled shower days.

Review of Resident 1's TARs for February 2024, March 2024, and April 2024, showed a task for "monthly skin checks." The fields provided for the monthly skin checks were blank, indicating that staff did not document/monitor the resident's skin.

Review of a Care History for All Residents document showed skin check records for Resident 1 dated 02/24/2024 and 03/30/2024. Both records showed documentation by a caregiver that indicated "yes" for the question "were there any issues or concerns with the resident's skin?". Further review showed answers of "red on bottom" documented as the location of concern.

Review of Resident 1's progress notes for the months of February 2024, March 2024, and April 2024, showed they did not contain any documentation of an assessment, evaluation, or course of action regarding the areas of redness noted on the skin check records.

<Resident 4>

Review of Resident 4's annual assessment, dated 11/17/2023, showed the resident was diagnosed with [redacted] and [redacted].

Review of Resident 4's NSA, dated 12/01/2023, showed that Resident 1 used a wheelchair and required skin checks with their showers two times a week, with skin issues to be reported as required by the facility's policy. Further review showed that Resident 4 was incontinent of bowel and bladder and that staff were to "monitor for signs of infection: redness, pain, rash, irritation."

Review of Resident 4's TARs for February 2024, March 2024, and April 2024, showed a task for "monthly skin checks." The fields provided for the monthly skin checks were blank, indicating that staff did not document/monitor the resident's skin.

Review of Resident 4's progress notes for March 2024 and April 2024, showed a caregiver had entered a note, dated 03/19/2024, that stated, "staff noticed open wound, was

<Resident 1>

Review of Resident 1's annual assessment, dated 11/29/2023, showed the resident was wheelchair dependent and diagnosed with [redacted]. Further review showed that Resident 1 had [redacted] and [redacted].

Review of Resident 1's NSA, dated 05/10/2023, showed that Resident 1 required skin checks two times a week on the resident's scheduled shower days.

Review of Resident 1's TARs for February 2024, March 2024, and April 2024, showed a task for "monthly skin checks." The fields provided for the monthly skin checks were blank, indicating that staff did not document/monitor the resident's skin.

Review of a Care History for All Residents document showed skin check records for Resident 1 dated 02/24/2024 and 03/30/2024. Both records showed documentation by a caregiver that indicated "yes" for the question "were there any issues or concerns with the resident's skin?". Further review showed answers of "red on bottom" documented as the location of concern.

Review of Resident 1's progress notes for the months of February 2024, March 2024, and April 2024, showed they did not contain any documentation of an assessment, evaluation, or course of action regarding the areas of redness noted on the skin check records.

<Resident 4>

Review of Resident 4's annual assessment, dated 11/17/2023, showed the resident was diagnosed with [redacted] and [redacted].

Review of Resident 4's NSA, dated 12/01/2023, showed that Resident 1 used a wheelchair and required skin checks with their showers two times a week, with skin issues to be reported as required by the facility's policy. Further review showed that Resident 4 was incontinent of bowel and bladder and that staff were to "monitor for signs of infection: redness, pain, rash, irritation."

Review of Resident 4's TARs for February 2024, March 2024, and April 2024, showed a task for "monthly skin checks." The fields provided for the monthly skin checks were blank, indicating that staff did not document/monitor the resident's skin.

Review of Resident 4's progress notes for March 2024 and April 2024, showed a caregiver had entered a note, dated 03/19/2024, that stated, "staff noticed open wound, was

reported to management. Further review showed the progress notes did not contain any other documentation regarding evaluation or treatment of the wound noted on 03/19/2024.

In an interview on 04/18/2024 at 10:30 AM Staff A, Administrator, and Staff B stated that Resident 4 would frequently get blisters on their buttocks due to incontinence.

In an interview on 04/18/2024 at 10:50 AM, Staff A confirmed that no further action had been taken to evaluate or treat Resident 4's wound that was noted on 03/19/2024.

This is a recurring deficiency previously cited on 07/21/2021.

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24

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

Ashley Beutt
Administrator (or representative)

5/9/24
Date

WAC 388-78A-2210 Medication services.

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the medication administration records accurately reflected medication services provided and required for 4 of 5 sampled residents (Residents 1, 2, 4 and 5). This failure resulted in Resident 2 and Resident 4 receiving their medications differently than how prescribed due

reported to management." Further review showed the progress notes did not contain any other documentation regarding evaluation or treatment of the wound noted on 03/19/2024.

In an interview on 04/18/2024 at 10:30 AM Staff A, Administrator, and Staff B stated that Resident 4 would frequently get blisters on their buttocks due to incontinence.

In an interview on 04/18/2024 at 10:50 AM, Staff A confirmed that no further action had been taken to evaluate or treat Resident 4's wound that was noted on 03/19/2024.

This is a recurring deficiency previously cited on 07/21/2021.

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, Willow Grove 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-2210 Medication services.

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the medication administration records accurately reflected medication services provided and required for 4 of 5 sampled residents (Residents 1, 2, 4 and 5). This failure resulted in Resident 2 and Resident 4 receiving their medications differently than how prescribed due

to transcription errors, inaccurate medication administration documentation, and placed residents at risk of health complications.

Findings included...

Medication documentation errors

<Resident 2>

Review of Resident 2's Negotiated Care Plan (NSA, the facility's titled negotiated service agreement), dated 03/08/2024, showed that "Care staff will be responsible for medication administration."

Review of Resident 2's medication administration records (MARs) for February 2024 and March 2024 showed the resident was prescribed a vitamin supplement and levothyroxine (a hormone medication). Further review of the MARs showed the vitamin supplement was documented inaccurately as "administered" on 02/13/2024 and the levothyroxine was documented inaccurately as "administered" on 03/08/2024, 03/10/2024, and 03/12/2024.

In an interview on 04/16/2024 at 2:40 PM Staff A, Administrator, and Staff B, Director of Care, stated that the vitamin supplement and the levothyroxine had not been administered on the dates noted above and identified the chartings as documentation errors. Staff B stated the medications had not been available for administration on those dates.

<Resident 5>

Review of Resident 5's NSA, dated 04/17/2023, showed that the facility provided medication assistance.

Review of Resident 5's MAR for March 2024 showed the resident was prescribed a vitamin supplement. Further review of the MAR showed the vitamin supplement was documented inaccurately as "administered" on 03/04/2024 and 03/11/2024.

In an interview on 04/19/2024 at 11:45am, Staff B stated that the vitamin supplement had not been administered on 03/04/2024 and 03/11/2024 and identified the chartings as documentation errors. Staff B stated that the medication had not been on site the entire month of March.

In an interview on 04/17/2024 at 11:20 AM Staff A stated that they had not completed any

to transcription errors, inaccurate medication administration documentation, and placed residents at risk of health complications.

Findings included…

Medication documentation errors

<Resident 2>

Review of Resident 2's Negotiated Care Plan (NSA, the facility's titled negotiated service agreement), dated 03/08/2024, showed that "Care staff will be responsible for medication administration."

Review of Resident 2's medication administration records (MARs) for February 2024 and March 2024 showed the resident was prescribed a vitamin supplement and levothyroxine (a hormone medication). Further review of the MARs showed the vitamin supplement was documented inaccurately as "administered" on 02/13/2024 and the levothyroxine was documented inaccurately as "administered" on 03/08/2024, 03/10/2024, and 03/12/2024.

In an interview on 04/16/2024 at 2:40 PM Staff A, Administrator, and Staff B, Director of Care, stated that the vitamin supplement and the levothyroxine had not been administered on the dates noted above and identified the chartings as documentation errors. Staff B stated the medications had not been available for administration on those dates.

<Resident 5>

Review of Resident 5's NSA, dated 04/17/2023, showed that the facility provided medication assistance.

Review of Resident 5's MAR for March 2024 showed the resident was prescribed a vitamin supplement. Further review of the MAR showed the vitamin supplement was documented inaccurately as "administered" on 03/04/2024 and 03/11/2024.

In an interview on 04/19/2024 at 11:45am, Staff B stated that the vitamin supplement had not been administered on 03/04/2024 and 03/11/2024 and identified the chartings as documentation errors. Staff B stated that the medication had not been on site the entire month of March.

In an interview on 04/17/2024 at 11:20 AM Staff A stated that they had not completed any

medication audits since the end of January 2024.

Review of the facility's last medication audit showed it was completed on 01/27/2024.

Transcription documentation errors

<Resident 1>

Review of Resident 1's NSA, dated 05/10/2023, showed the resident had orders for crushed medications due to a choking risk and that the facility provided medication assistance.

Review of Resident 1's physician's orders, dated 09/06/2022, showed instructions to "crush all crushable meds and administer with medium of choice."

Review of Resident 1's MARs for February 2024, March 2024, and April 2024, showed no transcribed instructions to crush the resident's medications.

<Resident 4>

Review of Resident 4's NSA, dated 12/03/2023, showed they had orders to crush medications due to their history of choking and that the facility provided medication assistance.

Review of Resident 4's physician's orders, dated 04/05/2021, showed instructions to "crush medications and administer with medium of choice."

Review of Resident 4's MARs for February 2024, March 2024, and April 2024, showed no transcribed instructions to crush medications.

In an interview on 04/16/2024 at 2:20 PM, Staff A was asked how caregivers knew which residents had crushed medication orders. Staff A replied that caregivers knew from their medication training.

Observation of the facility's medication cart on 04/16/2024 at 2:20 PM, showed a post-it note on the computer monitor that read "medications whole [not crushed] in sauce," with a list of resident names that included Resident 1 and Resident 4.

In an interview on 04/17/2024 at 12:25 PM, Staff F, Caregiver/Med-tech, was asked which

medication audits since the end of January 2024.

Review of the facility's last medication audit showed it was completed on 01/27/2024.

Transcription documentation errors

<Resident 1>

Review of Resident 1's NSA, dated 05/10/2023, showed the resident had orders for crushed medications due to a choking risk and that the facility provided medication assistance.

Review of Resident 1's physician's orders, dated 09/06/2022, showed instructions to "crush all crushable meds and administer with medium of choice."

Review of Resident 1's MARs for February 2024, March 2024, and April 2024, showed no transcribed instructions to crush the resident's medications.

<Resident 4>

Review of Resident 4's NSA, dated 12/03/2023, showed they had orders to crush medications due to their history of choking and that the facility provided medication assistance.

Review of Resident 4's physician's orders, dated 04/05/2021, showed instructions to "crush medications and administer with medium of choice."

Review of Resident 4's MARs for February 2024, March 2024, and April 2024, showed no transcribed instructions to crush medications.

In an interview on 04/16/2024 at 2:20 PM, Staff A was asked how caregivers knew which residents had crushed medication orders. Staff A replied that caregivers knew from their medication training.

Observation of the facility's medication cart on 04/16/2024 at 2:20 PM, showed a post-it note on the computer monitor that read "medications whole [not crushed] in sauce," with a list of resident names that included Resident 1 and Resident 4.

In an interview on 04/17/2024 at 12:25 PM, Staff F, Caregiver/Med-tech, was asked which

residents had crushed medication orders. Staff F stated that Resident 6 was the only resident that had an order to crush medications. When asked how Staff F knew when to crush medications, Staff F replied, "because they told me and there is a post-it here." Observation at that time showed Staff F then pointed to the post-it note on the computer monitor on the medication cart.

In an interview on 04/17/2024 at 3:20 PM, Staff A stated that med-techs were not crushing medication for Resident 4 because "he chews them."

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24

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

Ashley Bennett
Administrator (or Representative)

5/9/24
Date

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were renewed and available for administration for 3 of 5 sampled residents (Residents 1, 2, and 5). This failure resulted in the residents not receiving their prescribed medications and placed the residents at risk of health complications.

Findings included...

Review of the facility's undated policy titled, "Medication Reordering," showed, "Medications will be reordered eight days prior to running out," "Medication/Pill audits will be conducted regularly to ensure we have adequate stock," and "Medications will be in house prior to running out."

<Resident 1>

residents had crushed medication orders. Staff F stated that Resident 6 was the only resident that had an order to crush medications. When asked how Staff F knew when to crush medications, Staff F replied, “because they told me and there is a post-it here.” Observation at that time showed Staff F then pointed to the post-it note on the computer monitor on the medication cart.

In an interview on 04/17/2024 at 3:20 PM, Staff A stated that med-techs were not crushing medication for Resident 4 because “he chews them.”

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were renewed and available for administration for 3 of 5 sampled residents (Residents 1, 2, and 5). This failure resulted in the residents not receiving their prescribed medications and placed the residents at risk of health complications.

Findings included…

Review of the facility’s undated policy titled, “Medication Reordering,” showed, “Medications will be reordered eight days prior to running out,” “Medication/Pill audits will be conducted regularly to ensure we have adequate stock,” and “Medications will be in house prior to running out.”

<Resident 1>

Statement of Deficiencies	License # 2389	Compliance Determination # 39646
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Review of Resident 1's Negotiated Care Plan (NSA, the facility's titled negotiated service agreement), dated 05/10/2023, showed that the facility provided medication assistance.

Review of Resident 1's assessment, dated 11/29/2023, showed the resident was diagnosed with [redacted]

Review of Resident 1's medication administration record (MAR) for February 2024, showed that Resident 1 had a prescription order for a weekly injection of Trulicity (an injectable medication used to lower blood sugar levels). The February MAR showed that Resident 1 did not receive their Trulicity injection on 02/04/2024, 02/11/2024, and 02/18/2024.

Review of a fax document regarding Resident 1's Trulicity, showed the pharmacy was contacted by the facility on 02/06/2024 (two days after the first missed dose). Further review showed the pharmacy responded on 02/07/2024, with a notification that the prescribed dose was on back order.

Review of a fax document regarding Resident 1's Trulicity, showed Resident 1's provider was contacted on 02/15/2024 (eight days after learning of the back order), with a note that stated the prescribed dose was on backorder. Further review showed the provider responded on 02/16/2024, with orders for a different dose of Trulicity.

In an interview on 04/16/2024 at 3:05 PM Staff A, Administrator, stated that they were unable to provide any additional information or documentation regarding the time gaps between the faxed communications regarding Resident 1's Trulicity refill.

<Resident 2>

Review of Resident 2's NSA, dated 03/08/2024, showed that care staff were responsible for medication administration.

Review of Resident 2's assessment, dated 01/24/2024, showed they were diagnosed with [redacted] and [redacted]

Review of Resident 2's February 2024 MAR showed that the resident had a prescription order for sodium chloride (electrolyte replacement) three times a day. Further review of the MAR showed that Resident 2 did not receive the medication from 02/20/2024 through 02/29/2024 and was documented as, "waiting on delivery," "waiting on pharmacy," "waiting on medication delivery," and "held".

Review of Resident 2's February 2024 and March 2024 MARs showed that the resident had a prescription order for adult multivitamin with minerals one time a day. Further review of

Review of Resident 1's Negotiated Care Plan (NSA, the facility's titled negotiated service agreement), dated 05/10/2023, showed that the facility provided medication assistance.

Review of Resident 1's assessment, dated 11/29/2023, showed the resident was diagnosed with [redacted].

Review of Resident 1's medication administration record (MAR) for February 2024, showed that Resident 1 had a prescription order for a weekly injection of Trulicity (an injectable medication used to lower blood sugar levels). The February MAR showed that Resident 1 did not receive their Trulicity injection on 02/04/2024, 02/11/2024, and 02/18/2024.

Review of a fax document regarding Resident 1's Trulicity, showed the pharmacy was contacted by the facility on 02/06/2024 (two days after the first missed dose). Further review showed the pharmacy responded on 02/07/2024, with a notification that the prescribed dose was on back order.

Review of a fax document regarding Resident 1's Trulicity, showed Resident 1's provider was contacted on 02/15/2024 (eight days after learning of the back order), with a note that stated the prescribed dose was on backorder. Further review showed the provider responded on 02/16/2024, with orders for a different dose of Trulicity.

In an interview on 04/16/2024 at 3:05 PM Staff A, Administrator, stated that they were unable to provide any additional information or documentation regarding the time gaps between the faxed communications regarding Resident 1's Trulicity refill.

<Resident 2>

Review of Resident 2's NSA, dated 03/08/2024, showed that care staff were responsible for medication administration.

Review of Resident 2's assessment, dated 01/24/2024, showed they were diagnosed with [redacted] and [redacted].

Review of Resident 2's February 2024 MAR showed that the resident had a prescription order for sodium chloride (electrolyte replacement) three times a day. Further review of the MAR showed that Resident 2 did not receive the medication from 02/20/2024 through 02/29/2024 and was documented as, "waiting on delivery," "waiting on pharmacy," "waiting on medication delivery," and "held".

Review of Resident 2's February 2024 and March 2024 MARs showed that the resident had a prescription order for adult multivitamin with minerals one time a day. Further review of

the MARs showed that Resident 2 did not receive the medication from 02/20/2024 through 03/04/2024 and was documented as, "waiting on delivery," "waiting on med arrival," "oos [out of stock]," "waiting on delivery," and "held".

Review of Resident 2's February 2024 MAR showed that the resident had a prescription order for melatonin (supplement) one time a day. Further review of the MAR showed the Resident 2 did not receive the medication from 02/20/2024 through 02/29/2024 and was documented as, "waiting on pharmacy" and "held."

Review of a fax document, dated 02/26/2024 and regarding Resident 2's sodium chloride, multivitamin, and melatonin, showed a request for the medications. No documentation was provided to show the facility attempted to renew the medications prior to 02/26/2024.

Review of Resident 2's March 2024 and April 2024 MARs showed that the resident had a prescription order for magnesium oxide (supplement) one time a day. Further review of the MARs showed that Resident 2 did not receive the medication from 03/14/2024 through 04/19/2024 and was documented as, "medication is not available. Will order today" and "held".

Review of a fax document, dated 03/14/2024 and regarding Resident 2's magnesium oxide, showed that the pharmacy faxed the provider regarding the prescription. No documentation was provided to show the facility attempted to renew the medication after 03/14/2024.

Review of Resident 2's March 2024 MAR showed that the resident had a prescription order for levothyroxine (hormone medication for underactive thyroid) one time a day. Further review of the MAR showed that Resident 2 did not receive the medication from 03/07/2024 through 03/13/2024 and was documented as "waiting on pharmacy" and "held".

In an interview on 04/16/2024 at 2:40 PM Staff A and Staff B, Director of Care, stated that on the dates reviewed (listed above) the medications were not on site and that anytime the MARs documented the lack of medication administration as "held," it meant they were waiting on a refill.

In an interview on 04/17/2024 at 12:39 PM, Staff D, Administrative Assistant/Caregiver, stated that the facility's protocol was to put a medication on hold if it was not on site, so they didn't continue to document the medication as not given, on the MARs.

In an interview on 04/18/2024 at 4:24 PM, Staff A and Staff B stated they did not have orders from the residents' health care providers to hold the medications when they were waiting on refills.

the MARs showed that Resident 2 did not receive the medication from 02/20/2024 through 03/04/2024 and was documented as, “waiting on delivery,” “waiting on med arrival,” “oos [out of stock],” “waiting on delivery,” and “held”.

Review of Resident 2’s February 2024 MAR showed that the resident had a prescription order for melatonin (supplement) one time a day. Further review of the MAR showed the Resident 2 did not receive the medication from 02/20/2024 through 02/28/2024 and was documented as, “waiting on pharmacy” and “held.”

Review of a fax document, dated 02/26/2024 and regarding Resident 2’s sodium chloride, multivitamin, and melatonin, showed a request for the medications. No documentation was provided to show the facility attempted to renew the medications prior to 02/26/2024.

Review of Resident 2’s March 2024 and April 2024 MARs showed that the resident had a prescription order for magnesium oxide (supplement) one time a day. Further review of the MARs showed that Resident 2 did not receive the medication from 03/14/2024 through 04/10/2024 and was documented as, “medication is not available. Will order today” and “held”.

Review of a fax document, dated 03/14/2024 and regarding Resident 2’s magnesium oxide, showed that the pharmacy faxed the provider regarding the prescription. No documentation was provided to show the facility attempted to renew the medication after 03/14/2024.

Review of Resident 2’s March 2024 MAR showed that the resident had a prescription order for levothyroxine (hormone medication for underactive thyroid) one time a day. Further review of the MAR showed that Resident 2 did not receive the medication from 03/07/2024 through 03/13/2024 and was documented as “waiting on pharmacy” and “held”.

In an interview on 04/16/2024 at 2:40 PM Staff A and Staff B, Director of Care, stated that on the dates reviewed (listed above) the medications were not on site and that anytime the MARs documented the lack of medication administration as “held,” it meant they were waiting on a refill.

In an interview on 04/17/2024 at 12:39 PM, Staff D, Administrative Assistant/Caregiver, stated that the facility’s protocol was to put a medication on hold if it was not on site, so they didn’t continue to document the medication as not given, on the MARs.

In an interview on 04/18/2024 at 4:24 PM, Staff A and Staff B stated they did not have orders from the residents’ health care providers to hold the medications when they were waiting on refills.

<Resident 5>

Review of Resident 5's March 2024 and April 2024 MARs showed that the resident had a prescription order for vitamin D2 (vitamin supplement) one time a week. Further review of the MARs showed that Resident 5 did not receive the medication from 03/18/2024 through 04/08/2024 and was documented as "waiting on meds," "still have not received med from pharmacy," "out of medication," and "medication out of stock."

In an interview on 04/18/2024 at 11:45 AM, Staff B stated there had been documentation errors on the Resident 5's MAR and that Resident 5 did not receive the vitamin D2 from 03/04/2024 through 04/08/2024 as the medication was not on site. Staff B stated they had two different orders from two different providers, and the facility had not addressed the issue until the middle of March.

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24

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

Ashley Bennett — Administrator (or Representative)

5-9-24 — Date

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

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

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.78 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that nurse delegated tasks were performed by qualified and trained staff for 3 of 5 sampled residents (Residents 1, 3, and 4). This failure placed the residents at risk of harm and medication errors due to receiving nurse delegated medication and tasks from unqualified caregivers.

<Resident 5>

Review of Resident 5's March 2024 and April 2024 MARs showed that the resident had a prescription order for vitamin D2 (vitamin supplement) one time a week. Further review of the MARs showed that Resident 5 did not receive the medication from 03/18/2024 through 04/08/2024 and was documented as "waiting on meds," "still have not received med from pharmacy," "out of medication," and "medication out of stock."

In an interview on 04/19/2024 at 11:45 AM, Staff B stated there had been documentation errors on the Resident 5's MAR and that Resident 5 did not receive the vitamin D2 from 03/04/2024 through 04/08/2024 as the medication was not on site. Staff B stated they had two different orders from two different providers, and the facility had not addressed the issue until the middle of March.

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_____ _____

Administrator (or Representative) Date

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

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

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that nurse delegated tasks were performed by qualified and trained staff for 3 of 5 sampled residents (Residents 1, 3, and 4). This failure placed the residents at risk of harm and medication errors due to receiving nurse delegated medication and tasks from unqualified caregivers.

Findings included..

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a task the registered nurse delegator (RND):

-Assesses the resident's nursing care needs and determines the patient's condition is stable and predictable

-Obtains written consent from the authorized representative for nurse delegation within 30 days.

-Assesses the ability of the nursing assistant (NA) or home care aide (HCA) to competently perform the delegated nursing task in the absence of direct or immediate supervision.

-The RND ensures safe and effective services are provided and re-evaluation and documentation occur at least every 90 days.

<Resident 1>

Review of Resident 1's assessment, dated 11/29/2023, showed the resident was diagnosed with [redacted] and [redacted].

Review of Resident 1's medication administration records (MARs) for February 2024, March 2024 and April 2024, showed orders for Resident 1's blood sugar to be checked two times a week and Trulicity (an injectable medication for diabetes to lower blood sugar levels) to be administered one time a week (both tasks requiring nurse delegation). Further review showed that the Trulicity injections and blood sugar checks were performed by caregivers that had not been assessed for competency by the RND.

In an interview on 04/16/2024 at 2:40 PM, Resident 1 stated that caregivers administered their weekly Trulicity injection. Resident 1 further stated that at times the facility caregivers performed the resident's blood sugar checks.

In an interview on 04/16/2024 at 4:12 PM, Staff A, Administrator, stated that staff held the syringe for Resident 1 during the administration of the Trulicity injection.

Review of Resident 1's undated medical chart showed no documentation of any records related to nurse delegation tasks and requirements.

Findings included…

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a task the registered nurse delegator (RND):

-Assesses the resident's nursing care needs and determines the patient's condition is stable and predictable.

-Obtains written consent from the authorized representative for nurse delegation within 30 days.

-Assesses the ability of the nursing assistant (NA) or home care aide (HCA) to competently perform the delegated nursing task in the absence of direct or immediate supervision.

-The RND ensures safe and effective services are provided and re-evaluation and documentation occur at least every 90 days.

<Resident 1>

Review of Resident 1's assessment, dated 11/29/2023, showed the resident was diagnosed with [redacted], and [redacted].

Review of Resident 1's medication administration records (MARs) for February 2024, March 2024, and April 2024, showed orders for Resident 1's blood sugar to be checked two times a week and Trulicity (an injectable medication for diabetes to lower blood sugar levels) to be administered one time a week (both tasks requiring nurse delegation). Further review showed that the Trulicity injections and blood sugar checks were performed by caregivers that had not been assessed for competency by the RND.

In an interview on 04/16/2024 at 2:40 PM, Resident 1 stated that caregivers administered their weekly Trulicity injection. Resident 1 further stated that at times the facility caregivers performed the resident's blood sugar checks.

In an interview on 04/16/2024 at 4:12 PM, Staff A, Administrator, stated that staff held the syringe for Resident 1 during the administration of the Trulicity injection.

Review of Resident 1's undated medical chart showed no documentation of any records related to nurse delegation tasks and requirements.

<Resident 3>

Review of Resident 3's assessment, dated 09/28/2023, showed the resident was diagnosed with [redacted]. The assessment contained documentation by the RND that indicated that Resident 3 required nurse delegation for their eye drop administration.

Review of Resident 3's MARs for February 2024, March 2024, and April 2024, showed they were prescribed eye drops to be given three times a day. Further review showed that the eye drops were administered by caregivers that had not been assessed for competency by the RND.

Review of Resident 3's undated medical chart showed it did not contain any records for nurse delegation tasks.

In an interview on 04/19/2024 at 12:10 PM, Staff A stated they were not aware that Resident 3 required nurse delegation for their eye drops.

<Resident 4>

Review of Resident 4's assessment, dated 11/17/2023, showed the resident was diagnosed with [redacted] and [redacted]. The assessment documented Resident 4's level of understanding as "sometimes." Further review showed that Resident 4 required nurse delegation for eye drops that were previously ordered.

Review of Resident 4's Negotiated Care Plan (NSA, the facility's titled Negotiated Service Agreement), dated 12/01/2023, showed the facility administered crushed medications in a carrier (a nurse delegated task when a resident is unable to understand what they are being given) to Resident 4.

On 04/18/2024 at 09:30 AM, a department licensor attempted to interview Resident 4. Resident 4 was unable to answer questions due to their dysphagia and cognition. It was undetermined if Resident 4 comprehended information being presented to them.

Review of Resident 4's undated medical chart showed it did not contain any records for nurse delegation tasks.

In an interview on 04/18/2024 at 4:24 PM, Staff A stated the facility did not have any residents that received nurse delegation.

<Resident 3>

Review of Resident 3's assessment, dated 09/29/2023, showed the resident was diagnosed with [redacted]. The assessment contained documentation by the RND that indicated that Resident 3 required nurse delegation for their eye drop administration.

Review of Resident 3's MARs for February 2024, March 2024, and April 2024, showed they were prescribed eye drops to be given three times a day. Further review showed that the eye drops were administered by caregivers that had not been assessed for competency by the RND.

Review of Resident 3's undated medical chart showed it did not contain any records for nurse delegation tasks.

In an interview on 04/19/2024 at 12:10 PM, Staff A stated they were not aware that Resident 3 required nurse delegation for their eye drops.

<Resident 4>

Review of Resident 4's assessment, dated 11/17/2023, showed the resident was diagnosed with [redacted] and [redacted]. The assessment documented Resident 4's level of understanding as "sometimes." Further review showed that Resident 4 required nurse delegation for eye drops that were previously ordered.

Review of Resident 4's Negotiated Care Plan (NSA, the facility's titled Negotiated Service Agreement), dated 12/01/2023, showed the facility administered crushed medications in a carrier (a nurse delegated task when a resident is unable to understand what they are being given) to Resident 4.

On 04/18/2024 at 09:30 AM, a department licensor attempted to interview Resident 4. Resident 4 was unable to answer questions due to their dysphagia and cognition. It was undetermined if Resident 4 comprehended information being presented to them.

Review of Resident 4's undated medical chart showed it did not contain any records for nurse delegation tasks.

In an interview on 04/18/2024 at 4:24 PM, Staff A stated the facility did not have any residents that received nurse delegation.

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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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24.

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

Ashley Burtt — Administrator (or Representative)

5/9/24 — Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff had completed respirator fit testing for 4 of 4 sampled staff (Staff A, B, C, and D). This failure placed residents and staff at risk of exposure to an infectious communicable disease.

Findings included...

Per WAC 296-842-15005, facilities must conduct fit testing (test completed by specially trained personnel to ensure N95 mask seals effectively to reduce the chance of exposure to respiratory viruses) before employees are assigned duties that may require the use of respirators and at least every twelve months after initial testing.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in Long Term Care settings were responsible to "follow regulations pertaining to respiratory protection," including respirator fit testing for long term care workers.

Review of Staff A's, Administrator, personnel file showed a hire date of 02/18/2022. Further review showed no documentation of respirator fit testing.

Review of Staff B's, Director of Care, personnel file showed a hire date of

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-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff had completed respirator fit testing for 4 of 4 sampled staff (Staff A, B, C, and D). This failure placed residents and staff at risk of exposure to an infectious communicable disease.

Findings included…

Per WAC 296-842-15005, facilities must conduct fit testing (test completed by specially trained personnel to ensure N95 mask seals effectively to reduce the chance of exposure to respiratory viruses) before employees are assigned duties that may require the use of respirators and at least every twelve months after initial testing.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in Long Term Care settings were responsible to "follow regulations pertaining to respiratory protection," including respirator fit testing for long term care workers.

Review of Staff A's, Administrator, personnel file showed a hire date of 02/18/2022. Further review showed no documentation of respirator fit testing.

Review of Staff B's, Director of Care, personnel file showed a hire date of

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04/18/2023. Further review showed no documentation of respirator fit testing.

Review of Staff C's, Caregiver/Med-tech, personnel file showed a hire date of 03/02/2023. Further review showed no documentation of respirator fit testing.

Review of Staff D's, Administrative Assistant/Caregiver, personnel file showed a hire date of 04/04/2023. Further review showed no documentation of respirator fit testing.

In an interview on 04/12/2024 at 9:10 AM, Staff A indicated they had not been conducting fit testing.

In an interview on 04/19/2024 at 11:04 AM, Staff E, Director of Business, stated that they had no records for respirator fit testing for any staff.

Plan/Attestation Statement

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

Ashley Burtt — Administrator (or Representative)

5/9/24 — Date

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

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

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

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the contents of the negotiated service agreement were updated to accurately reflect the services and interventions for 1 of 5 sampled residents (Resident 1). This failure placed the resident at

04/18/2023. Further review showed no documentation of respirator fit testing.

Review of Staff C's, Caregiver/Med-tech, personnel file showed a hire date of 03/02/2023. Further review showed no documentation of respirator fit testing.

Review of Staff D's, Administrative Assistant/Caregiver, personnel file showed a hire date of 04/04/2023. Further review showed no documentation of respirator fit testing.

In an interview on 04/12/2024 at 9:10 AM, Staff A indicated they had not been conducting fit testing.

In an interview on 04/19/2024 at 11:04 AM, Staff E, Director of Business, stated that they had no records for respirator fit testing for any staff.

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the contents of the negotiated service agreement were updated to accurately reflect the services and interventions for 1 of 5 sampled residents (Resident 1). This failure placed the resident at

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risk of having unmet service needs

Findings included...

Review of Resident 1's assessment, dated 11/28/2023, showed that Resident 1 had multiple falls since their last assessment, they were to eat in the dining room to allow for staff supervision due to aspiration (when something you swallow enters the airway or lungs), and they had orders for blood sugar checks and Trulicity (an injectable medication used to lower blood sugar).

Review of Resident 1's Negotiated Care Plan (NSA, the facility's titled Negotiated Service Agreement), dated 05/10/2023, showed it did not contain any documentation related to their multiple recent falls or interventions to be implemented to reduce fall risk. Resident 1's NSA did not contain information related to their high aspiration risk or that they required supervision while they ate their meals. Further review showed the NSA did not document and define the facility's role in the administration of the Trulicity injection.

In an interview on 04/16/2024 at 09:20 AM, Staff A, Administrator, stated that NSAs were done independently from the assessments. Staff A stated that assessments should reflect what is required to be in the NSA

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24

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

Ashley Burtt 5-9-24

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;

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

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

risk of having unmet service needs.

Findings included…

Review of Resident 1's assessment, dated 11/29/2023, showed that Resident 1 had multiple falls since their last assessment, they were to eat in the dining room to allow for staff supervision due to aspiration (when something you swallow enters the airway or lungs), and they had orders for blood sugar checks and Trulicity (an injectable medication used to lower blood sugar).

Review of Resident 1's Negotiated Care Plan (NSA, the facility's titled Negotiated Service Agreement), dated 05/10/2023, showed it did not contain any documentation related to their multiple recent falls or interventions to be implemented to reduce fall risk. Resident 1's NSA did not contain information related to their high aspiration risk or that they required supervision while they ate their meals. Further review showed the NSA did not document and define the facility's role in the administration of the Trulicity injection.

In an interview on 04/16/2024 at 09:20 AM, Staff A, Administrator, stated that NSAs were done independently from the assessments. Staff A stated that assessments should reflect what is required to be in the NSA.

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, Willow Grove 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;

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

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

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure annual safety assessments were completed for residents who used medical devices for 1 of 5 sampled residents (Resident 1), failed to ensure assessments were updated after a change in condition for 1 of 5 sampled residents (Resident 4), and failed to ensure the facility conducted annual assessments for 2 of 5 sampled residents (Residents 4 and 5). These failures placed residents at risk of injury due to using medical devices that had not been assessed to safely use, placed residents at risk of unmet care and services following changes in condition, and placed residents at risk of having unassessed service needs.

Findings included...

<Resident 1>

Review of Resident 1's assessment, dated 11/29/2023, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed that Resident 1 was wheelchair dependent, required staff to assist them for transfers, and that Resident 1 had a transfer pole (a floor to ceiling grab bar) in their room.

Observation on 04/16/2024 at 2:40 PM, showed a transfer pole installed in Resident 1's room.

In an interview on 04/19/2024 at 8:40 AM, Staff A, Administrator, stated that Resident 1 did not have an annual safety assessment to determine if the transfer pole was safe for the resident to use.

<Resident 4>

Review of an incident report, dated 01/21/2024, showed that Resident 4 had a fall on 01/20/2024 that resulted in an injury and required treatment in the emergency department.

Review of hospital records, dated 01/24/2024, showed that Resident 4 went to the emergency room after a fall on 01/20/2024. The records showed that Resident 4 had a right hip fracture that required surgery to repair.

Review of Resident 4's annual assessment, dated 11/17/2023 showed it was a Comprehensive Assessment Reporting Evaluation (CARE) assessment completed by a department case manager. Further review showed the facility did not conduct their own annual assessment after the fall that resulted in surgical intervention (change of condition).

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure annual safety assessments were completed for residents who used medical devices for 1 of 5 sampled residents (Resident 1), failed to ensure assessments were updated after a change in condition for 1 of 5 sampled residents (Resident 4), and failed to ensure the facility conducted annual assessments for 2 of 5 sampled residents (Residents 4 and 5). These failures placed residents at risk of injury due to using medical devices that had not been assessed to safely use, placed residents at risk of unmet care and services following changes in condition, and placed residents at risk of having unassessed service needs.

Findings included…

<Resident 1>

Review of Resident 1's assessment, dated 11/29/2023, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed that Resident 1 was wheelchair dependent, required staff to assist them for transfers, and that Resident 1 had a transfer pole (a floor to ceiling grab bar) in their room.

Observation on 04/16/2024 at 2:40 PM, showed a transfer pole installed in Resident 1's room.

In an interview on 04/19/2024 at 9:40 AM, Staff A, Administrator, stated that Resident 1 did not have an annual safety assessment to determine if the transfer pole was safe for the resident to use.

<Resident 4>

Review of an incident report, dated 01/21/2024, showed that Resident 4 had a fall on 01/20/2024 that resulted in an injury and required treatment in the emergency department.

Review of hospital records, dated 01/24/2024, showed that Resident 4 went to the emergency room after a fall on 01/20/2024. The records showed that Resident 4 had a right hip fracture that required surgery to repair.

Review of Resident 4's annual assessment, dated 11/17/2023 showed it was a Comprehensive Assessment Reporting Evaluation (CARE) assessment completed by a department case manager. Further review showed the facility did not conduct their own annual assessment after the fall that resulted in surgical intervention (change of condition)

Statement of Deficiencies	License # 2399	Compliance Determination # 38648
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on 01/20/2024.

<Resident 5>

Review of Resident 5's annual assessment, dated 04/07/2023, showed it was a CARE assessment completed by a department case manager.

In an interview on 04/17/2024 at 4:35 PM, Staff A stated they used the CARE assessments for their state pay residents. Staff A stated that they were unaware that the state CARE assessments could not be utilized as the facility's annual assessment.

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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24.

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

Ashley Bennett — Administrator (or Representative)

5/9/24 — Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to

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

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her.

on 01/20/2024.

<Resident 5>

Review of Resident 5's annual assessment, dated 04/07/2023, showed it was a CARE assessment completed by a department case manager.

In an interview on 04/17/2024 at 4:35 PM, Staff A stated they used the CARE assessments for their state pay residents. Staff A stated that they were unaware that the state CARE assessments could not be utilized as the facility's annual assessment.

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, Willow Grove 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-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

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

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies.

(d) Individual's ability to leave the assisted living facility unsupervised; and

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

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

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(a) Modes of expression;

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(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

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(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker, and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within fourteen days of the resident's move-in date for 1 of 5 sampled residents (Resident 2). This failure placed Resident 2 at risk of unmet care needs related to not being assessed after they transitioned into the facility.

Findings included...

Review of Resident 2's medical chart showed they were admitted on [redacted]2024. Further review showed it did not contain a full assessment within 14 days after admission.

In an interview on 04/16/2024 at 9:20 AM, Staff A, Administrator, stated that a full assessment is completed prior to a resident's admission and that the assessment is not updated again until the annual assessment is completed a year after admission.

Plan/Attestation Statement

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

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Based on interview and record review, the facility failed to complete a full assessment within fourteen days of the resident's move-in date for 1 of 5 sampled residents (Resident 2). This failure placed Resident 2 at risk of unmet care needs related to not being assessed after they transitioned into the facility.

Findings included…

Review of Resident 2's medical chart showed they were admitted on [redacted] 2024. Further review showed it did not contain a full assessment within 14 days after admission.

In an interview on 04/16/2024 at 9:20 AM, Staff A, Administrator, stated that a full assessment is completed prior to a resident's admission and that the assessment is not updated again until the annual assessment is completed a year after admission.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2399	Compliance Determination #39646
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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, Willow Grove is or will be in compliance with this law and / or regulation on (Date) 6-2-24

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

Ashley Bennett 5/9/24

Administrator (or Representative) Date

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Legacy1864, LLC
Willow Grove
1620 E Mead St
Spokane, WA 99216

RE: Willow Grove # 2399

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/19/2024 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:

Stephanie Jenks, Field Manager
Residential Care Services
Region 1, Unit B
8517 E Trent Ave, Ste 102

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Legacy1864, LLC
Willow Grove
1620 E Mead St
Spokane, WA 99218

RE: Willow Grove # 2399

Dear Administrator:

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- Wrote the enclosed report; and
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  - 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:

Stephanie Jenks, Field Manager
Residential Care Services
Region 1, Unit B
8517 E Trent Ave, Ste 102

Spokane Valley, WA 99212

• 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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

During the full licensing inspection, it was determined that the facility did not document their investigations following incidents that required emergency medical interventions. During the inspection, the administrator began to create a new incident report template that included their investigation documentation

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 (509)993-7821.

Spokane Valley, WA 99212

• 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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

During the full licensing inspection, it was determined that the facility did not document their investigations following incidents that required emergency medical interventions. During the inspection, the administrator began to create a new incident report template that included their investigation documentation.

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:
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• 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 (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure