



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

03/13/2025

NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC
Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

RE: Avamere at Port Townsend # 2408

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 56343 (Completion Date 03/13/2025) and 52582 (Completion Date 01/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/13/2025 and found no deficiencies.

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

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

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

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

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

(b) A national fingerprint background check.

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

WAC 388-78A-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.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

WAC 388-78A-2210 Medication services.

(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 :

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

The Department staff who did the On Site verification:

Anissa Bearden, Licensors

Celeste Vashey, ALF LTC Licensors

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

Sincerely,



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

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

The department completed data collection for an unannounced on-site follow-up on 01/06/2025 and 01/06/2025 of:
Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

This document references the following SOD dated: 01/08/2025

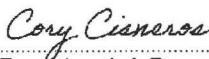
The following sample was selected for review during the unannounced on-site visit: 4 of 58 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

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	01/22/2025 Date
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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.

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Peder Berg

Administrator (or Representative)

1/30/25

Date

WAC 388-78A-2610 Infection control.

- (1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
- (2) The assisted living facility must:
 - (c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;
 - (d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 6 of 6 resident's (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], Resident 5 [R5], and Resident 6 [R6]) rooms. This failure placed all 58 of 58 residents, staff, and visitors at risk for spread of infectious disease or illness.

Findings included...

Record review of the Center of Disease Control and Prevention (CDC) website document titled, "clinical safety: Hand Hygiene for Healthcare Workers", dated 02/27/2024, showed hand hygiene protected both healthcare personnel and patients. A common challenge was to keep the skin on the healthcare personnel hands healthy and clean. Under the section titled, "when to use an alcohol-based hand sanitizer (ABHS)", showed unless hands were visibly soiled, ABHS was preferred over soap and water in most clinical settings. Under the section titled, "when to wash with soap and water", showed when hands were visibly soiled, before eating, after using the restroom, and during care of patients with suspected or confirmed infection during outbreaks of Clostridioides difficile (a contagious virus that was easily transmitted through a person stool) and norovirus (an infectious virus that is easily transmitted that cause stomach upset, nausea, vomiting, and diarrhea). Under the section titled, "Healthcare Facilities: Make hand Hygiene a priority", showed they were to require healthcare personnel to perform hand hygiene based on CDC recommendations, ensure that healthcare providers perform hand hygiene with soap and water when hands were visibly soiled, and ensure supplies for adhering to hand hygiene were accessible when delivering patient care.

Record review of the CDC's website document titled, "Hand sanitizer Guidelines and Recommendations", dated 03/12/2024, showed hand sanitizers can quickly reduce the number of germs on hands in many situations. However sanitizers do not get rid of all types of germs, may not be effective when hands were visibly dirty or greasy, might not remove harmful chemicals, such as pesticides, and heavy metals like lead, and soap

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and water were more effective than hand sanitizer at removing certain kinds of germs like norovirus, cryptosporidium (an infection that causes a person to have loose stools), Clostridioides difficile, as well as chemicals. Under the section titled, "tips", showed Do not use hand sanitizers if a person's hands were visibly dirty or greasy.

Record review of CDC's fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to prevent the spread of germs and keep employees healthy. Hand hygiene was one of the best ways to prevent employees from getting sick and spreading germs to others in the workplace. Good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It can also mean using alcohol-based hand sanitizer with at least 60% alcohol if soap and water were not readily available. Employees were to wash their hands use soap and water instead of hand sanitizer when their hands were visibly dirty. Under the section titled, "tips for protecting employee health", showed provide soap, water, and way to dry hands (for example paper towels or a hand dryer) so employees can wash and dry hands properly. An alcohol-based hand sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Record review of the Washington State Department of Health's (DOH) document DOH 505-144 titled, "hand hygiene policy and procedure", dated "May 2018", showed effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team would comply with current CDC hand hygiene guidelines. Under the section titled, "indications for handwashing and hand rubbing", showed handwashing was to be conducted when hands were visibly dirty or contaminated with proteinaceous material or were visibly soiled with blood or other body fluids, wash hands with either non-antimicrobial soap and water or an antimicrobial soap and water. Handwashing may also be used routinely decontaminating hands (reduce bacterial count on hands by performing hand hygiene) in the clinical situations that included after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands were not visibly soiled. Indications for use of hand rubbing included if hands were not visibly soiled. When gloves were used and removed the healthcare personnel were to decontaminate hands after removing gloves.

Record review of the facility's document titled, "infection control manual", dated 07/18/2021, showed people who live or work together, such as in an assisted living facility, were more likely to share germs. Many infections could be prevented with basic infection prevention and control steps, such as hand hygiene. Under the section titled, "specific standard precautions", showed hand hygiene referred to the practice of removing or killing germs that were on the hands so that germs do not spread to other people or surfaces. To practice hand hygiene, keep your hand clean by either washing with soap and water or using an alcohol-based hand sanitizer. Change gloves frequently and perform hand hygiene each time gloves were changed as dirty gloves can spread germs, too. Keeping your hands clean was the most important thing that could be done to prevent infections. Staff were to wash their hand with soap and water for at least 20 seconds if their hands were visibly soiled, if hands had contact with blood or body fluids, before and after assisting residents with toileting or perineal care, after use of the toilet, and before handling food. Hands were to be dried thoroughly with paper towels and the water was to be turned off with a paper towel. "Hand sanitizer may be used in all other hand hygiene situations not mentioned above", that was listed above. Under the section titled, "engaging everyone in infection prevent and control" for area "survey readiness",

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showed survey teams monitored compliance with state and federal health care regulations. The community was required to have safeguards in place to prevent health care workers from being hurt or injured on the job, including from infections and infectious diseases. Under the section titled, "how do infections spread?", showed germs could be shared on the hands or gloves of health care workers, on surfaces in the facility, and on medical equipment. If these were not properly cleaned and disinfected, the germs may spread to other people and the environment. Older people, due to declining ability of their immune systems to resist germs, were more susceptible to infection and can become infected more easily.

Record review of the "Department of Social And Health Services" document, Completion date 10/24/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2610] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 11/20/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, [the facility] is or will be in compliance with this law and/or regulation on 12/08/2024."

R1

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R1 moved into the facility on [REDACTED]/2016 and received [REDACTED] services.

In an interview and observation on 01/06/2025 at 1:02 PM, R1 said they supplied their own soap and paper towels for their room. R1's bathroom had been observed to have lavender chamomile hand soap and Yardley London bar soap. R1's bathroom had not been supplied with facility provided soap, paper towels or disposable hand towels for the staff to use.

In an interview and observation on 01/06/2025 at 1:10 PM, Staff G, Caregiver and Staff D, Agency Certified Medical Assistant, entered R1's room. Staff G said R1 did not need current assistance in the restroom. Staff G said if R1 had asked the facility staff to help them in the restroom then they would. When the Department inquired if the facility provided residents hand soap and paper towels in their rooms for facility staff to wash their hands Staff D said the residents shopped for their own supplies when they went out into the community.

R2

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [REDACTED] 2024 and was a private pay resident.

In an interview and observation on 01/06/2025 at 12:03 PM, R2 said they could not remember if the facility provided them hand soap and paper towels for the staff to use in their room. R2's kitchenette had a bottle of dawn dish soap and a roll of paper towels. R2's bathroom had a bar of hand soap next to the sink and two blue cloth hand towels.

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There was no facility provided soap or paper towels in the bathroom or at the kitchenette sink available for the staff to wash their hands.

R3

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R3 moved into the facility on [REDACTED]/2023 and was a private pay resident.

In an observation and interview on 01/06/2025 at 3:43 PM, R3 stated they bought the paper towels that were hung up under the cabinet in the kitchenette area by the sink. There was no observed soap or soap dispenser available at that kitchenette sink for staff to use to wash their hands if needed. The sink had multiple plants that lined the outer edges of the sink on the counter. At 3:51 PM inside of R3's bathroom, there was a bottle of 7.5 fluid ounces of soft soap fresh breeze hand soap. There were no paper towels or disposable hand towels in R3's bathroom available for staff to use.

R4

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R4 moved into the facility on [REDACTED]/2021 and received [REDACTED] services. The document showed that R4 experienced urinary incontinence and required moderate assistance from staff with activities of daily living needs.

In an observation on 01/06/2025 at 12:03 PM, inside R4's kitchenette sink area it was observed that R4 had a bottle of dawn dish soap. There was no other soap or soap dispenser and disposable paper towels in the area of the kitchenette sink available for the staff to use to wash their hands. Inside R4's bathroom at the sink there was a bottle of peri cleanser. There were no other soap, soap dispenser, or disposable paper towels available for staff to use to wash their hands available.

R5

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R5 moved into the facility on [REDACTED]/2022 and was a private pay resident.

In an observation and interview on 01/06/2025 at 1:11 PM, inside R5's room the kitchenette sink had a bottle of green dawn dish soap. There was no other soap or soap dispenser and disposable paper towels in the area of the kitchenette sink available for staff to use if they needed to wash their hands. At 1:18 PM, inside R5's bathroom at the sink was a pink bar of soap that had "camay" imprinted on it. There was no other soap or soap dispenser and disposable paper towels available in the bathroom for staff to use to wash their hands. R5 was unable to say if the facility provided soap and paper towels in their room for the staff to use. R5 was noted to have a difficult time expressing their words. R5 had green and white incontinent cloth pad in their room, on their bed, and one that was on the seat cushion of their fabric chair that was in the corner of the living area of their room.

R6

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Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R6 moved into the facility on [REDACTED]/2024 and was a private pay resident.

In an interview and observation on 01/06/2025 at 12:06 PM, R6 stated the facility did not provide their room with soap or disposable paper towels at either the kitchenette or bathroom sink for the staff to use. R6 stated that the caregivers assisted them with their showers two times a week and with their laundry services. At 12:14 PM inside R6's bathroom at the sink, it was observed there was a bottle of soap with a label that showed "the unscented company". There was no other soap or soap dispenser and disposable paper towels available for the staff to use to wash their hands. There was a cloth rag that hung on the towel bar that R6 stated was their own. R6's kitchenette sink was observed and noted that there was a bottle of Meyer's hand soap. There was no disposable paper towels, soap, or soap dispenser available for staff to wash their hand with.

In an interview on 01/06/2025 at 3:13 PM, Staff H, Caregiver, stated if their hands were soiled or dirty the facility's expectation was for the caregiver to put a glove over their soiled hand, exit the residents room to walk down the hallway to the resident accessible laundry room if they were on the second or third floor and wash their hands with soap and water in the laundry rooms sink. Staff H stated if their glove broke during resident care and their hand got soiled, they would use the residents sink with whatever soap was available in the resident's room to get their hands clean. Staff H stated they have had their gloves break in the past during resident care. Staff H stated the facility provided only [REDACTED] resident's soap in soap dispensers for the staff to wash their hands within the residents' room. Staff H stated the staff hand washing procedure consisted of staff putting on gloves, performing the resident task in the resident room, then exiting the resident room and go down the hallway to the sink in the laundry room on the second or third floor of the facility to wash their hands with soap, water, and dry with paper towels. Staff E, Caregiver, Staff H, Caregiver and Staff D said the facility provided hand soap only to Medicaid paid residents that would be a liquid soap stored in soap dispensers in the resident's rooms.

In an interview on 01/06/2025 at 3:52 PM, Staff B, Director of Health Services/Registered Nurse, stated they were not going to answer the question if the facility provided soap and paper towels in the residents' rooms for the staff to wash their hands with if they were visibly soiled. Staff B stated Staff A, executive director, would discuss the topic. Staff B stated R5 had expressive aphasia (a condition when it was difficult to express thoughts and ideas through speech). Staff B stated R5 was incontinent of urine and had a history of soiling their clothes and bed linens with urine, and that there was noticeable odor at times. Staff B stated when R5 was out of their room and downstairs in the dining room or attending activities, the caregivers would go into R5's room to remove the soiled incontinent pads, linens, and any clothing to get rid of the urine. Staff B stated if the caregivers hands became soiled or had gotten urine on their hands, the expectation would be for the caregiver to put a glove on their soiled hand, exit the room, walk down the hallway to the nearest laundry room sink, remove the glove and then wash their hands with soap and water. Staff B stated if the caregiver's glove broke and their hand became soiled, they were expected to take the rest of the glove off turn it inside out, open the resident's door with the inside of the glove, exit the resident's room and go to the nearest laundry room sink to wash their hands with soap and water. Staff B stated if the caregiver's hands were really soiled the caregiver could always ask permission from the resident to rinse their hands in the

residents sink in their room. Staff B stated the staff were trained per the CDC's guidance of hand washing and reason why they exit the residents' room to go to the nears laundry room sink to wash their hands with soap, water, and dry with paper towels. Staff B stated the assisted living facility was "light care" and the residents that reside at the facility did not require a lot of personal care.

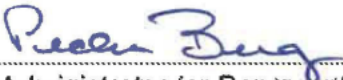
In an interview on 01/06/2025 at 5:09 PM, Staff A, Executive Director, stated all caregivers were required to wear gloves with personal resident care. Staff A stated soap and disposable paper towels were provided and accessible by all caregivers for only the [REDACTED] paid residents that resided in the facility. Staff A stated that each staff member went through training on handwashing and infection control policy and procedures when they were asked what the facility did to ensure all private pay residents had soap and paper towels in their rooms for staff to wash their hands with. Staff A stated staff were expected to use hand sanitizer to wash their hands in the resident's room, exit the resident's room, and go to the nearest laundry room sink to wash their hands with soap, water, and paper towels.

This is an uncorrected deficiency previously cited on 10/24/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 2/21/25.

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


Administrator (or Representative)

1/30/25
Date

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a Washington State name and Date of Birth background check completed for 1 of 2 contracted agency caregivers (Staff F) prior to them working at the facility. The facility failed to ensure that the 1 of 2 contracted agency staff (Staff D) had their national fingerprint background check results within the required time. These failures placed all 58 of 58 residents at risk for being cared for by a staff member with a potentially

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disqualifying history.

Findings included...

Washington Administrative Code (WAC) 388-06-0530 "When does the 120-day provisional period begin? The 120-day provisional period begins on the date an applicant, long-term care worker, or service provider begins providing care to a vulnerable adult or child."

Record review of the "Department of Social And Health Services" document, Completion date 10/24/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2462] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 11/20/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, [the facility] is or will be in compliance with this law and/or regulation on 12/08/2024."

Name and Date of Birth Background Check

Record review of the facility document untitled, and undated, showed Staff F, Agency Certified Medical Assistant, first date worked for the facility was on 01/03/2025.

Record review of Resident 1's (R1), Medication Administration Record, dated 12/01/2024 through 12/31/2024, showed Staff F provided R1 their medications on 12/22/2024.

Record review of Staff F's, "Notification of Background Check Result", dated 12/30/2024, showed it was completed eight days after Staff F's first day worked at the facility.

National Fingerprint Background Check

Record review of the facility document untitled, and undated, showed Staff D, Agency Certified Medical Assistant, first date worked for the facility was on 12/06/2024.

Record review of Resident 7 (R7), Medication Administration Record, dated 07/01/2024 through 07/31/2024, showed Staff D, provided R7 their medication on 07/07/2024.

In an interview on 01/06/2025 at 3:33 PM, Staff D stated they had worked and administered R1's medication since May 2024.

In an interview on 01/06/2025 at 4:34 PM, Staff A, Executive Director, said the facility did not keep track of agency staff first day worked at the facility since they were not employees of the facility. Staff A said they did not think the agency itself kept track of when an agency staff member had their first shift at the facility. Staff A expressed understanding that agency staff members needed fingerprint background checks if they had worked for the facility past 180 days. Staff A said Staff D was in the process to get their fingerprints completed. Staff A said Staff D was to complete that process through

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the agency company they worked for, and the facility did not have access to the fingerprint background check information. Staff A acknowledge the expectation for any staff member or contracted long term care worked was to have a final fingerprint background check within 180 days of first date worked at the facility.

On 01/07/2025 at 12:15 PM, the Department re-requested Staff F's first day worked at the facility to review due to Staff F signing off that they provided medication to R1 on 12/22/2024 and therefore worked prior to the 01/03/2025 date that was originally provided. The Department re-requested Staff D's first day worked at the facility to review due to Staff D's signing off that they provided medication to R7 on 07/07/2024 and therefore worked prior to the 12/06/2024 date that was originally provided.

Record review of an email sent to the Department on 01/07/2025 at 3:31 PM, showed Staff A said Staff F first date worked at the facility was on 12/22/2024. Staff A said the facility had not been able to complete a name and date of birth background check for Staff F on 12/22/2024 as they were brought in as an emergency basis to work for the facility. Staff A did not provide an updated first day worked at the facility for Staff D to review.

In an interview on 01/08/2025 at 1:11 PM, Staff A acknowledged that Staff D stated they had worked for the facility as early as May 2024 and that they signed off on R7's MAR in July 2024. Staff A acknowledged that Staff D should have had a fingerprint background check completed. Staff A acknowledged that the facility would receive a recitation because Staff F did not have a name and date of birth background check prior to them working for the facility.

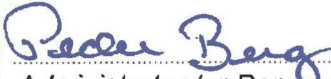
As of 01/08/2024 at 1:00 PM, the facility was unable to provide a national fingerprint background check or their original first day worked for the facility for Staff D for review.

This is an uncorrected deficiency previously cited on 10/24/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date)2/21/25.

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


Administrator (or Representative)

1/30/25
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

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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.
- (2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and develop a 30-day negotiated resident service plan for 1 of 1 new sampled residents (Resident 6 [R6]). This failure placed R6 at risk for staff untrained of the care and services required and unmet care needs.

Findings included...

Record review of the facility's document titled, "process for level of care (LOC) evaluation and Service Plan", dated "06/2024", showed service plans should be completed prior to move in, reviewed and updated with any modifications at move-in, within 30 days (14 days for Washington), quarterly from move in date, and as needed with any significant change of condition. Service plan should be printed for staff to review and sign and put in the service plan binder. Under the section titled, "Procedure for updating LOC Evaluation and Service Plan", showed by the most recent LOC and service plan the word "copy" was to be clicked to open the evaluation. The type of review was to be checked as in 30-day. Each residents focuses, goals, and interventions were to be reviewed and verified to and updated to ensure they were accurate as well as provide clear instruction for the staff and complete the service plan.

Record review of the "Department of Social And Health Services" document, Completion date 10/24/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2130] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 11/20/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, [the facility] is or will be in compliance with this law and/or regulation on 12/08/2024."

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R6 moved into the facility on [REDACTED]/2024.

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Record review of R6's undated and unsigned service agreement showed R6 admitted to the facility on [REDACTED]/2024.

On 01/06/2025 at 11:28 AM, the Department sent a request to Staff A, Executive Director, for R6's 30-day service plan be provided for review.

On 01/06/2025 at 11:57 AM, the Department sent a request to Staff B, Director Health Service, for R6's 30-day service plan be provided for review.

Record review of R6's Service Agreement (facility's version of the negotiated service agreement), dated 12/03/2024, was sent to the Department on 01/06/2025 at 1:22 PM. R6's service agreement showed it was completed [REDACTED] after R6 moved into the facility.

On 01/06/2025 at 3:10 PM, the Department sent a request to Staff A and Staff B for R6's 30-day service plan be provided for review.

In an interview on 01/06/2025 at 4:10 PM, Staff B stated their electronic service plan system did not have an option for 30-day service plan and would be labeled "other". Staff B stated they completed a 30-day LOC assessment for all new residents. Staff B stated if the resident's assessment did not change, then she does not do another service plan as they had the service plan within the 30 days of the resident moving in. When the Department was asked for R6's 30-day service plan Staff B stated they did not complete a 30 day service plan as there was no changes to R6's assessment that was completed on 01/06/2025 as the 30 day assessment. Staff B stated they were unaware that another service plan was to be completed within 30 days of the resident moving into the facility after the regulation was reviewed with them by the Department. Staff B stated they had only updated R6's service plan for laundry services on 01/06/2025.

On 01/06/2025 at 3:57 PM, an email sent by Staff A to the Department, showed there was an undated and unsigned service agreement for R6 for review.

Record review of R6's undated and unsigned service agreement, showed it was printed on 01/06/2025. The service plan showed there was a revised update to the laundry section and fall that were dated 01/06/2025. There was no other documentation on the service plan to showed it was updated within 30 days of R6's move in.

In an interview on 01/08/2025 at 1:11 PM, Staff A stated Staff B completed R6's 30-day LOC assessment. Staff A stated because there were no changes to R6's 30-day LOC assessment Staff B kept going and did not make any changes to R6's service plan. Staff A stated for documentation purposes for R6's 30-day service plan, the documentation was not completed and acknowledged what the failed practice was.

This is an uncorrected deficiency previously cited on 10/24/2024 for subsection 2.

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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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 2/21/25.

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

Pedro Bery
Administrator (or Representative)

1/30/25
Date

WAC 388-78A-2210 Medication services.

(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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were administered their medications as ordered for 1 of 4 sampled residents (Resident 1 [R1]). This failure placed R1 at risk for medical complications due to not receiving their medications as prescribed.

Finding included...

Record review of the facility's document titled, "Medication Management", dated "3/2022", showed the following: "...6. Community staff should document each time they provide medication administration assistance on the medication administration record [MAR] in PCC [point click care-facilities electronic health record]. PRN [as needed] medications should have specific instructions to the medication aide including why they are used and when to specifically give the medication...14. All medication dispensing or administration errors should be investigated. All medications are to be dispensed or administered according to prescribed physician orders. When a staff member fails to dispense or administer a medication as prescribed, the incident should be investigated using the incident report. A plan of correction should be put in place after a medication error occurs."

Record review of the facility's document titled, "Medication Error Policy," dated 01/13/2022, showed the definition of a medication error as: "A medication error is defined as any unexpected outcome in the provision of medication administration. This would include, but not limited to: Giving an incorrect medication or dosage to a resident, Failing to follow the most current physician's order, Failing to coordinate the recipient's medications with the resident's physician, staff or the Director of Health Services, Failing to communicate with other staff or the Director of Health Services regarding the needs of the resident, Or any other issue or error as related to the

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provision of medication for any residents as, defined by the Director of Health Services." The document showed it was a medication error if a medication technician failed to follow physician order for resident medication administration.

Record review of the facility's document titled, "Medication Competency Form ", undated, showed the medication technicians were to check and evaluate on if they checked the medication instruction sheet for special instructions, if they had checked the medication labeled to the MAR three times, documented all medications or refusals according to standard practice, checked that all medication sheets of the resident prior to going on to the next resident to avoid any missed medications, and give medications according to standards.

Record review of the "Department of Social And Health Services" document, Completion date 10/24/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2210] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 11/20/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, [the facility] is or will be in compliance with this law and/or regulation on 12/08/2024."

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R1 moved into the facility on [REDACTED]/2016 and received [REDACTED] services.

Record review of R1's Service Agreement, dated 06/19/2024, showed R1 had multiple medical diagnoses that included [REDACTED]. R1's blood pressure would be taken two times daily. R1 had a complete medication regimen that placed the resident at risk for complications. The licensed nurse was to review R1's medications quarterly and notify the provider of any concerns. Staff were to provide R1 medication assistance and would document all medications on the MAR. R1 required assistance with preparing and having their medications handed to them to take. R1 required assistance with preparing and handing the prepared insulin to R1 two times a day.

Record review of R1's MAR, dated 12/01/2024 through 12/31/2024, showed R1 had an order for lisinopril (a prescribed medication that helps lower high blood pressure) to be administered two times a day. The medication was to be held if the systolic blood pressure (SBP, top number of the blood pressure reading) was less than 100. Review of the administration on 12/20/2024 showed R1's systolic blood pressure reading was 91. R1 was administered their dose of lisinopril on 12/20/2024 and not held per the physician orders. R1 had a medication order for hydralazine HCl (a prescribed medication to help treat high blood pressure) to be administered as needed two times a day for high blood pressure. The order showed the medication was to be administered if R1's SBP reading was over 160 or if R1's diastolic blood pressure (DBP, bottom number of the blood pressure reading) was above 100. Review of R1's blood pressure readings on the MAR, showed on 12/15/2024 R1's blood pressure reading in the evening at 4:00 PM to 5:00 PM was 168/88. Review of the hydralazine administrations showed R1 was not administered a dose on 12/15/2024 for their SBP being 168. R1 had an order for

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insulin glargine (a prescribed injected medications to help reduce high blood sugars and maintain in a therapeutic level when a person has diabetes) to have 22 units injected every day at 6:00 PM. Review of R1's administration on the MAR showed on 12/15/2024, 12/27/2024, and 12/29/2024 there was no documentation to show that R1 was administered their insulin.

Record review of R1's MAR, dated 01/01/2025 through 01/06/2025, showed R1 had an order for hydralazine HCl to be administered as needed two times a day for high blood pressure. The order showed the medication was to be administered if R1's SBP reading was over 160 or if R1's DBP reading was above 100. Review of R1's blood pressure readings on the MAR showed on 01/04/2025 in the morning at 6:30 AM, R1's DBP reading was 107. Review of R1's hydralazine administrations showed R1 was not administered their hydralazine per the physician's order.

In an interview on 01/06/2025 at 3:25 PM, Staff D, Agency Certified Medical Assistant, stated the medication technicians were responsible to check R1's as needed medications on the MAR to verify if they were required to give R1 additional medication based on R1's blood pressure readings. Staff D stated that the blood pressure parameters were on the MAR that the medication technicians were to follow. Staff D stated if there were blanks on a resident's MAR, it indicated that the resident refused their medications. Staff D stated, "oh never", when asked if R1 ever refused their insulin. Staff D pulled up R1's December 2024 MAR and reviewed R1's Lantus 22 units order at 6:00 PM, that showed on 12/15/2024, 12/27/2024, and 12/29/2024 there was no documentation. Staff D stated the blanks meant the medications was not given and was strange for R1 as they always took their insulin. Staff D stated R1's doctor was to be notified any time R1's DBP or SBP was out of range.

In an interview on 01/06/2025 at 3:52 PM, Staff B, Director Health Services, stated the facility administered R1's prescribed medications. Staff B and Staff C, Resident Care Coordinator, both reviewed R1's Lantus 22 units administrations at 6:00 PM on R1's December 2024 MAR. Staff B stated if the resident had refused the medication, then the medication technicians would still sign out the medication dose and it would have a code documented to show it was refused. Staff B was unsure why there was no documentation for the administration dose for R1 Lantus on 12/15/2024, 12/27/2024, and 12/29/2024. Staff B and Staff C acknowledged that on 12/20/2024 R1's lisinopril should not have been administered, on 12/15/2024 in the evening R1's SBP was above the prescribed parameter and R1's as needed hydralazine medications should have been administered and on 01/04/2024 in the morning R1's DBP reading was out of parameter and should have been administered their hydralazine as needed medication.

This is an uncorrected deficiency previously cited on 10/24/2024.

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

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01/08/2025

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 2/21/25.

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

Reuben Burg

Administrator (or Representative)

1/30/25

Date

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



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

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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 10/08/2024 and 10/10/2024 of:

Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

The following sample was selected for review during the unannounced on-site visit: 7 of 53 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Celeste Vashey, ALF LTC Licenser
Anissa Bearden, Licenser
Emily Boniface, Community Program Nurse Licenser

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.

Cory Cisneros

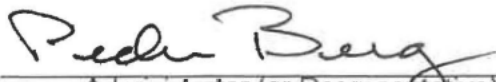
Residential Care Services

11/07/2024

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.

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



Administrator (or Representative)

11/20/24

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

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 2 of 2 areas (Interior facility and Exterior facility). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 53 of 53 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's policy, titled, "External Environmental Services", revised "11/2021", showed the purpose was to keep the campus beautiful and safe for the enjoyment of the residents and the community. The campus should be kept well-manicured and in good repair. The building exteriors should be kept in good repair. The exterior of the property should be walked at a minimum once a week.

Record review of the facility provided document, titled, "internal environmental services", dated "11/2021", showed the community should be kept clean and well-maintained. That should be accomplished through a regular cleaning schedule, a preventative maintenance program and repair or enhancement of existing structures, systems and fixtures. The executive director, maintenance director, and marketing staff should walk the building every morning to determine environmental needs. Attempts should be made during the walk to remove marks on walls and to pick up any trash that may be on the floor. Documentations should be kept regarding all items needing repairs or cleaning. These items should be logged in the maintenance log.

Record review of the facility provided document, titled, "housekeeping", dated "11/2021", showed assisted-living apartment should be cleaned weekly, unless otherwise noted in a resident's assistance/service plan. Services that were included in basic assisted-living level of care included weekly routine cleaning, and annual cleaning.

Record review of the facility provided document, titled, "Pets", dated "10/2021",

Administrator (or Representative)

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

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 2 of 2 areas (Interior facility and Exterior facility). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 53 of 53 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

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Record review of the facility provided document, titled, "housekeeping", dated "11/2021", showed assisted-living apartment should be cleaned weekly, unless otherwise noted in a resident's assistance/service plan. Services that were included in basic assisted-living level of care included weekly routine cleaning, and annual cleaning.

Record review of the facility provided document, titled, "Pets", dated "10/2021",

showed residents may keep pets so long as the resident, a family member or a friend could care for them responsibly and maintain the apartment and the pet's environment in a clean, healthy, and sanitary condition.

Record review of the facility's, "Disclosure of Services Required by RCW 18.20.300", revised "01/2023", showed the assisted living must maintain resident living quarters and other areas residents used in a safe, clean, and comfortable condition.

Record review of the Centers for Disease Control and Prevention article, titled, "Mold", dated 09/26/2024, showed mold could look like spots of many different colors, and it could smell musty. If you see or smell mold, you should remove it. Mold would grow where there was moisture, such as around leaks in roofs, windows, or pipes, or where there had been a flood. Mold grows on wood, ceiling tiles, cardboard, paints, wallpaper, insulation, carpet, and many other items. When mold spores drop on places with excessive moisture, such as where leakage may have occurred in pipes, walls, or where there had been flooding, the mold would grow. Under the section titled, "prevention", showed there were steps to take to prevent mold growth in your home that included clean up and dry out the home or area that there was a leak fully and quickly within 24 to 48 hours after a flood. Under the section titled, "cleaning", showed if you see mold or smell mold, it should be removed.

Interior of Facility

Mechanical Room

In an observation on 10/08/2024 at 10:33 AM, inside the soiled side of the staff laundry room, was a door labeled, "elevator mechanical room". In front of the mechanical room door on the ground was a large red taped rectangle with an X inside. Inside of the red taped area was a tall black trash can that blocked half of the mechanical room's door. On the door was a sign that showed, "please do not block door. This is a violation". Staff C, Maintenance Director, walked by the black trash can to open the door. Staff C then closed the elevator mechanical room door and moved away from the black trash can without moving it.

In an interview and observation on 10/10/2024 at 12:20 PM, inside the soiled side of the staff laundry room, was a door labeled, "elevator mechanical room". In front of the mechanical room door the tall black trash can remained sitting and blocking half of the elevator mechanical door. Staff A stated nothing was to be stored in the red taped area on the ground or in front of the elevator mechanical door.

South Dining Room

In an observation on 10/08/2024 at 11:53 AM, Staff D, Dietary Services Manager, opened the unlocked cabinet doors under the public sink in the South dining room, when it was observed the bottom of the cabinet had loose boards and, the back was down. The bottom of the cabinet board in front was unlevelled and had black dotted substance that resembled mold all over. The front of the board was not flushed with the frame of the cabinet and was all black. Staff D closed the sink's cabinet doors. At 11:55 AM, the Department, observed under the sink and noted some of the wooden boards were loose. There was a musty smell that was present upon opening the cabinet doors. The bottom of the cabinet wood was broken in half. There were five boards that were loose and unsecured. Upon lifting one of the loose boards, there were multiple small

and large areas of black substance that was on the board and on the wood that the board was on top of.

In an interview and observation on 10/08/2024 at 12:49 PM, Staff C looked under the south dining room public sink cabinets and stated that there had been a leak. Staff C stated that he was not aware of any leaks under the sink since they started working at the facility on 02/23/2024. Staff C stated the wood was not wet and touched the boards. Staff C picked up one of the loose boards and turned it over and it was noted to have large amounts of small and large areas of black dots and spots. There were the same black spots and dots on the wood that the piece of board was picked up from. Staff C was unable to state what the black dots and spots were on the wood in the cabinet.

In an observation on 10/10/2024 at 11:10 AM, inside the cabinets, under the sink in the south dining room, multiple boards that were observed were removed. There was one board that remained that continued to have large amounts of black dots and spots all over. In the back of the cabinet on the white wall in the right lower corner that was a large area that was all black. There was a musty smell when the cabinet doors were opened.

In an interview and observation on 10/10/2024 at 11:42 AM, observed under the south dining room sink cabinet, Staff A, Executive Director, stated that there was a pipe that had broken and leaked water under the cabinet. Staff A acknowledged the wood under the cabinet and the wall had black substance, spots, and dots that resembled mold. Staff A stated that happened 30 days prior. Staff A stated there was no work order made for the need to repair as it was an emergent situation.

Second floor Resident Laundry Room

In an observation and interview on 10/08/2024 at 11:21 AM, on the second floor in the resident used laundry room, behind the washing machine closest to the sink, on the wall there was a recessed white metal frame that was halfway up the wall that housed the area where the water hoses were attached to the water spickets for the washing machine. Underneath the recessed metal white frame, the wall's paint and material was missing. The material had peeled exposing other layers of material and some areas were bubbled from water damage. The walls beige paint was missing and exposed white material with some areas of green. The wall was like this all the way down until it reached the gray rubber trim that was a few inches up from the ground. On the floor there were beige colored drops of paint that was under the area of the peeling wall. Staff C stated the wall looked like there had been a water leak at some point. At 11:23 AM, a few inches of the flooring in front of the closed mechanical room door that was inside the laundry room was missing. The edge of the flooring was jagged with raw wood exposed that continued under the mechanical room door. Staff C opened the mechanical room door, and it was noted that the bottom of the door touched the jagged edge of the flooring and pulled it back exposing more raw wood and dark brown flooring substance.

Record review of the facility provided document, titled, "work orders", dated 04/02/2024 through 10/09/2024, showed there were no work orders documented for any repairs or concerns addressed for the second-floor assisted living resident laundry room leak, or the south dining room sink leak for review.

Computer Area

In an observation and interview on 10/08/2024 at 10:26 AM, the computer area across from the south side dining room showed there had been a dolly (cart to transport items) propped up against the wall. There had been a couple of laptops observed in a box in the corner of the counter. There was a printer on the counter next to the box of laptops. Staff C, Maintenance Director, said the computer items would be moved into the library area of the facility. Staff C said the facility did not have a lot of room for storage and the facility mainly used the room to store activity items. Staff C said the dolly was there for when newly admitted residents needed it to help move in their items.

In an observation on 10/10/2024 at 11:52 AM, the computer area across from the south side dining room showed the printer and laptops in the box remained in the corner on the counter. The counter also had a bean bag toss structure, a spinning wheel structure, and a silver container that held balls. Underneath the counter was a black wire basket that held balls. There were 4 chairs, a round table, an activity cart that held dumbbells, and the dolly stood horizontally on all four legs within the room.

Resident 2 (R2)

Record review of R2's Service Plan, completed 07/19/2024, showed "housekeeping" as a service with instructions indicating weekly housekeeping including trash removal and assistance with daily trash removal.

In an observation on 10/09/2024 at 3:40 PM, the carpet in R2's residence was malodorous of urine, and had soiled areas of darker carpet throughout the living room and bedroom. In between the bedroom and living room was a doorway, and in the doorway was a baby-gate used to keep R2's dog in the bedroom area.

In an interview on 10/09/2024 at 3:50 PM, R2 said they could no longer walk from the couch to the door of the residence, and they needed increased assistance with household tasks due to leg pain and swelling.

Exterior of facility

Trash

In an observation and interview on 10/08/2024 at 10:47 AM, outside of the dumpster enclosure area showed there were two dryers that did not have any doors or knobs, a wooden pallet, air conditioning structure, a piece of a black metal bedframe, black trash can, and a black desk chair. Staff C, Maintenance Director, said at times they would call a local junk man to retrieve their extra items. Staff C said they did not have a scheduled time of when the local man would remove the items located outside of the trash area.

In an observation on 10/08/2024 at 11:13 AM, outside near the grass and the resident used walking pathway next to a large green metal box on the left side were, blue and raw wood-colored long boards stored. There were 10 boards that were not stacked, unlevelled, and accessible to residents.

In an observation on 10/08/2024 at 10:48 AM, the Department approached the dumpster enclosed area that had two large metal doors that were closed and secured

with a metal rod that entered the ground. Inside the dumpster enclosure area noted there were two dumpsters that were a quarter full, and one dumpster that had graded walls, that had the bottom covered with cardboard. On the ground in between the two dumpsters were large amounts of soiled white paper, matted white substance imbedded on the cement ground, blue disposable gloves, brown paper and other various amount of trash that lined the back of the cement wall. In some areas by the cement wall behind the two trash dumpsters, the ground was unable to be observed related to the amount trash. On the left side of the dumpster enclosure wall and a dumpster there were multiple blue disposable gloves, a stack of multiple paper cups, a large plastic bag with substances inside that sat on top of a plastic bin that had was a quarter the way full of dark brown and green fluid, and other various trash items that all were on the ground. The trash area had a strong pungent foul smell. In between the second dumpster and the graded wall dumpster on the ground was a flattened coke box, blue disposable gloves, white plastic jug, and other miscellaneous trash that was on the ground. The cement ground from the back of the dumpster enclosure wall to half of the length of the dumpster in between the second dumpster and the graded wall dumpster had not been visible due to the trash and debris. On the right side of the graded wall dumpster up against the wall of the dumpster enclosure on the ground were various pieces of clear and blue plastic, a black and white shoe that had pine needles on top of the toe part, various pieces of styrofoam, and other various garage items. There was a pathway leading to three large propane tanks that were unable to be accessible and walk through related to the amount of various sized cardboard and multiple five-gallon buckets. There was a black rodent trap that was flat on the ground up along the right side of the dumpster enclosure wall. The cement ground and the pathway were covered with large amounts of flattened, formed boxes that were dry, wet, crumbled, various size cardboard pieces and recyclable items. Some of the flatten cardboard pieces had standing water that sat on top of it and leaves.

In an observation on 10/09/2024 at 10:43 AM, upon approaching the dumpster enclosure area that had the double doors closed, inside the dumpster enclosure area remained the same as it was observed on 10/08/2024. The area continued to have a strong pungent smell of trash. The dumpster with the graded wall was only a quarter full of cardboard and the other two dumpsters were half full.

In an interview on 10/10/2024 at 11:27 AM, Staff A, Executive Director, stated Staff C, Maintenance Director, was responsible to ensure that the trash area was kept clean and in an acceptable condition. Staff A stated the recycle dumpster (the graded side dumpster) was picked up weekly and the two trash dumpsters were picked up three times a week. Staff A stated the facility was responsible to take any appliances or large items that needed to be thrown out to the waste management. Staff A stated they used their personal truck and not a pickup service to discard the old appliances.

In an observation and interview on 10/10/2024 at 11:45 AM, Staff A and the Department approached the double doors that were shut to the dumpster enclosure area. Inside the dumpster enclosed area, the trash and cardboard remained thick and piled as observed on 10/08/2024. Staff A stated the deer get into the trash often and cause the trash to come out and fall on the ground. Staff A stated the wind caused the cardboard to be on the ground, but when the dumpster with the graded walls was observed, it was only half full of cardboard. The Department pointed out that some of the cardboard had standing water on top of it with multiple leaves, and multiple layers of cardboard and other recyclable items. Staff A acknowledged that the dumpster enclosed area was not in an acceptable condition. Staff A stated the trash area was the number one area for pest

control. Staff A stated the dumpster enclosure was to be cleaned weekly.

Backside of the Kitchen

In an observation and interview on 10/08/2024 at 10:55 AM, the backside of the kitchen door showed a blue laundry hamper that had white wet linens inside of it. Staff D, Dietary Services Manager said they stored the wet linens outside of the kitchen door. Staff D said the linens got picked up every Friday from an outside service.

In an interview on 10/08/2024 at 11:00 AM, Staff C and Staff D acknowledged that the backside of the kitchen area was the front side porch area for the residents to access.

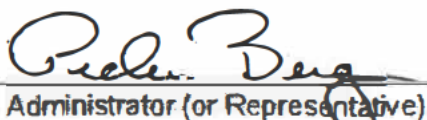
In an observation and interview on 10/08/2024 at 11:05 AM, the electrical panel had a blue net that had been propped up against it. Staff C said the blue net was used for the game bad mitten and it had usually been stored in the covered area by the north side dining back porch. Staff C had been observed to move the blue net under the north side dining back porch. In the corner of the porch was a table umbrella that was upside down. There was a container of blue coral car wash cleaning detergent, and linens stacked on blue styrofoam.

This is a recurring deficiency previously cited on 08/21/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 11/20/2024
12/08/2024

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


Administrator (or Representative)

11/20/2024
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

117/

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature did not go below 105 and above 120 degrees Fahrenheit (F) for 3 of 3 floors (1st floor, 2nd floor, 3rd floor) of the facility. This failure placed 53 of 53 residents and staff at risk for potential skin burns.

Findings included...

control. Staff A stated the dumpster enclosure was to be cleaned weekly.

Backside of the Kitchen

In an observation and interview on 10/08/2024 at 10:55 AM, the backside of the kitchen door showed a blue laundry hamper that had white wet linens inside of it. Staff D, Dietary Services Manager said they stored the wet linens outside of the kitchen door. Staff D said the linens got picked up every Friday from an outside service.

In an interview on 10/08/2024 at 11:00 AM, Staff C and Staff D acknowledged that the backside of the kitchen area was the front side porch area for the residents to access.

In an observation and interview on 10/08/2024 at 11:05 AM, the electrical panel had a blue net that had been propped up against it. Staff C said the blue net was used for the game bad mitten and it had usually been stored in the covered area by the north side dining back porch. Staff C had been observed to move the blue net under the north side dining back porch. In the corner of the porch was a table umbrella that was upside down. There was a container of blue coral car wash cleaning detergent, and linens stacked on blue styrofoam.

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Administrator (or Representative)

Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature did not go below 105 and above 120 degrees Fahrenheit (F) for 3 of 3 floors (1st floor, 2nd floor, 3rd floor) of the facility. This failure placed 53 of 53 residents and staff at risk for potential skin burns.

Findings included...

Record review of the facility provided document, titled, "Logbook Documentation", undated, showed it was documented water temperature checks for the hot water test temperatures. The hot water temperatures were checked on 09/03/2024, that showed nine areas that included all three floors of the assisted living side of the facility hot water temperatures measured between 120.1 to 121.1. The same nine areas on all three floors of the assisted living side of the facility hot water temperatures for dates 09/09/2024, 09/17/2024, 09/23/2024, and 10/02/2024 all ranged from 120.2 to 121.2.

In an observation on 10/08/2024 at 10:27 AM, on the first floor in the public bathroom across from the south dining room on the left the hot water temperature was 122.3 degrees F.

In an interview on 10/08/2024 at 10:29 AM, Staff C, Maintenance, stated they kept the facility's hot water temperatures per the regulation of nothing below 120 degrees F. Staff C stated they had the hot water temperatures range from 120 to 122 degrees F.

In an observation and interview on 10/08/2024 at 11:00 AM, Staff C showed the mechanical room on the second floor with four hot water tanks inside the room. Three hot water tanks were listed at 135°F and one tank was set to 140° F. Staff C confirmed the tank settings showed the intended values for each tank.

In an observation on 10/08/2024 at 11:22 AM, on the third floor in the resident laundry room, the public sink's hot water temperature was 124.7 degrees F. When the hot water was running, the water was hot to touch and could see steam rising from the running water.

In an observation on 10/08/2024 at 11:25 AM, on the second floor the public bathroom by door 251 showed the water temperature in the sink was 120.6 degrees.

In an observation on 10/08/2024 at 11:26 AM, on the second floor the public bathroom by the hair salon showed the water temperature in the sink was 122.5 degrees.

In an observation on 10/08/2024 at 11:35 AM, on the third-floor resident used laundry room sink's hot water was 124.7 degrees F.

In an interview on 10/08/2024 at 11:42 AM, Staff C stated they checked the facility's hot water temperatures every month as a task in their electronic system "TELS".

In an interview and record review on 10/08/2024 at 12:43 PM, Staff C stated they were unsure what regulation that showed the hot water temperatures were not to be under 120 degrees F. Staff C searched for the regulation on their personal cell phone and showed the Department the Washington state regulation that showed the hot water temperature for resident accessible sink areas was to remain in between 105°and 120°F.

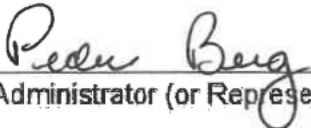
In an interview on 10/08/2024 at 12:48 PM, Staff A, Executive Director acknowledged the concern that the facility water temperatures exceeded the 120-degree regulation.

Plan/Attestation Statement

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12/08/2024

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



Administrator (or Representative)

11/28/2024

Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 3 sampled pets (Resident 9's [R9] pet, and Resident 2's [R2] pet) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of diseases transmittable to humans. This failure placed 53 of 53 residents and 39 staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility's, "Disclosure of Services Required by RCW 18.20.300", revised "01/2023", showed the assisted living permitted cats and small dogs under the condition that the resident must maintain immunizations and comply with the community pet policy and agreement.

Record review of the facility's document, titled, "Pets", dated "10/2021", showed it was a policy to provide guidelines for permitting and maintaining residents' pets. Pets were permitted with prior approval from the Executive Director.

Record review of the pet record binder, showed there was a facility document titled, "Permitting and Maintaining Pets", dated "10/2010", that documented pets may be kept by residents with prior approval of the administrator. Approval for the pet and an agreement for health care vaccinations and maintenance would be documented on the permission for pets form and filed with the resident's records.

Record review R9's pet record document, titled, "Invoice", dated 09/21/2021, showed R9 had a canine that was last seen by the veterinary clinic on 09/21/2021 and was administered their rabies one year vaccination that was next due on 09/21/2022. There

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 3 sampled pets (Resident 9's [R9] pet, and Resident 2's [R2] pet) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of diseases transmittable to humans. This failure placed 53 of 53 residents and 39 staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility's, "Disclosure of Services Required by RCW 18.20.300", revised "01/2023", showed the assisted living permitted cats and small dogs under the condition that the resident must maintain immunizations and comply with the community pet policy and agreement.

Record review of the facility's document, titled, "Pets", dated "10/2021", showed it was a policy to provide guidelines for permitting and maintaining residents' pets. Pets were permitted with prior approval from the Executive Director.

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Record review R9's pet record document, titled, "Invoice", dated 09/21/2021, showed R9 had a canine that was last seen by the veterinary clinic on 09/21/2021 and was administered their rabies one year vaccination that was next due on 09/21/2022. There

were no other current pet vaccination records for R9's canine for review.

Record review of R2's pet record document, titled, "Rabies Vaccination Certificate", dated 07/03/2019, showed R2 had a canine that was last vaccinated on 07/03/2019 and their next vaccination was due on 07/03/2022. There were no other current vaccination records in the binder for R2's canine for review.

In an observation and interview on 10/09/2024 at 3:40 PM, in R2's living space sitting on R2's lap, was a small, dark colored, half-shaven dog. R2 explained that the dog was theirs, lived with them, and that they only had one animal at this time as the second dog they had was put down due to old age and health concerns a couple months prior. R2 said they were the only person responsible for caring for the animal and that the dog was half-shaven due to having had fleas very recently.

In an interview on 10/09/2024 at 10:40 AM, Staff G, Receptionist, stated the pet vaccination records in the pet record binder that was provided were the most updated vaccination documents. Staff G stated the activity department was responsible to keep the pet records up to date.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/3/2025~~

12/08/2024

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


Administrator (or Representative)

11/20/24
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 4 of 4 resident (Resident 2 [R2], Resident 4 [R4],

were no other current pet vaccination records for R9's canine for review.

Record review of R2's pet record document, titled, "Rabies Vaccination Certificate", dated 07/03/2019, showed R2 had a canine that was last vaccinated on 07/03/2019 and their next vaccination was due on 07/03/2022. There were no other current vaccination records in the binder for R2's canine for review.

In an observation and interview on 10/09/2024 at 3:40 PM, in R2's living space sitting on R2's lap, was a small, dark colored, half-shaven dog. R2 explained that the dog was theirs, lived with them, and that they only had one animal at this time as the second dog they had was put down due to old age and health concerns a couple months prior. R2 said they were the only person responsible for caring for the animal and that the dog was half-shaven due to having had fleas very recently.

In an interview on 10/09/2024 at 10:40 AM, Staff G, Receptionist, stated the pet vaccination records in the pet record binder that was provided were the most updated vaccination documents. Staff G stated the activity department was responsible to keep the pet records up to date.

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Administrator (or Representative)

Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 4 of 4 resident (Resident 2 [R2], Resident 4 [R4],

Resident 5 [R5], and Resident 7 [R7]) rooms. This failure placed all 53 of 53 residents, staff, and visitors at risk for spread of infectious disease or illness.

Findings included...

Record review of the Center of Disease Control and Prevention (CDC) document, titled, "About Hand Hygiene for Patients in Healthcare Settings", dated 02/27/2024, showed, patients in healthcare setting were at risk of getting infections while receiving treatment for other conditions. Cleaning your hands could prevent the spread of germs, including those that were resistance to antibiotics, and protect healthcare personnel and patients. Under the section titled, "how to clean hands", showed they were to, wet their hands with warm water, apply a nickel or quarter sized amount of soap to the hand, rub hands together to form a lather, continue to rub for 15 seconds, rinse hands well under running water, and then dry hands using a paper towel and then turn off water with a paper towel.

Record review of CDC's fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to prevent the spread of germs and keep employees healthy. Hand hygiene was one of the best ways to prevent employees from getting sick and spreading germs to others in the workplace. Good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It can also mean using alcohol-based hand sanitizer with at least 60% alcohol if soap and water were not readily available. Employees were to wash their hands use soap and water instead of hand sanitizer when their hands were visibly dirty. Under the section titled, "tips for protecting employee health", showed provide soap, water, and way to dry hands (for example paper towels or a hand dryer) so employees can wash and dry hands properly. An alcohol-based hand sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Record review of an email sent to the Department on 10/18/2024 at 11:59 AM, showed the facility does not have a specific policy for "hand washing". The facility follows the CDC guidelines that was part of the infection control manual.

R2

Record review of R2's "Admission Record," dated 10/08/2024, showed R2 moved into the facility on [REDACTED]/2016. The admission record indicated R2 was receiving [REDACTED] services.

In an observation on 10/09/2024 at 3:45 PM, R2's bathroom showed a pump-style liquid hand soap and hanging next to the sink was a soiled hand towel. There were no paper towels observed in R2's bathroom.

In an interview on 10/09/2024 at 3:55 PM, R2 said the facility provided the hand soap but has never supplied the resident with paper towels.

R4

Record review of R4's "Admission Record", dated 10/08/2024, showed R4 moved into the facility on [REDACTED]/2016. The admission record indicated R4 was on [REDACTED] services.

In an observation and interview on 10/09/2024 at 1:10 PM, R4's bathroom had bar soap on their counter sink. There was a towel that hung on the towel rack. R4 said Collateral Contact 2, R4's Power of Attorney, provided them with soap in their bathroom. There were no paper towels observed in R4's bathroom.

R5

In an observation and interview on 10/09/2024 at 1:31 PM, inside R5's bathroom and common area sinks, there was no facility provided soap or paper towels available for staff to use. R5 stated the soap at both the sinks was soap they had purchased with their sister. R5 stated the facility did not provide them with soap.

R7

In an interview on 10/10/2024 at 12:04 PM, R7 stated the facility did not provide soap or paper towel in their bathroom or common areas sinks. R7 stated they purchase their own soap and paper towels.

In an interview on 10/10/2024 at 11:15 AM, Staff N, Caregiver, stated the facility only provided soap to the resident rooms that were state funded. Staff N stated they would use hand sanitizer if their hands were visibly soiled and then find a public sink when they would wash their hands with soap and dry with paper towels.

In an interview on 10/10/2024 at 12:06 PM, Staff F, Medication Technician, stated they would wash their hands with whatever soap was available in the resident's room. Staff F stated they had used the resident personal supply of soap. Staff F stated the residents typically had the good smelling soap. Staff F stated the facility only provided residents that were covered by state funding supplies such as soap.

Plan/Attestation Statement

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IDR Requested - 11/20/24

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

Peder Berg
Administrator (or Representative)

11/20/2024
Date

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-

In an observation and interview on 10/09/2024 at 1:10 PM, R4's bathroom had bar soap on their counter sink. There was a towel that hung on the towel rack. R4 said Collateral Contact 2, R4's Power of Attorney, provided them with soap in their bathroom. There were no paper towels observed in R4's bathroom.

R5

In an observation and interview on 10/09/2024 at 1:31 PM, inside R5's bathroom and common area sinks, there was no facility provided soap or paper towels available for staff to use. R5 stated the soap at both the sinks was soap they had purchased with their sister. R5 stated the facility did not provide them with soap.

R7

In an interview on 10/10/2024 at 12:04 PM, R7 stated the facility did not provide soap or paper towel in their bathroom or common areas sinks. R7 stated they purchase their own soap and paper towels.

In an interview on 10/10/2024 at 11:15 AM, Staff N, Caregiver, stated the facility only provided soap to the resident rooms that were state funded. Staff N stated they would use hand sanitizer if their hands were visibly soiled and then find a public sink when they would wash their hands with soap and dry with paper towels.

In an interview on 10/10/2024 at 12:06 PM, Staff F, Medication Technician, stated they would wash their hands with whatever soap was available in the resident's room. Staff F stated they had used the resident personal supply of soap. Staff F stated the residents typically had the good smelling soap. Staff F stated the facility only provided residents that were covered by state funding supplies such as soap.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-

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

823-0040 , that is the resident's primary special need.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 2 sampled staff (Staff A) completed the required developmental disability training. This failure placed Resident 1 (R1) and Resident 10 (R10) at risk for unmet care needs and support services provided by untrained staff.

Findings included...

WAC 388-112A-0400 "What is specialty training and who is required to take it? (1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (a) Developmental disabilities specialty training as described in WAC 388-112A-0420...(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (a) Developmental disabilities specialty training as described in WAC 388-112A-0420"

Record review of the facility provided document, titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R10 was identified to have a Developmental Disability (DD). The document showed R10 moved into the facility on [REDACTED]/2022.

Record review of the facility provided document, titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R1 was identified to have a Developmental Disability (DD).

Record review of R1's Admission Record, dated 10/08/2024, showed R1 moved into the facility on [REDACTED]/2018 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of the facility provide document, titled, "employee listing", dated 10/08/2024, showed Staff A, Executive Director, was hired at the facility on 11/14/2022.

Record review on 10/09/2024 of Staff A's employee documents showed Staff A did not have the required specialty training for developmental disability for review.

In an interview on 10/10/2024 at 11:27 AM, Staff A stated they had never taken the DD course. Staff A does not have a certificate of completion for the DD training to provide to the Department for review. Staff A acknowledged that there were residents that had DD that resided at the facility.

Plan/Attestation Statement

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12/08/2024

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

Peder Berg

Administrator (or Representative)

11/21/2024

Date

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a Washington State name and Date of Birth background check and fingerprints completed for 1 of 1 contracted agency caregivers (Staff H) prior to them working at the facility. The facility failed to ensure that the 1 of 3 new staff (Staff B) had their national fingerprint background check results within the required time. These failures placed all 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

WAC 388-06-0530 "When does the 120-day provisional period begin? The 120-day provisional period begins on the date an applicant, long-term care worker, or service provider begins providing care to a vulnerable adult or child."

Record review of the facility provided document, titled, "Employee Listing", dated 10/08/2024, showed Staff B, Health Services Director, was hired at the facility on 11/28/2022.

In an interview on 10/10/2024 at 11:27 AM, Staff A stated they had never taken the DD course. Staff A does not have a certificate of completion for the DD training to provide to the Department for review. Staff A acknowledged that there were residents that had DD that resided at the facility.

Plan/Attestation Statement

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Date

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a Washington State name and Date of Birth background check and fingerprints completed for 1 of 1 contracted agency caregivers (Staff H) prior to them working at the facility. The facility failed to ensure that the 1 of 3 new staff (Staff B) had their national fingerprint background check results within the required time. These failures placed all 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

WAC 388-06-0530 "When does the 120-day provisional period begin? The 120-day provisional period begins on the date an applicant, long-term care worker, or service provider begins providing care to a vulnerable adult or child."

Record review of the facility provided document, titled, "Employee Listing", dated 10/08/2024, showed Staff B, Health Services Director, was hired at the facility on 11/28/2022.

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

Record review of facility provided untitled and undated document that was Staff B's interim fingerprint scheduling, showed Staff B was enrolled with the fingerprint vendor on 12/02/2022 at 3:40 PM.

Record review of facility provided untitled and undated document that was Staff B's interim fingerprint scheduling, showed on 03/09/2022 at 10:20 AM, Staff B had a fingerprint appointment scheduled, when their fingerprints were rejected.

Record review of facility provided untitled and undated document that was Staff B's interim fingerprint scheduling, showed on 03/17/2023 at 2:20 PM, Staff B had a fingerprint appointment scheduled, when their fingerprints were rejected.

Record review of facility provided untitled and undated document that was Staff B's interim fingerprint scheduling, showed on 06/20/2024 at 11:30 AM, Staff B completed their final fingerprint that had resulted. There was no other documentation that Staff B had a fingerprint appointment was made during the 15-month range of 03/18/2023 through 06/19/2024 for review.

Record review of Staff B's final fingerprint background check results was dated 06/20/2024, that was 450 days past the required time.

In an interview on 10/09/2024 at 4:10 PM, Staff A, Executive Director, stated Staff P, Business Office Manager, was responsible to ensure all new and old staff that required a Washington state name and date of birth background check and/or national fingerprint background were completed and reviewed.

In an interview on 10/10/2024 at 10:23 AM, Staff A stated Staff B had gone five different times to get their fingerprint checks completed for their national fingerprint background check.

In an interview on 10/10/2024 at 10:28 AM, Staff P stated they were responsible to ensure all staff's Washington state name and date of birth background checks and national fingerprint background checks were completed within the required requirements. Staff P acknowledged Staff B's final fingerprint was not completed in a timely manner.

Agency Caregivers

Record review of the facility provided document titled, "weekly schedule", dated 10/06/2024 through 10/12/2024, for the shift 2:00 PM until 10:00 PM on 10/09/2024 showed Staff H, Agency Caregiver, was scheduled as worked. Review of the schedule for the days showed there were three other shifts that an agency caregiver had or was scheduled to work.

In an observation and interview on 10/09/2024 at 3:56 PM, on the first floor of the facility across from the south dining room was Staff H pushing a large cart. Staff H stated it was their first time working at the facility. Staff H was observed to wear a name badge with their name and "NAC [nursing assistant certified]" with the agency company's name.

Record review on 10/09/2024 at 3:59 AM, of the facility's background check result

binder for the staff, showed there was no Washington state name and date of birth or fingerprint background check for Staff H for review.

In an interview on 10/09/2024 at 4:35 PM, Staff A, Executive Director, stated the facility did not check agency staff background checks as they had a contract with the agency company that ensures all the staff that they contract to the facility to work have all the required requirements. Staff A stated they did not have a background check for the Department to review.

As of 10/15/2024 at 5:00 PM, the facility was unable to provide a Washington state name and date of birth or fingerprint background check for Staff H for 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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/3/2025~~ 12/08/2024

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

IDR Requested 11/20/24

Pedro Berg
Administrator (or Representative)

11/20/2024
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 53 of 53 residents at risk for receiving food that was at risk for exposure to food-borne illnesses.

Findings included...

WAC 246-215-03351

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

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

(a) In a clean, dry location;

(b) Where it is not exposed to splash, dust, or other contamination; and

(c) At least six inches (15 cm) above the floor.

(2) food in packages and working containers may be stored less than six inches (15 cm)

binder for the staff, showed there was no Washington state name and date of birth or fingerprint background check for Staff H for review.

In an interview on 10/09/2024 at 4:35 PM, Staff A, Executive Director, stated the facility did not check agency staff background checks as they had a contract with the agency company that ensures all the staff that they contract to the facility to work have all the required requirements. Staff A stated they did not have a background check for the Department to review.

As of 10/15/2024 at 5:00 PM, the facility was unable to provide a Washington state name and date of birth or fingerprint background check for Staff H for 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, Avamere at Port Townsend 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 53 of 53 residents at risk for receiving food that was at risk for exposure to food-borne illnesses.

Findings included...

WAC 246-215-03351

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

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

(a) In a clean, dry location;

(b) Where it is not exposed to splash, dust, or other contamination; and

(c) At least six inches (15 cm) above the floor.

(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.”

Record review of the facility’s policy titled, “General Food Preparation and Handling”, dated “10/2021”, under the section titled, “food storage”, showed foods were received, checked, and stored properly as soon as they were delivered.

Food

In an observation on 10/08/2024 at 2:05 PM, in the walk-in refrigerator to the right there was a white box stored on the ground with the label of hardwood smoked center cut sliced bacon. There was a clear plastic container with a red lid that sat on top of the box of bacon that had a handwritten label of “ham”.

In the back of the walk-in refrigerator near the hinged area of the walk-in freezer’s door was a brown box that was stored on the ground with a label of pulled white turkey. In the back of the walk-in refrigerator to the left in front of the bottom shelf on the ground was a brown box that showed “potatoes”. At 2:07 PM inside the walk-in freezer there were three large white boxes with green print with label of “Sunkist”. All three boxes were stored on the ground with other boxes and plastic containers with red lids of previously made food stored inside of them. There was another large brown box that was stored flat on the ground that had a label “ham and water product”.

In an interview on 10/08/2024 at 2:18 PM, Staff D, Dietary Services Manager, stated nothing edible was to be stored on the ground. All boxes of edible food were to be at least six inches off of the ground.

In an interview and observation on 10/08/2024 at 2:27 PM, inside the walk-in refrigerator, Staff D stated the boxes that were on the ground that included the two brown boxes, and the white box of sliced bacon were not to be on the ground. Staff D stated there was a delivery yesterday 10/07/2024. Inside the walk-in freezer, Staff D acknowledged that the four boxes were not to be stored on the ground and stated they would get all the boxes off of the ground.

In an observation on 10/09/2024 at 10:03 AM upon entering the kitchen while the Department was washing their hands, near the entry way of the dry pantry room, there was a large box of green and yellow bananas stored on the ground. Staff I, Cook, walked by the box of bananas on the ground. Staff Q, Cook, walked by the box of banana’s on the ground then came back to the banana’s and began kicking the box while still on the ground into the dry pantry room. At 10:05 AM, inside the walk-in freezer there was an open white box with the label “cheese manicotti”, that was stored flat on the ground.

In an observation on 10/10/2024 at 10:58 AM, inside the walk-in freezer to the left was a box of blue bunny vanilla cones that were stored on the ground flat with a large round container of wholesome farms ice cream that was stored on top of the box.

Cleanliness

In an observation on 10/08/2024 at 2:18 PM, in the kitchen on the ceiling above the assembly line across from the grill were air vents that had a large amount of gray and brown fuzz that was moving with the air flow.

In an observation on 10/09/2024 at 11:30 AM, in the kitchen Staff I was standing at the assembly line across from the grill dishing ready to eat food from the hot holding bar onto plates. Above where Staff I was standing on the ceiling were air vents that continued to have large amounts of gray and brown fuzz that was moved with the air flow.

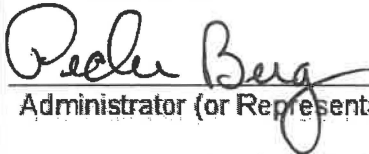
In an interview on 10/16/2024 at 2:20 PM, Staff D stated there was no system in place to clean the air vents in the kitchen prior to Department entering the facility on 10/08/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/2/2025~~

12/08/2024

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



Administrator (or Representative)

11/20/2024

Date

WAC 388-78A-2230 Medication refusal.

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

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

(i) Conducts an evaluation; and

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 1 of 7 sampled residents (Resident 3 [R3]) refused their medication. This failure placed R3 at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

In an observation on 10/08/2024 at 2:18 PM, in the kitchen on the ceiling above the assembly line across from the grill were air vents that had a large amount of gray and brown fuzz that was moving with the air flow.

In an observation on 10/09/2024 at 11:30 AM, in the kitchen Staff I was standing at the assembly line across from the grill dishing ready to eat food from the hot holding bar onto plates. Above where Staff I was standing on the ceiling were air vents that continued to have large amounts of gray and brown fuzz that was moved with the air flow.

In an interview on 10/16/2024 at 2:20 PM, Staff D stated there was no system in place to clean the air vents in the kitchen prior to Department entering the facility on 10/08/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Avamere at Port Townsend 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-2230 Medication refusal.

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

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

(i) Conducts an evaluation; and

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 1 of 7 sampled residents (Resident 3 [R3]) refused their medication. This failure placed R3 at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

Record review of facility's policy, titled, "Medication Error Policy", revised 01/13/2022, showed that if the facility staff failed to follow the most current physician order it would be considered a medication error. The overall responsibility of defining and responding to medication errors was on the Director of Health Services and the facility Administrator.

R3

Record review of R3's "Admission Record", dated 10/18/2024, showed R3 moved into the facility on [REDACTED] /2024. R3 had a diagnosis of [REDACTED].

Record review of R3's Negotiated Service Agreement, signed on 06/24/2024, under the medication management section showed the goal had been to receive R3's medications and treatments as ordered by provider. The facility staff would provide R3 their medication assistance and would document all medications on their MAR (medication administration record).

Record review of R3's, "Physician Orders for Admission", dated 05/01/2024, showed R3 had not been appropriate to self-administer their medications. The medical provider indicated they wanted to be notified each time the resident refused their medications or treatments.

Record review of R3's July MAR, dated 07/01/2024 - 07/31/2024 showed, R3 had an order for Erythromycin Ophthalmic Ointment, start date 05/21/2024, for their unspecified glaucoma where they were supposed to have eye drops administered three times a day. R3 refused their medication 8 of 31 days. The MAR showed R3 had an order for Alphagan P Ophthalmic Solution (eye drops) start date 05/21/2024 for their unspecified glaucoma where they were supposed to have eye drops administered 2 times a day. R3 refused their medication on 07/16/2024.

Record review of R3's, "Progress Notes", dated 07/11/2024 - 07/24/2024 showed no progress notes that indicated the reason why R3 did not receive their Erythromycin eye drops.

Record review of R3's, "Progress Notes", dated 07/16/2024, did not indicate why R3 did not receive their Alphagan eye drops.

Record review of R3's August MAR, dated 08/01/2024 - 08/13/2024 showed, R3 had an

order for Erythromycin Ophthalmic Ointment, start date 05/21/2024, for their unspecified glaucoma where they were supposed to have eye drops administered three times a day. R3 refused their medication 5 of 13 days.

Record review of R3's "Physician Progress/Information Record", dated 08/11/2024, showed the facility had faxed R3's physician that R3 refused their Erythromycin Ophthalmic Ointment, that R3 stated they no longer used it, and the facility requested to discontinue the medication. The physician responded on 08/13/2024 and stated that they had not been R3's physician since they moved out of California three months prior.

In an interview on 10/09/2024 at 10:31 AM, Collateral Contact 3 (CC3), R3's Daughter, said R3 used to have a medical provider when they lived in California but since they moved to the facility, R3 did not have established care provider.

In an interview on 10/10/2024 at 10:57 AM, Staff B, Health Services Director, said if a resident missed their medication, it would be considered a medication error, and the resident would need to go on alert charting for at least 72 hours or longer if needed. Staff B said R3 did not get their prescribed eye drop medication because they needed to establish care with an in state medical provider. Staff B said R3's out of state medical providers eye drops could not be discontinued until R3 had an in state medical provider. Staff B said until they received a discontinued order for R3's medical provider the facility staff wrote R3 refused their medication on their MAR. Staff B acknowledged the information they provided had not been documented to review in R3's progress notes.

Record review of an email sent to the Department on 10/18/2024 at 12:00 PM, showed Staff B wrote that that R3 moved to the facility from California and did not have established care with an Ophthalmologist until a few months after their move. Staff B wrote that R3's medical doctor was not notified after each refused Erythromycin eye drop medication.

In an interview on 10/18/2024 at 12:42 PM, Staff B stated R3 did not have a medical provider upon their move to the facility. Staff B noted R3's medical provider had been in California. Staff B said R3 established care with a medical provider in Washington in July 2024.

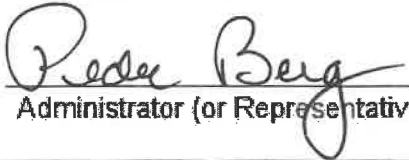
This document was prepared by Residential Care Services for the Locator website.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/3/2025~~

12/08/2024

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


Administrator (or Representative)

11/26/24
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.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and develop initial, and 30-day negotiated resident service plan for 1 of 2 new sampled residents (Resident 7 [R7]). This failure placed R7 at risk for staff untrained of the care and services required and unmet care needs.

Findings included...

Record review of the facility provided document titled, "resident move-in audit procedure", dated "10/2021", showed the purpose of the audit was to ensure that items in the resident record were organized, uniform, and completed per company policy. The resident care coordinator or designee should perform a move-in audit utilizing the resident move-in marketing and clinical checklist within 24 hours of move-in, 48 hours' post-move in and at 30 days. The resident move-in marketing and clinical checklist should be brought to stand-up and status communicated to ensure all items were completed by those responsible for tasks.

Record review of the facility provided document titled, "move-in procedure", dated

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, Avamere at Port Townsend 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-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.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and develop initial, and 30-day negotiated resident service plan for 1 of 2 new sampled residents (Resident 7 [R7]). This failure placed R7 at risk for staff untrained of the care and services required and unmet care needs.

Findings included...

Record review of the facility provided document titled, "resident move-in audit procedure", dated "10/2021", showed the purpose of the audit was to ensure that items in the resident record were organized, uniform, and completed per company policy. The resident care coordinator or designee should perform a move-in audit utilizing the resident move-in marketing and clinical checklist within 24 hours of move-in, 48 hours' post-move in and at 30 days. The resident move-in marketing and clinical checklist should be brought to stand-up and status communicated to ensure all items were completed by those responsible for tasks.

Record review of the facility provided document titled, "move-in procedure", dated

"04/2022", showed move-in and clinical record included the following screening (evaluation), service plan (negotiated service agreement (NSA), face sheet, move-in checklist and more.

Record review of R7's Admission Record, dated 10/08/2024 , showed R7 moved into the facility on /2024, with multiple medical diagnoses that included and .

Record review of R7's level of care and service plan, dated 04/11/2024, showed it was R7's move-in assessment.

Record review of R7's level of care and service plan, dated 04/24/2024, showed it was R7's pre-move in assessment.

Record review of R7's level of care and service plan, dated 07/16/2024, showed it was R7's 14-day assessment.

Record review of R7's level of care and service plan, dated 07/16/2024, showed it was R7's quarterly assessment.

On 10/08/2024 at 1:05 PM, the Department requested R7's initial, 30-day, and most updated negotiated service agreement.

As of 10/08/2024 at 5:00 PM, the Department had not received a negotiated service agreement for R7 to review.

On 10/09/2024 at 10:00 AM, the Department requested all of the negotiated service agreements that were completed for R7 for review.

On 10/09/2024, the Department received an untitled document, signed and dated 10/09/2024, that was R7's resident service plan.

In an interview on 10/09/2024 at 5:22 PM, Staff B, Health Services Director, stated that the resident assessments that were completed generated the residents service plan. Staff B stated the facility did not have an initial service plan or 30-day service plan that had been completed to provide to the Department for review. Staff B stated the pre-move in assessment would trigger for the initial resident service plan to be completed.

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

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/3/2025~~ 12/08/2024

IDR Requested 11/20/24

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

Peder Berg
Administrator (or Representative)

11/20/2024
Date

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 2 sampled residents (Resident 3 [R3]). This failure placed R3 at risk for not having an assessment to identify and meet R3's healthcare needs.

Findings included...

Record review of the facility's policy titled, "Residency and Move-In Process and Procedure," revised "12/2023", showed the executive director or designee would meet with a new resident prior to them moving in to become acquainted with the resident and assess any special needs the resident had. The resident would be evaluated on the degree of assistance the resident needed to obtain or order their medications, the degree of assistance the person needed with ambulation, mobility, and the use of assisted devices. The degree of assistance needed with activities of daily living, the level of care the resident needed related to their medical conditions, mental functional

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, Avamere at Port Townsend 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-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 2 sampled residents (Resident 3 [R3]). This failure placed R3 at risk for not having an assessment to identify and meet R3's healthcare needs.

Findings included...

Record review of the facility's policy titled, "Residency and Move-In Process and Procedure," revised "12/2023", showed the executive director or designee would meet with a new resident prior to them moving in to become acquainted with the resident and assess any special needs the resident had. The resident would be evaluated on the degree or assistance the resident needed to obtain or order their medications, the degree of assistance the person needed with ambulation, mobility, and the use of assisted devices. The degree of assistance needed with activities of daily living, the level of care the resident needed related to their medical conditions, mental functional

capability, and the resident's behavioral status. If the facility can meet the residents needs the level of care evaluation should be completed by a trained employee and creation of an initial service plan.

Record review of R3's "Admission Record", dated 10/18/2024, showed R3 moved into the facility on [REDACTED] /2024. R3 had multiple diagnosis which included [REDACTED] and [REDACTED]

Record review of R3's, "AL Level of Care and Service Plan Type Pre-Move In" assessment, dated [REDACTED] /2024, showed the assessment was completed the day R3 admitted into the facility, not prior to their admission.

In an interview on 10/09/2024 at 5:22 PM, Staff B, Health Services Director, said for new residents who wanted to admit into the facility they would review their physician orders, meet the prospective resident, and complete their preadmission assessment after they moved in.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 11/21/2024 12/08/2024

IDR Requested 11/20/24

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

Peder Berg

Administrator (or Representative)

11/20/2024

Date

WAC 388-78A-2040 Other requirements.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain fire safety per the state fire marshal regulations for 1 of 1 facility reviewed. These failures placed 53 of 53 residents, staff, and visitors' life and safety at risk in the event of a fire.

Findings included...

RCW 70.160.075 "Smoking prohibited within twenty-five feet of public places or places of employment - Application to modify presumptively reasonable minimum distance. Smoking is prohibited within a presumptively reasonable minimum distance of twenty-

capability, and the resident's behavioral status. If the facility can meet the residents needs the level of care evaluation should be completed by a trained employee and creation of an initial service plan.

Record review of R3's "Admission Record", dated 10/18/2024, showed R3 moved into the facility on [REDACTED]/2024. R3 had multiple diagnosis which included [REDACTED] and [REDACTED].

Record review of R3's, "AL Level of Care and Service Plan Type Pre-Move In" assessment, dated [REDACTED]/2024, showed the assessment was completed the day R3 admitted into the facility, not prior to their admission.

In an interview on 10/09/2024 at 5:22 PM, Staff B, Health Services Director, said for new residents who wanted to admit into the facility they would review their physician orders, meet the prospective resident, and complete their preadmission assessment after they moved in.

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, Avamere at Port Townsend 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-2040 Other requirements.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain fire safety per the state fire marshal regulations for 1 of 1 facility reviewed. These failures placed 53 of 53 residents, staff, and visitors' life and safety at risk in the event of a fire.

Findings included...

RCW 70.160.075 "Smoking prohibited within twenty-five feet of public places or places of employment - Application to modify presumptively reasonable minimum distance. Smoking is prohibited within a presumptively reasonable minimum distance of twenty-

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

five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited so as to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means."

Record review of the document titled, "final bill report Initiative-901", dated 12/08/2005, showed it was a clean indoor air act amendment, that prohibits smoking in a public place, except within designated smoking areas. "Public place" was the portion of any building or vehicle use by or open to the public, regardless of who owns it and whether or not a fee is charged for entry. The definition of a public place also includes a private residence or home-based business when that residence or business was used to provide licensed adult care or other similar social services care on the premises. Smoking was not allowed within a "presumptively reasonable minimum distance" from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking was prohibited. I-901 defines a "presumptively reasonable distance" as twenty-five feet.

Record review of the facility provided document titled, "disclosure of services", undated, under the section titled, "services related to smoking", showed the facility would permit smoking in a designated outside areas consistent with Initiative 901 as specified in the resident's negotiated service agreement.

"Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NFPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

Smoking

In an interview on 10/08/2024 at 10:46 AM, Staff C, Maintenance, stated staff, residents, and visitors were not allowed to smoke within 25 feet of the facility building. Staff C stated there were designated smoking areas in the front and back of the facility for staff, visitors, and residents to smoke.

In an observation on 10/08/2024 at 1:20 PM, from inside the private dining room looking out the windows, Resident 7 [R7], and Resident 8 [R8] were observed to be smoking cigarettes just outside the private dining room window and the side door of the facility and less than 6 feet from the facility building.

In an observation on 10/08/2024 at 2:43 PM, in front of the facility, across from the windows of the private dining room and by a side door to the facility was a black cigarette disposable receptacle post that was 8 feet, 1 inch from the building and window. On the walkway pillar that was near the black cigarette disposable receptacle post was a sign that showed, "please do not throw cigarette butts on the ground".

In an observation on 10/08/2024 at 2:51 PM, outside of the facility in the front, there were multiple signs posted that showed there was to be no smoking within 25 feet of the facility building.

In an observation on 10/08/2024 at 3:15 PM, from inside the private dining room looking out the windows, R7 was sitting in the chair that was up against the wall 7 inches from facility building smoking a cigarette.

In an observation on 10/08/2024 at 5:04 PM, from inside the private dining room looking out the windows, R7 sat in a chair that was up against the wall of the facility and R8 sat on the seat of their four wheeled walker that were outside less than four feet of the private dining room windows and the facility building, both smoking cigarettes.

In an observation on 10/09/2024 at 11:29 AM, from inside the private dining room looking out the windows, R7 was observed to sit in the chairs that were 7 inches from the window and the assisted living building smoking cigarettes.

In an observation on 10/09/2024 at 1:52 PM, from inside the private dining room looking out the windows, R7 and R8 were sitting together less than four feet from the private dining room window and the assisted living facility building both smoking cigarettes.

In an interview on 10/10/2024 at 11:06 AM, Staff B, Health Service Director, said the facility had an ongoing problem with residents not smoking in the designated smoking area. Staff B acknowledged residents exit the front building doors, turn right, and smoke in the covered area underneath the building.

In an observation and interview on 10/10/2024 at 11:33 AM, from inside the private dining room with Staff A, Executive Director, looking out the windows, R7 sat in the chair that was up against the side of the facilities building smoking a cigarette. Staff A acknowledged that R7 was not in a designated smoking area.

Doors propped open

In an observation and interview on 10/08/2024 at 10:54 AM, outside in the back of the facility the back kitchen door had cardboard that was in between the doors frame and the door. The brown cardboard was by the doors handle and the area that the lock protrudes out of the side of the door that latches and locks it shut. Staff C, Maintenance Director, stated they were unsure why the cardboard was in between the kitchen's door and frame. Staff D, Dietary Service Manager, stated the cardboard was in between the kitchen's door and frame to keep the door unlocked to allow kitchen staff to come back in the facility. Staff D acknowledge that there were no kitchen staff outside that required the need to come into the kitchen.

In an observation and interview on 10/08/2024 at 11:19 AM, the door to the electrical room across from vacant room 270, was propped open with a wooden wedge that was wedged under the bottom of the door. There was a black animal leash that was tied on the side rail on the wall to the other side of the doorway. Staff C stated they were unsure why the door was propped open with the leash.

In an observation on 10/08/2024 at 12:56 PM, the first floors charting room door had been propped open with a rubber stopper that had been wedged underneath the bottom of the door.

In an observation on 10/09/2024 at 9:59 AM, the closet with mechanical equipment inside, across from the right public bathroom near the south dining room, the door was propped open with a black and yellow screwdriver that was wedged underneath the

bottom of the door.

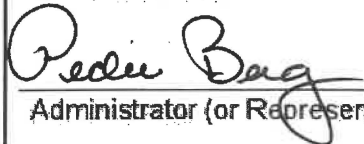
In an observation on 10/09/2024 at 10:09 AM, outside in the back of the facility, the kitchen door was noted to have a piece of brown cardboard that was in the door frame where the door latched and locked, the door was able to be opened, despite the door handle being locked.

In an interview on 10/10/2024 at 11:06 AM, Staff B said the facility had an ongoing problem with residents who smoked as they propped open facility doors because they did not want to walk to the front of the building where the designated smoking area was. Staff B said facility residents propped open doors with cardboard or wedges. Staff A entered the conversation at 11:11 AM and acknowledged the facility had an ongoing problem with residents who propped open the facility doors. Staff A acknowledged the facility kitchen staff propped open the back kitchen door when they went out to take the garbage out because if the door closed it would lock behind them. Staff A said there was no excuse as to why the facility staff should prop open the doors.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/20/2024~~ 12/08/2024

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


Administrator (or Representative)

11/20/2024
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete on-going assessments focused on residents identified problems and a change of condition

bottom of the door.

In an observation on 10/09/2024 at 10:09 AM, outside in the back of the facility, the kitchen door was noted to have a piece of brown cardboard that was in the door frame where the door latched and locked, the door was able to be opened, despite the door handle being locked.

In an interview on 10/10/2024 at 11:06 AM, Staff B said the facility had an ongoing problem with residents who smoked as they propped open facility doors because they did not want to walk to the front of the building where the designated smoking area was. Staff B said facility residents propped open doors with cardboard or wedges. Staff A entered the conversation at 11:11 AM and acknowledged the facility had an ongoing problem with residents who propped open the facility doors. Staff A acknowledged the facility kitchen staff propped open the back kitchen door when they went out to take the garbage out because if the door closed it would lock behind them. Staff A said there was no excuse as to why the facility staff should prop open the doors.

Plan/Attestation Statement

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

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Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete on-going assessments focused on residents identified problems and a change of condition

for 2 of 7 sampled residents (Resident 1[R1], Resident 4 [R4]). This failure placed these residents at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included...

Record review of the facility provided document titled, "change of condition procedure", dated 07/20/2023, showed the document was a policy to establish clear guidelines for identification, interventions, and documentation of a resident's change in condition. It was to ensure that the interdisciplinary team was aware of the resident changes of condition, and all changes were evaluated, monitored, and documented. Under the section titled, "acute changes of condition", showed change of conditions were reviewed daily in stand-up via the 24-hour report in point click care (PCC). The registered nurse (RN) would evaluate the resident and change of condition noted to determine the need for additional services or interventions. Changes of condition were reviewed with direct care staff during daily shift change.

Record review of the facility provided document titled, "Employee Listing", printed 10/08/2024, showed Staff B, Director Health Services was hired on 11/28/2022.

R1

Record review of the facility's undated characteristic roster, dated 10/08/2024, showed R1 moved in on [REDACTED]/2018.

Record review of R1's "Admission Record," dated 10/08/2024, showed R1 had diagnoses to include

[REDACTED] and [REDACTED].

Record review of an incident report for R1, dated 02/27/2024, showed R1 had a fall.

Record review of R1's assessment, titled, "AL Level of Care and Service Plan-WA," completed 03/30/2024 showed R1 was independent with mobility and ambulation, independent with transfers and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

Record review of an incident report for R1, dated 06/14/2024, showed R1 had a fall.

Record review of R1's Service Plan, dated 06/14/2024 showed R1 was independent with mobility/ambulation, independent with transferring, and stated R1 "has not had any

recent falls or been identified as a fall risk at this time."

Record review of R1's assessment, titled, "AL Level of Care and Service Plan-WA," completed 07/05/2024 showed R1 was independent with mobility and ambulation, independent with transfers, and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

Record review of an incident report for R1, dated 09/18/2024, showed R1 fell while they were attempting to put their laundry away.

In an observation on 10/09/2024 at 5:57 PM, Staff B showed the screen with progress notes logs for R1 for the dates 09/18/2024 through 09/23/2024. Shown on the screen was a note from 09/18/2024 at 11:05 AM, labeled as ISP (interim service plan) and said "Fall: Take all vital signs, including pain. Observe for any injury and document any other findings. Keep on alert for a minimum of 72 hours. Please chart Day/Evening/Noc shift. Notify CBC (Community Based Care) with any c/c(complaints)."

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/18/2024 at 11:06 and described how staff found the resident in their closet where they fell as they attempted to put their laundry away.

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/18/2024 at 12:06 PM and said R1 attended mealtime that day.

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/19/2024 at 3:01 PM; 27 hours after the last note entered.

No other notes for R1 were provided to show the instructions from the ISP were followed nor that the resident's condition was monitored after the fall on 09/18/2024 at 11:01 AM.

In an interview on 10/09/2024 at 5:57 PM, Staff B said there was a 27-hour charting gap after 09/19/2024 because the medication technician was supposed to chart and they didn't.

Record review of R1's assessment, titled, "AL Level of Care and Service Plan-WA," completed 10/03/2024 showed R1 was independent with mobility and ambulation, independent with transfers, and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

In an interview on 10/09/2024 at 5:51 PM, Staff B, Director of Health Services, verbally reviewed the most recent assessment, completed on 10/03/2024, for R1 and stated that

the assessment did not identify falls as a risk factor for the resident. Staff B said the assessment listed "no risk factors," and that the box for "falls in the past 3 months," was not checked and should have been. Staff B acknowledged that a fall risk should have been identified and included in R1's most recent assessment completed on 10/03/2024.

No service plan for the 10/03/2024 assessment was provided to the department to review.

In an interview on 10/09/2024 at 5:55 PM, Staff B stated R1 did not have a completed and current negotiated service agreement based on the most recent assessment from 10/03/2024.

In an interview on 10/09/2024 at 5:40 PM, Staff B said the facility assessments provide the content for the resident service plans.

In an interview on 10/09/2024 at 5:40 PM Staff B stated there were gaps and missing assessments for residents.

In an interview on 10/09/2024 at 5:43 PM, Staff B explained the response process for resident falls. Staff B said residents are put on 72 hours monitoring and an interim service plan is created. Staff B said the interim service plan is documented in a progress note and it will say type: ISP with the monitoring instructions for staff in the progress note.

In an interview on 10/09/2024 at 5:46 PM, Staff B, said alert charting is supposed to be done when a resident is feeling ill, has emotional upset, goes to the ER, for resident-to-resident altercations new medication changes, a change in medication dosage, a discontinuation of medications, and other changes in condition like a resident fall. Staff B said medication technicians are responsible for alert charting and entering progress notes. Staff B said staff are to enter a progress note in a resident chart at least once per shift meaning there should be at least two progress notes per resident per day.

In an interview on 10/10/2024 at 12:35PM, Staff F, medication technician, said medication technicians are supposed to enter a note for each resident every shift unless there are instructions in the resident chart requiring more frequent charting.

R4

Record review of R4's "Admission Record", dated 10/08/2024, showed R4 moved into the facility on [REDACTED] /2016. R4 had clinical diagnoses of [REDACTED] and [REDACTED].

Record review of R4's Negotiated Service Agreement (NSA), dated 03/13/2024, under the section titled, "cognition", showed R4 had been oriented and could recall and obtain information. The assistive devices section showed R4 utilized a wheelchair. The fall risk section showed that R4 had not had any recent falls or had been identified as a fall risk.

Record review of the Department of Social & Health Services CARE Assessment, "Service Summary Current Annual", dated 09/24/2024, showed R4 had one fall within the last six months when they attempted to check their wheelchair. Under activities of daily living section showed R4 could not raise their arms, they had general weakness, left sided weakness, limited range of motion, were partial weight bearing, had poor balance, a weak grip, tremors, and an unsteady gait. The equipment section showed R4 used a motorized wheelchair. Per R4 they needed assistance with their wheelchair and batteries. R4 had a fall when they attempted to set up the wheelchair. R4 reported they tried to complete tasks on their own. The facility staff were supposed to ask if R4 needed assistance at night to set up the equipment in the morning.

On 10/10/2024 at 11:02 AM the facility had been unable to provide an assessment to show that R4 had been evaluated to use an electric wheelchair.

In an observation and interview on 10/09/2024 at 1:10 PM, R4 had been observed to sit in a manual wheelchair. R4 said they had a detachable wheel that made their manual wheelchair into an electric wheelchair. R4 said they were supposed to put the detachable wheel on the back of their wheelchair. R4 said that they had to go around their wheelchair to the backside of it to put the heavy detachable wheel on. R4 reported they had fallen multiple times trying to put the detachable wheel on their wheelchair. R4 said the last time they tried to put the wheel on had been approximately two weeks ago. R4 said the wheel had fallen off their wheelchair and they left it under the dining room table. Observation showed a black attachable wheel had been located under R4's dining room table.

In an interview on 10/10/2024 at 10:29 AM, Staff E, Resident Care Coordinator, said R4 had not used their electronic wheelchair since approximately May 2024 and used their manual wheelchair. Staff E said an assessment had not been completed since R4 did not actively use the electronic wheelchair. Staff E said they were not aware R4 had any falls related to their attempted use of their electric wheelchair. Staff E said they thought R4 could recall information.

In an interview on 10/10/2024 at 11:02 AM, Staff B said R4 had not used their electric wheelchair in the two years that they worked for the facility. Staff B said they had not assessed R4 for their electric wheelchair since they had not used it. Staff B had not been aware R4 had falls related to their attempted use of their electric wheelchair. Staff

B said R4 had been very with it.

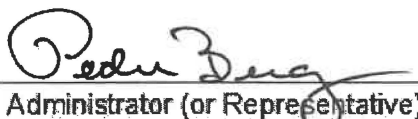
In an interview on 10/15/2024 at 11:16 AM, Collateral Contact 2 (CC2), R4's Power of Attorney, said R4's shoulders were degenerated and R4 could not manage putting on the detachable wheel to make their wheelchair electric. CC2 said R4 had the electric wheelchair for 3 years. CC2 said when R4 used the electric wheelchair it went well for the first six months to a year. CC2 said R4 stopped using the electric wheelchair because the wheel kept falling off. CC2 reported R4 attempted to use the electric wheelchair approximately two weeks ago but it had been too much for R4 to do independently. CC2 said to their knowledge the facility staff had never assessed R4's ability to independently use the electric wheelchair. CC2 said they wished the facility staff helped R4 with the medical equipment from the start. CC2 confirmed R4 historically had falls.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/9/2024~~

12/08/2024

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


Administrator (or Representative)

11/20/2024
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
 - (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 interview, observation, and record review, the facility failed to monitor resident well-being and take appropriate actions for 1 of 7 sampled residents (Resident

B said R4 had been very with it.

In an interview on 10/15/2024 at 11:16 AM, Collateral Contact 2 (CC2), R4's Power of Attorney, said R4's shoulders were degenerated and R4 could not manage putting on the detachable wheel to make their wheelchair electric. CC2 said R4 had the electric wheelchair for 3 years. CC2 said when R4 used the electric wheelchair it went well for the first six months to a year. CC2 said R4 stopped using the electric wheelchair because the wheel kept falling off. CC2 reported R4 attempted to use the electric wheelchair approximately two weeks ago but it had been too much for R4 to do independently. CC2 said to their knowledge the facility staff had never assessed R4's ability to independently use the electric wheelchair. CC2 said they wished the facility staff helped R4 with the medical equipment from the start. CC2 confirmed R4 historically had falls.

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:
 - (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 interview, observation, and record review, the facility failed to monitor resident well-being and take appropriate actions for 1 of 7 sampled residents (Resident

1 [R1]). This failure placed these residents at risk for unmet care needs and resident decline due to lack of the identification of and response to resident condition changes.

Findings included...

Record review of an email the Department received on 10/17/2024 at 11:09 AM, showed Staff A, Executive Director, stated the facility did not have a policy related to alert charting available for review.

RCW 18.20.020(6)

"General responsibility for the safety and well-being of the resident" means the provision of the following: Prescribed general low sodium diets; prescribed general diabetic diets; prescribed mechanical soft foods; emergency assistance; monitoring of the resident; arranging health care appointments with outside health care providers and reminding residents of such appointments as necessary; coordinating health care services with outside health care providers consistent with RCW 18.20.380; assisting the resident to obtain and maintain glasses, hearing aids, dentures, canes, crutches, walkers, wheelchairs, and assistive communication devices; observation of the resident for changes in overall functioning; blood pressure checks as scheduled; responding appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning; or medication assistance as permitted under RCW 69.41.085 and as defined in RCW 69.41.010.

Record review of facility's policy "Medication Error Policy," dated 01/13/2022, showed that it was a medication error if a medication technician failed to follow physician order for resident medication administration.

Record review of facility's policy titled "Policy on Falls," dated "04/2022", showed The resident should be routinely reassessed at minimum every six months or if a change of condition occurs but can be more frequent if the resident is observed with unsafe/impulsive behaviors and/or unsafe gait/self-transfer. In the event of a fall, the resident should be assessed by a licensed nurse or designee, or EMS [Emergency Medical Services] if the licensed nurse was not present to determine if they needed medical services due to significant injury. If significant injury was present, the resident should be sent to hospital for physician intervention. If no significant injury was present, the resident should be assisted up and treated with simple first aid if needed by the licensed nurse or qualified designee. Physician and Resident Representative should be notified as soon as is practicable by the HCC (medication aide) or designee. An incident report should be completed by the person witnessing the fall and placed on alert charting for no less than 72 hours until the nurse or qualified designee investigates and determines next steps.

R1

Record review of the facility's undated characteristic roster, provided to the department

10/08/2024, showed R1 moved in on [REDACTED]/2018.

Record review of R1's "Admission Record," dated, 10/08/2024, showed R1 had diagnoses to include [REDACTED]

and [REDACTED].

Record review of R1's incident report, dated 02/27/2024, showed R1 had a fall.

Record review of R1's assessment titled "AL Level of Care and Service Plan-WA," completed 03/30/2024, showed R1 was independent with mobility and ambulation, independent with transfers and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

Record review of R1's incident report, dated 06/14/2024, showed R1 had a fall.

Record review of R1's Service Plan, dated 06/14/2024, showed R1 was independent with mobility/ambulation, independent with transferring, and stated R1 "has not had any recent falls or been identified as a fall risk at this time."

Record review of R1's assessment titled "AL Level of Care and Service Plan-WA," completed 07/05/2024, showed R1 was independent with mobility and ambulation, independent with transfers, and was not identified as a fall risk. The assessment noted R1 had not had a fall within the past three months.

Record review of incident report for R1, dated 09/18/2024, showed R1 fell when they were attempting to put their laundry away.

Record review of R1's assessment titled "AL Level of Care and Service Plan-WA," completed 10/03/2024, showed R1 was independent with mobility and ambulation, independent with transfers, and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

In an interview on 10/09/2024 at 5:51 PM, Staff B, Director of Health Services, reviewed the most recent assessment, completed on 10/03/2024, for R1 and stated that the assessment did not identify falls as a risk factor for the resident. Staff B said the assessment listed "no risk factors," and that the box for "falls in the past 3 months," was not checked and should have been.

In an interview on 10/09/2024 at 5:55 PM, Staff B stated R1 did not have a completed and current negotiated service agreement based on the most recent assessment from

10/03/2024.

In an interview on 10/09/2024 at 5:43 PM, Staff B explained the response process for resident falls. Staff B said residents were put on 72 hours monitoring and an interim service plan (ISP) was created. Staff B said the interim service plan was documented in a progress note and it will say ISP with the monitoring instructions for staff in the progress note.

In an interview on 10/09/2024 at 5:46 PM, Staff B, said alert charting was supposed to be done when a resident was feeling ill, had emotional upset, went to the ER, for resident-to-resident altercations, new medication changes, a change in medication dosage, a discontinuation of medications, and other changes in condition like a resident fall. Staff B said medication technicians were responsible for alert charting and entering progress notes. Staff B said staff were to enter a progress note in a resident chart at least once per shift, meaning there should be at least two progress notes per resident per day.

In an observation on 10/09/2024 at 5:57 PM, Staff B showed the screen with progress notes logs for Resident 1 for the dates 09/18/2024 through 09/23/2024. Shown on the screen was a note from 09/18/2024 at 11:05 AM, labeled as ISP (interim service plan) and said "Fall: Take all vital signs, including pain. Observe for any injury and document any other findings. Keep on alert for a minimum of 72 hours. Please chart Day/Evening/Noc shift. Notify CBC (Community Based Care) with any c/c(complaints)."

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/18/2024 at 11:06 and described how staff found the resident in their closet where they fell as they attempted to put their laundry away.

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/18/2024 at 12:06 PM and said R1 attended mealtime that day.

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/19/2024 at 3:01 PM; 27 hours after the last note entered.

No other notes for R1 were provided to show the instructions from the ISP were followed nor that the resident's condition was monitored after the fall on 09/18/2024 at 11:01 AM.

In an interview on 10/09/2024 at 5:57 PM, Staff B said there was a 27-hour gap because the medication technician was supposed to chart, and they didn't.

In an interview on 10/10/2024 at 12:35PM, Staff F, medication technician, said medication technicians were supposed to enter a note for each resident every shift unless there were instructions in the resident chart requiring more frequent charting.

In an interview on 10/09/2024 at 5:40 PM, Staff B, stated there were gaps and missing assessments for residents.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 11/2/2025

12/08/2024

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

Peder Berg
Administrator (or Representative)

11/20/2024
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:

(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;

(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.

In an interview on 10/09/2024 at 5:40 PM, Staff B, stated there were gaps and missing assessments for residents.

Plan/Attestation Statement	
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_____	_____
Administrator (or Representative)	Date

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 - (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;
 - (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.

(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 5 of 7 sampled residents (Resident 4 [R4], Resident 3 [R3], Resident 1 [R1], Resident 2 [R2] and Resident 7 [R7]). This failure placed residents at risk for unmet care needs and decreased quality of life.

Findings included...

Record request on 10/08/2024 at 10:00 AM, showed the Department requested the facility policies related to NSA's and as of 10/23/2024 the Department had not received them for review.

In an interview on 10/10/2024 at 10:43 AM, Staff B, Health Services Director, stated the facility had already provided the policies requested from the Department to review.

Record review of the facility's policy titled, "Family Assistance with Medications and Treatments", revised "07/2017", showed if a resident preferred a family member to assist or administer their medications the family member would develop and submit a written plan to the facility that described the name of the family member that would provide the medication assistance. A description of the medication that would be provided by the family member. An alternative plan in the event the primary family member was unable to fulfil their duties as specified in the written plan. An emergency contact person and telephone number if the facility observed changes in the residents overall functioning or condition that could relate to the treatment plan and any other information necessary. The resident, resident representative, person responsibly to implement the plan would sign and date the plan as an addendum for the negotiated service agreement.

Record review of the facility's policy titled, "Policy on Falls", dated "04/2022", showed an interim service plan (ISP) should be completed and available for all care staff, as to the immediate interventions in place to reduce the risk of a repeat fall. Care staff should document in the resident's electronic health record each shift based on the instructions in the ISP. If determined, the care plan (negotiated service agreement [NSA]) should be updated once consistent interventions were identified or required. Resident and/or resident representative should be notified of any changes that occur and updated with the resident status as needed or requested. After each resident's fall, records should be reviewed for any previous falls to determine if there was a pattern and what interventions have been put in place prior and whether the care plan was being followed at time of the event. If the care plan was followed, further interventions would be determined to reduce further falls. Fall data should be reviewed in the residents' scheduled care plan meeting.

R4

Record review of R4's "Admission Record", dated 10/08/2024, showed R4 moved into

the facility on [REDACTED] /2016. R4's room had been located on the third floor. R4 had clinical diagnoses of [REDACTED] and [REDACTED]

Record review of R4's NSA, dated 03/13/2024, under the cognition section, showed R4 had been oriented and could recall and obtain information. The assistive devices section showed R4 utilized a wheelchair. The fall risk section showed that R4 had not had any recent falls or had been identified as a fall risk. The transferring section showed R4 had been independent with transfer needs at this time. The medication management section showed that R4 had a complex medication regimen where the facility staff ordered R4 their medications and R4 had been independent with managing their medication administration. Under the evacuation section it showed that R4 required assistance with verbal cueing and direction only but could ambulate independently to evacuate from the community or to a safety zone within the community in the event of an emergency.

Record review of R4's, "AL (Assisted Living) Level of Care and Service Plan Type Quarterly", dated 09/18/2024, under the fall risk evaluation section, showed R4 had not been a fall risk and had not had any recent falls. The transferring section showed R4 had been independent with their transfer needs. The medications and treatment section showed the facility staff ordered R4 their medications and R4 self-administered their medications. The evacuation section showed that R4 needed verbal assistance only if they needed to evacuate and R4 could ambulate independently to the safety zone. The dietary and nutrition management section showed R4 had a regular diet.

Record review of R4's, "Self-Medication Administration Assessment", dated 07/12/2024, showed R4 wished to self-administer their medications and there was an order from R4's medical provider they could self-administer their medications. The section that discussed if R4 required any assistance from staff or family showed Collateral Contact 2 (CC2), R4's Power of Attorney, would come into the facility and assist with setting up R4's weekly pill box. The document was signed by Staff B, Director Health Services, on 07/12/2024.

Record review of R4's, "Family Assistance with Medications and Treatments", dated 10/22/2021, showed R4 and the facility representative signed the document on 10/22/2021. At the bottom of the document, it read "Resident or responsible party signature above demonstrates agreeance with the above terms and policy for family assistance with medication."

Record review of Department of Social & Health Services, "Service Summary Current Annual", dated 09/24/2024, under the fall section showed R4 had 1 fall within the last 6 months. The equipment section showed R4 used a walker with seat and manual wheelchair. The medication management section showed R4 required assistance with self-administration daily. R4's ability fluctuated, they could not open containers and had poor coordination. The transfer section showed in the last 7 days R4 needed extensive one-person physical assistance. The status and assistance available section showed this need had been unmet. The nutritional section showed R4 needed to adhere to an ADA (American Diabetes Association) diet.

In an observation and interview on 10/09/2024 at 1:10 PM, R4 had been observed to sit in a manual wheelchair. R4 said they had a front wheeled walker in their closet that they used. R4's closet had been observed to have a front wheeled walker inside of it. R4

said they had fallen a few times in the past and when they pushed their pendant the facility staff helped assist them up. R4 said if they had to evacuate the building, they were unsure how they would do so because they used a wheelchair and were located on the third floor. R4 said the facility staff informed them not to use the elevators in an emergency. R4 said ultimately if they needed to exit the building, they would attempt to go down the stairs on their buttocks. R4 said CC2 filled their pill box for them with their medications weekly. R4 said they took their medications on their own. R4 had been observed to go in their kitchenette area and opened a drawer to retrieve their pill box.

In an interview on 10/10/2024 at 10:26 AM, Staff E, Resident Care Coordinator, said the facility staff ordered R4's medications and CC2 set them up for R4 monthly. Staff E said the facility did not have written family assistance with medication plan they could provide to review for R4. Staff E said they had not been aware R4 had any recent falls. Staff E and Staff F, Medication Technician stated that in the event of an emergency residents on the second and third floors who were not self-ambulatory would need to shelter in place. Staff E reviewed R4's NSA and noted that the evacuation section read that in the event of an emergency R4 required verbal assistance with independently ambulating. Staff E said the NSA did not notate where R4 was supposed to go in an emergency. Staff E said R4 would need to shelter in place.

In an interview on 10/10/2024 at 10:43 AM, Staff B, said the facility staff ordered R4's medications and CC2 set them up for R4 weekly. Staff B had been unsure how often R4 and CC2 should sign the family assistance with medication treatment plan and how often CC2 should provide a written plan to the facility. Staff B said in the event of an emergency the facility had fire doors, and the residents were to shelter in place, unless there was immediate danger such as a fire next to their room.

In an interview on 10/15/2024 at 11:16 AM, CC2 confirmed R4 historically had falls. CC2 noted at times R4 would not report their falls. CC2 confirmed the facility orders R4's medications and they fill R4's pill box weekly.

In an interview on 10/10/2024 at 1:21 PM, Staff A, Executive Director acknowledged the concern that R4's family assistance with medication plan had only been a written acknowledgement that R4's family would provide a written back up plan. Staff A acknowledged a written back up plan had not been provided to review to show what the backup plan was for R4 if R4's family could not fill their weekly medications for them.

Record review of R4's NSA, dated 03/13/2024, R4's falls section did not identify that R4 had a fall within the last six months, that R4 utilized a walker, and that R4 required extensive one-person physical assistance which had been indicated in the Department of Social & Health Services, "Service Summary Current Annual", dated 09/24/2024. R4's NSA did not identify that CC2 came to the facility weekly and assisted R4 with setting up their pill box. R4's NSA did not identify if R4 needed to evacuate the building that they lived on the third floor of the facility and utilized a wheelchair and would not be able to evacuate with verbal cuing but would require physical assistance.

R3

Record review of R3's, "Admission Record", printed 10/18/2024, showed R3 moved into the facility on [REDACTED] /2024 and lived on the second floor. R3 had multiple diagnosis which included [REDACTED] and [REDACTED].

Record review of R3's NSA, dated 06/24/2024, showed assistive device section was blank. The fall risk section showed R3 had not had any recent falls or had been identified as a fall risk at this time. Under the evacuation section it showed that R4 required assistance with verbal cueing and direction only but could ambulate independently to evacuate from the community or to a safety zone within the community in the event of an emergency. The bowel and bladder section showed R3 had been independent with all bowel needs.

Record review of R3's, "AL Level of Care and Service Plan Type Quarterly", dated 08/16/2024, under the mobility and transferring section showed R3 used a walker as an assistive device. The fall risk evaluation showed R3 had not had any falls within the past 3 months and was not a fall risk. The evacuation section showed that R3 needed verbal assistance only if they needed to evacuate and R3 could ambulate independently to the safety zone. There was a yes bubbled in that indicated the most recent emergency room and hospitalizations and provider visits had been reviewed. Under the bowel and bladder section showed R3 was not incontinent of their bowels and was independent with toilet needs.

Record review of an incident report for R3 dated 07/20/2024, showed R3 had a fall that occurred on 07/20/2024. R3 had fallen outside on the ground, a citizen who passed by helped R3 off the ground and went into the building to inform the facility staff. R3 got a skin tear on their front lower left leg. The document had been prepared by Staff J, Agency Health Care Coordinator.

Record review of R3's "Progress Notes", dated 07/20/2024 at "4:00", showed Staff J wrote R3 had a fall outside when they went on a walk. A citizen who passed by helped R3 up onto their walker and entered the building to notify the facility staff. R3 had been observed to have two small skin tears on their left shin.

Record review of R3's "Progress Notes", dated 07/20/2024 at "2:54", showed Staff J wrote R3 complained of left foot pain and there had been bruising observed on their left foot. The emergency medical services were called, and they transported R3 to the emergency room. When R3 returned with an after-visit summary it showed R3 sprained their left foot. R3 had been observed to have bruising on their hands related to the fall.

Record review of R3's "Progress Notes", dated 07/10/2024 at "7:03", showed Staff F, Medication Technician, wrote R3 stated they had not had a bowel movement in 5 days. R3's milk of magnesia medication had been provided.

Record review of R3's "Progress Notes", dated 07/10/2024 at "4:52", showed Staff B, Director Health Services, wrote R3 had multiple complaints of constipation today. R3 had been given milk of magnesia medication, warm prune juice with butter, and a suppository. R3 reiterated they had not had a bowel movement in five days.

Record review of R3's "Progress Notes", dated 07/11/2024 at "2:30", showed Staff B wrote R3 stopped by their office and reported they went to the emergency room, had been provided medication, and had a bowel movement.

In an interview and observation on 10/09/2024 at 10:31 AM, Collateral Contact 3 (CC3) R3's Daughter said R3 had been to the emergency room 3 times since their admission into the facility. CC3 said R3 went due to constipation, after a fall, and due to chest

pains on 06/09/2024. CC3 said R3 used a walker to ambulate. CC3 said since R3 resided on the second floor of the building they would not be able to independently get out of the building in the event of an emergency. At 10:55 AM, R3 entered their room and were observed to use their walker. R3's bathroom had been observed to have a toilet seat riser.

Record review of R3's NSA, dated 06/24/2024, R3's assistive device section did not identify that R3 used a walker to ambulate and utilized a toilet seat riser. R3's NSA did not identify that R3 had a fall on 07/20/2024. R3's NSA did not identify if R3 needed to evacuate the building that they lived on the second floor of the facility and utilized a walker and would not be able to evacuate the building with verbal cueing but would require physical assistance. R3's NSA did not identify that they had constipation that resulted in R3's need for interventions related to having a bowel movement.

R1

Record review of the facility's undated characteristic roster, provided to the department 10/08/2024, showed R1 moved in on [REDACTED]/2018.

Record review of R1's "Admission Record," dated 10/08/2024, showed R1 had diagnoses to include [REDACTED] and [REDACTED].

Record of an incident report for R1, dated 02/27/2024, showed R1 had a fall.

Record review of R1's assessment titled "AL Level of Care and Service Plan-WA," completed 03/30/2024, showed R1 was independent with mobility and ambulation, independent with transfers and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

Record review of an incident report for R1, dated 06/14/2024, showed R1 had a fall.

Record review of R1's Service Plan, dated 06/14/2024 showed R1 was independent with mobility/ambulation, independent with transferring, and stated R1 "has not had any recent falls or been identified as a fall risk at this time."

Record review of assessment titled "AL Level of Care and Service Plan-WA," completed 07/05/2024 showed R1 was independent with mobility and ambulation, independent with transfers, and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

Record review of an incident report for R1, dated 09/18/2024, showed R1 had a fall while attempting to put their laundry away.

Record review of assessment titled "AL Level of Care and Service Plan-WA," completed 10/03/2024 showed R1 was independent with mobility and ambulation, independent with transfers, and was not identified as a fall risk. The assessment noted the resident had not had a fall within the past three months.

In an interview on 10/09/2024 at 5:51 PM, Staff B, verbally reviewed the most recent assessment, completed on 10/03/2024, for R1 and stated that the assessment did not identify falls as a risk factor for the resident. Staff B said the assessment listed "no risk factors," and that the box for "falls in the past 3 months," was not checked and should have been. Staff B acknowledged that a fall risk should have been identified and included in R1's most recent assessment completed on 10/03/2024.

No service plan for the 10/03/2024 assessment was provided to the department to review.

In an interview on 10/09/2024 at 5:55 PM, Staff B stated R1 did not have a completed and current negotiated service agreement based on the most recent assessment from 10/03/2024.

In an observation on 10/09/2024 at 5:57 PM, Staff B showed the screen with progress notes logs for R1 for the dates 09/18/2024 through 09/23/2024. Shown on the screen was a note from 09/18/2024 at 11:05 AM, labeled as ISP (interim service plan) and said "Fall: Take all vital signs, including pain. Observe for any injury and document any other findings. Keep on alert for a minimum of 72 hours. Please chart Day/Evening/Noc shift. Notify CBC (Community Based Care) with any c/c(complaints)."

Record review of R1's progress notes dated 09/08/2024 to 10/09/2024 showed a note dated 09/18/2024 at 11:06 and described how staff found the resident in their closet where they fell as they attempted to put their laundry away.

In an interview on 10/09/2024 at 5:40 PM, Staff B said the facility assessments provide the content for the resident service plans.

In an interview on 10/09/2024 at 5:40 PM, Staff B, Director of Health Services, stated there were gaps and missing assessments for residents.

In an interview on 10/09/2024 at 5:55 PM, Staff B stated R1 did not have a completed and current negotiated service agreement based on the most recent assessment from 10/03/2024.

R2

The Department entered the facility on 10/08/2024 at 10:02 AM. Sample resident records were requested including admission records, negotiated service agreement, medication administration records, and progress notes, including for R2.

Record review of R2's "Admission Record," dated 10/08/2024, showed R2 admitted to the facility on [REDACTED]/2016. R2 had a diagnosis of [REDACTED].

Record review of R2's quarterly assessment labeled "AL Level of Care and Service Plan-WA," dated 04/24/2024, showed "staff monitors resident blood pressure and/or pulse in addition to monthly vitals or short-term LN (licensed nurse) monitoring 2xdaily *2.5."

Record review of R2's Service Plan, completed 07/19/2024, showed vitals monitoring as a service provided by the facility, with specific instructions to assist R2 with twice per day blood pressure readings. Vitals monitoring as a service was initiated 12/21/2023

and revised 04/13/2024 in R2's service plan.

Record review of R2's Service plan, completed 07/19/2024, showed "medication management," as a service area with instructions that stated staff were to provide resident with medication assistance and document all medications in the medication administration record (MAR). The service plan also said R2 was on a complex medication regimen requiring quarterly review by the licensed nurse and that R2 would receive medications and treatments as ordered by provider.

Record review of R2's medication administration record (MAR), dated 07/01/2024 to 10/09/2024, showed an order with start date of 08/31/2022, 7:15 AM for medication Hydralazine (blood pressure medication) to be given every 12 hours as needed when SBP(systolic blood pressure or top number in blood pressure reading) showed greater than 165mmHg(millimeters of mercury or "pressure") and DBP (diastolic blood pressure or the bottom number in a blood pressure reading) greater than 100mmHg.

Record review of R2's medication administration record (MAR), dated 07/01/2024 to 10/09/2024, showed an order with start date of 08/15/2024 12:58 PM for medication Hydralazine (blood pressure medication) to be given every 12 hours as needed when SBP(systolic blood pressure or top number in blood pressure reading) showed greater than 160 mmHg(millimeters of mercury or "pressure") and DBP (diastolic blood pressure or the bottom number in a blood pressure reading) was greater than 100mmHg.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed blood pressure reading of 162/105 on the evening of 08/17/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed blood pressure reading of 207/126 on the morning of 08/30/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed blood pressure reading of 185/100 on the evening of 09/16/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, did not show Hydralazine (blood pressure medication) was ever administered to R2.

Record review of R2's progress notes, dated 07/01/2024 to 10/09/2024, showed alert charting entries acknowledging the updated order on 08/15/2024 for hydralazine (blood pressure medication).

During an interview on 10/10/2024 at 12:32 PM, Staff F, medication technician, said they knew about the hydralazine (blood pressure medication) order because they had administered it at least one time in the last two years. Staff F acknowledged awareness of the updated order from 08/15/2024.

In an interview on 10/09/2024 at 6 PM, Staff B, Director of Health Services, said they did not realize R2 had an order for hydralazine (blood pressure medication).

In an interview on 10/09/2024 at 6:02 PM, Staff A, Executive Director, and Staff B said the facility performs monthly chart audits for resident MARs and acknowledged this order for R2 was missed.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed an order for

Tramadol (a pain medication) indicated to be given as needed for pain. The order start date was 04/25/2024 at 12:10PM.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed R2 received Tramadol on 09/01/2024 at 8:13 PM. The follow-up code to this administration was a "U" which meant unknown.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed R2 received Tramadol on 09/06/2024 at 7:18 PM. The follow-up code to this administration was a "U" which meant unknown.

Record review of R2's progress notes, dated 07/01/2024 to 10/09/2024, did not show notes that demonstrated follow-up on R2's pain.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a medication order for metoprolol (a blood pressure medication) with instructions to give once per day (scheduled in the evening) and to hold for pulse less than 55 or systolic blood pressure less than 110mmHg (millimeters of mercury or "pressure"). Order start date was 04/04/2023 at 4 PM.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a medication order for lisinopril (a blood pressure medication) with instructions to give twice per day and hold if systolic blood pressure (top numbers on blood pressure reading) was less than 100mmHg (millimeters of mercury or "pressure"). Order start date was 08/15/2024 at 4PM.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a blood pressure reading of 99/52 at 6:30 AM on 09/21/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed Lisinopril was given at 6:30 AM on 09/21/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a blood pressure reading of 99/64 at 4PM to 5PM on 09/28/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed Lisinopril and Metoprolol were both given at 4PM to 5PM on 09/28/2024.

Record review of R2's Service Plan, completed 07/19/2024, showed "housekeeping" as a service with instructions indicating weekly housekeeping including trash removal and assistance with daily trash removal.

Record review of R2's Service Plan, completed 07/19/2024, showed R2 as independent with pet care for R2's one dog.

In an observation on 10/09/2024 at 3:40 PM, the carpet in R2's residence was malodorous of urine and soiled causing areas of darker carpet throughout the living room and bedroom. In between the bedroom and living room was a doorway, and in the doorway was a baby-gate used to keep the dog in the bedroom area. On the bathroom floor was a rectangular, blue, pad (also known as a pee-pad) for the dog to use to urinate and defecate; the pad was not soiled at the time of the observation. R2's residence was located on the first floor of the building near an exit door used to exit and

re-enter to take the dog outside and for R2 to smoke. The door to the exterior is three times the width of R2's residence (from the window behind the couch to the entry door).

In an interview on 10/10/2024 at 11:30 AM Staff A said R2's carpet is cleaned every three months and should probably be cleaned every month.

Record review of R2's Service Plan, completed 07/19/2024, showed care coordination by facility as a service to R2.

In an interview on 10/09/2024 at 3:50 PM, R2 said they need more help with grocery shopping because having it delivered by a delivery service had become expensive and they would like help getting a caregiver. R2 said they told this to staff, but they cannot remember which staff.

During an observation and interview on 10/09/2024 at 3:50 PM, R2's bare feet and swollen legs were seen; R2's second toe in on their left foot was observed as purple and scaling. When asked if the toe had been injured, R2 replied they were unaware of the discoloration, but said they could no longer walk from the couch to the door of their residence due to increasing leg pain and swelling. R2's service plan was not updated until the Department's second request for a current assessment and service plan on 10/09/2024.

R7

Record review of R7's Admission Record, dated 10/08/2024, showed R7 moved into the facility on /2024, with multiple medical diagnoses that included

and

Record review of the facility provided R7's incident report and investigation for a fall, dated 08/20/2024, showed R7 had a fall in their apartment while the housekeeper was helping R7 move their television. R7 had tripped and fell to the ground. There was documentation that showed R7 had gait imbalance as a predisposing physiological factor that contributed to the fall. A new intervention was implemented to encourage R7 to alert care staff immediately in the event of a fall, prior to R7 getting themselves up from the floor. The investigation showed R7 had not had a fall since admission to the facility.

Record review of the facility provided R7's negotiated service agreement (NSA), dated 10/09/2024, under the section titled, "fall risk", showed R7 has not had "any recent falls or been identified as a fall risk" at that time. Staff were to encourage R7 to call for assistance if needed to reduce the risk of falling if feeling unsteady. The information was initiated on 04/11/2024 with no other documentation or updates completed. The intervention from the fall on 08/20/2024 was not documented on R7's NSA.

In an interview on 10/09/2024 at 5:22 PM, Staff B stated the residents assessments generate the residents service plans. Staff B stated the residents interim service plans would be implemented into the residents NSA when they were updated.

In an interview on 10/09/2024 at 5:40 PM, Staff B stated there are gaps and missing

assessments for residents.

In an interview on 10/09/2024 at 5:45 PM, Staff B said the very first service plan starts at move in and that a resident's first assessment triggers the service plan. Staff B explained that the service plan is what provides instructions for the care staff and that residents or resident representatives sign the care plan within the first couple of days after move-in.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/3/2025~~

12/08/2024

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

Peter Berg
Administrator (or Representative)

11/26/2024
Date

WAC 388-78A-2210 Medication services.

(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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were administered their medications as ordered for 1 of 7 sampled residents (Resident 2 [R2]). These failures placed R2 at risk for medical complications due to not receiving their medications as prescribed.

Finding included...

Record review of the facility provided document titled, "Medication Management", dated "3/2022", showed the following: "...6. Community staff should document each time they provide medication administration assistance on the medication administration record [MAR] in PCC [point click care-facilities electronic health record]. PRN [as needed] medications should have specific instructions to the medication aide including why they are used and when to specifically give the medication...14. All medication dispensing or administration errors should be investigated. All medications are to be dispensed or administered according to prescribed physician orders. When a staff member fails to dispense or administer a medication as prescribed, the incident should be investigated using the incident report. A plan of correction should be put in

assessments for residents.

In an interview on 10/09/2024 at 5:45 PM, Staff B said the very first service plan starts at move in and that a resident's first assessment triggers the service plan. Staff B explained that the service plan is what provides instructions for the care staff and that residents or resident representatives sign the care plan within the first couple of days after move-in.

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, Avamere at Port Townsend 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.

(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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were administered their medications as ordered for 1 of 7 sampled residents (Resident 2 [R2]). These failures placed R2 at risk for medical complications due to not receiving their medications as prescribed.

Finding included...

Record review of the facility provided document titled, "Medication Management", dated "3/2022", showed the following: "...6. Community staff should document each time they provide medication administration assistance on the medication administration record [MAR] in PCC [point click care-facilities electronic health record]. PRN [as needed] medications should have specific instructions to the medication aide including why they are used and when to specifically give the medication...14. All medication dispensing or administration errors should be investigated. All medications are to be dispensed or administered according to prescribed physician orders. When a staff member fails to dispense or administer a medication as prescribed, the incident should be investigated using the incident report. A plan of correction should be put in

place after a medication error occurs.”

Record review of the facility provided document titled, “Medication Error Policy,” dated 1/13/2022, showed the definition of a medication error as: “A medication error is defined as any unexpected outcome in the provision of medication administration. This would include, but not limited to: Giving an incorrect medication or dosage to a resident, Failing to follow the most current physician's order, Failing to coordinate the recipient's medications with the resident's physician, staff or the Director of Health Services, Failing to communicate with other staff or the Director of Health Services regarding the needs of the resident, Or any other issue or error as related to the provision of medication for any residents as, defined by the Director of Health Services.” The document showed it was a medication error if a medication technician failed to follow physician order for resident medication administration.

R2

Record review of R2's "Admission Record," dated 10/08/2024, showed R2 admitted to the facility on [REDACTED]/2016 with multiple medical diagnoses that included [REDACTED].

Record review of R2's quarterly assessment labeled " AL [assisted living] Level of Care and Service Plan-WA [Washington]," dated 04/24/2024, showed "staff monitors resident blood pressure and/or pulse in addition to monthly vitals or short-term LN (licensed nurse) monitoring 2xdaily *2.5."

Record review of R2's Service Plan, completed 07/19/2024, showed vitals monitoring as a service provided by the facility, with specific instructions to assist R2 with twice per day blood pressure readings. Vitals monitoring as a service was initiated 12/21/2023 and revised 04/13/2024 in R2's service plan.

Record review of R2's Service plan, completed 07/19/2024, showed "medication management," as a service area with instructions that stated staff were to provide resident with medication assistance and document all medications in the medication administration record (MAR). The service plan also said R2 was on a complex medication regimen requiring quarterly review by the licensed nurse and that R2 would receive medications and treatments as ordered by provider.

Record review of R2's medication administration record(MAR), dated 07/01/2024 to 10/09/2024, showed an order with start date of 08/31/2022, 7:15 AM for medication Hydralazine (blood pressure medication) to be given every 12 hours as needed when SBP (systolic blood pressure or top number in blood pressure reading) showed greater than 165 mmHg (millimeters of mercury or "pressure") and DBP (diastolic blood pressure or the bottom number in a blood pressure reading) greater than 100mmHg.

Record review of R2's medication administration record (MAR), dated 07/01/2024 to 10/09/2024, showed an order with start date of 08/15/2024 12:58 PM for medication Hydralazine (prescribed medication that helps lower high blood pressure) to be given every 12 hours as needed when SBP(systolic blood pressure or top number in blood pressure reading) showed greater than 160 mmHg(millimeters of mercury or "pressure") and DBP (diastolic blood pressure or the bottom number in a blood pressure reading) was greater than 100mmHg.

Record review of R2's MAR, dated 08/01/2024 to 08/31/2024, showed blood pressure reading of 162/105 on the evening of 08/17/2024.

Record review of R2's MAR, dated 08/01/2024 through 08/31/2024, showed blood pressure reading of 207/126 on the morning of 08/30/2024.

Record review of R2's MAR, dated 09/01/2024 to 09/30/2024, showed blood pressure reading of 185/100 on the evening of 09/16/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, did not show Hydralazine (prescribed medication to help lower high blood pressure) was ever administered to R2.

Record review of R2's progress notes, dated 07/01/2024 to 10/09/2024, showed alert charting entries acknowledging the updated order on 08/15/2024 for hydralazine (blood pressure medication).

During an interview on 10/10/2024 at 12:32 PM, Staff F, Medication Technician, said they knew about the hydralazine order because they had administered it at least one time in the last two years. Staff F acknowledged awareness of the updated order from 08/15/2024.

In an interview on 10/09/2024 at 6 PM, Staff B, Director of Health Services, said they did not realize R2 had an order for hydralazine.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a medication order for metoprolol (a blood pressure medication) with instructions to give once per day (scheduled in the evening) and to hold for pulse less than 55 or systolic blood pressure less than 110mmHg (millimeters of mercury or "pressure"). Order start date was 04/04/2023 at 4 PM.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a medication order for lisinopril (a blood pressure medication) with instructions to give twice per day and hold if systolic blood pressure was less than 100mmHg(millimeters of mercury or "pressure"). Order start date was 08/15/2024 at 4PM.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a blood pressure reading of 99/52 at 6:30 AM on 09/21/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed Lisinopril was given at 6:30 AM on 09/21/2024.

Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed a blood pressure reading of 99/64 at 4PM to 5PM on 09/28/2024. Record review of R2's MAR, dated 07/01/2024 to 10/09/2024, showed Lisinopril and Metoprolol were both given at 4PM to 5PM on 09/28/2024.

In an interview on 10/09/2024 at 6:02 PM, Staff A, Executive Director, and Staff B said the facility performs monthly chart audits for resident MARs and acknowledged the order for R2 was not administered when R2's blood pressure was out of the physician prescribed parameters.

Statement of Deficiencies

License #: 2408

Compliance Determination # 48279

Plan of Correction

Avamere at Port Townsend

Completion Date

Page 49 of 49

Licensee: NorthWest HC Seaport Landing (WA)

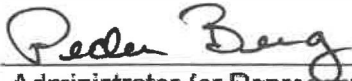
10/24/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) ~~11/2/2025~~

12/08/2024

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



Administrator (or Representative)

11/20/2024

Date

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

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, Avamere at Port Townsend 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



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

11/07/2024

NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC
Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

RE: Avamere at Port Townsend # 2408

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/24/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Mail the Plan/Attestation Statement and report with original signatures to:

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

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

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.

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

Based on observation and interview the facility did not have the survey binder accessibly available in a public location. The facility placed the survey binder in a public location for all residents, visitors, and the Department to review.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

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

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

Based on interview and record review the facility some staff were unable to identify they state hotline number was to be call for any allegation abuse and neglect without being prompted multiple occasions. The facility continued to provide ongoing training and education to all staff about abuse and neglect within the last year for review.

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;

10/24/2024

Page 3 of 3

- 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)254-3190.

Sincerely,

Cory Cisneros

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

Enclosure