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

TCF NURSING SERVICES INC
The Legacy of Bothell
20626 76th Ave SE
Snohomish, WA 98296

RE: The Legacy of Bothell License # 2411

Dear Administrator:

This letter addresses Compliance Determination(s) 26990 (Completion Date 07/21/2023) and 24404 (Completion Date 05/31/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/21/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2040-1, WAC 388-78A-2090, WAC 388-78A-2090-1, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-2, WAC 388-78A-2090-2-a, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3, WAC 388-78A-2090-4, WAC 388-78A-2090-4-a, WAC 388-78A-2090-4-b, WAC 388-78A-2090-5, WAC 388-78A-2090-5-a, WAC 388-78A-2090-5-b, WAC 388-78A-2090-5-c, WAC 388-78A-2090-6, WAC 388-78A-2090-6-a, WAC 388-78A-2090-6-b, WAC 388-78A-2090-6-c, WAC 388-78A-2090-6-d, WAC 388-78A-2090-6-e, WAC 388-78A-2090-7, WAC 388-78A-2090-7-a, WAC 388-78A-2090-7-b, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii, WAC 388-78A-2090-7-d, WAC 388-78A-2090-8, WAC 388-78A-2090-8-a, WAC 388-78A-2090-8-b, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-9, WAC 388-78A-2090-10, WAC 388-78A-2090-11, WAC 388-78A-2090-11-a, WAC 388-78A-2090-11-b, WAC 388-78A-2090-11-c, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b, WAC 388-78A-2100-1, WAC 388-78A-2130-1-c, WAC 388-78A-2150-1, WAC 388-78A-2483, WAC 388-78A-2483-1, WAC 388-78A-2484-1, WAC 388-78A-2700-1-g-iv, WAC 388-78A-2310-2-f, WAC 388-78A-2950-6, WAC 388-78A-2730-1-b

The Department staff who did the on-site verification:
Scottie Sindora, ALF Licensor
Erin Steinbrenner, Nursing Consultant Institutional

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

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

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

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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 05/23/2023 and 05/24/2023 of:
The Legacy of Bothell
305 240th St SW
Bothell, WA 98021

The following sample was selected for review during the unannounced on-site visit: 7 of 30 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility.

Scottie Sindora, ALF Licensor
Erin Steinbrenner, Nursing Consultant Institutional

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

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

Jamie Singer
Residential Care Services

6/7/2023
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.

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Sheree O. Kingl
Administrator (or Representative)

06/14/2023
Date

WAC 388-78A-2040 Other requirements.

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

This requirement was not met as evidenced by:

Based on observation and interview the Assisted Living Facility (ALF) failed to ensure one of one Oxygen Supply Closet had posted notification that oxygen tanks were being stored there. This failed placed 15 of 15 residents at risk for injury.

Findings included...

NOTE: NFPA Code 99 – Healthcare Facility Guidance for fire protection. Chapter 9 Gas Equipment. OXYGEN – USE NO OIL. § 6.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 meters (5 feet) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to that area; they shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.

An observation during the environmental tour with Staff G (Administrator), on 05/23/2023 at 8:55AM, showed a storage closet on the west side of the "Legacy 1" building. Staff G unlocked the storage room door and there was a rack holding 7 oxygen tanks placed in the corner. There was no sign on the storage room closet to indicate oxygen tanks were being stored in the closet.

In an interview, on 05/23/2023 at 9:02 AM, Staff G stated that there should be a sign on the storage closet door.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Legacy of Bothell is or will be in compliance with this law and / or regulation on (Date) July 7, 2023

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

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Theresa O. Knight
Administrator (or Representative)

06/14/2023
Date

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

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

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

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

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

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

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

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

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

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

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

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

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

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

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

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

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

(b) Developmental disability,

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

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

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

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

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

(a) Ability to perform activities of daily living,

(b) Medication management ability, including:

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

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

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete an assessment for 1 of 7 sampled residents (Resident 3) within 14 days of Resident 3's move-in date. This placed Resident 3 at risk of harm by care staff unfamiliar with unassessed care needs.

Findings included...

NOTE: On 05/15/2013 a "Dear Assisted Living Facility Administrator" letter was issued to ALF providers related to the safety risks associated with the use of all medical devices, including transfer poles, Posey or lap belts, and side bed rails. The letter stated, "Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted.

Review of a Face Sheet showed the ALF admitted Resident 3 on [redacted]/2023 with multiple diagnoses, to include [redacted].

Review of an Assessment, dated 04/03/2023, showed Resident 3 had an indwelling catheter (tube inserted to drain urine), required food be provided in pureed form and used a slide board device for transfers.

Observation, on 05/24/2023 at 8:10 AM, showed bed rails secured to each side of Resident 3's bed, to be approximately 30 inches in length and 12 inches in height, with vertical metal slats measuring 3 ¼ inches apart. Observation on 05/24/2023 at 8:30 AM, showed Resident 3 stood up from a chair and ambulated with the use of a four-wheel walker with minimal assistance from Staff J (Caregiver). Additional observation during breakfast at 9:30 AM showed Resident 3 ate a regular textured meal.

In an interview, on 05/24/2023 at 11:00 AM, Staff J (Caregiver) stated Resident 3 had side rails on her bed since her move-in date.

In an interview, on 05/24/2023 at 8:03 AM, Staff J (Caregiver) confirmed Resident 3 did not have an indwelling catheter and did not use a slide board for transfers.

In an interview, on 05/24/2023 at 11:03 AM, Staff I (Lead Caregiver) confirmed Resident 3 received regular texture food as the instruction for pureed food was when she was in the hospital.

Review of Resident 3's Assessment, dated 04/03/2023, showed Resident 3 had not been assessed of their ability to safely use side rails. There was no documentation to show Resident 3 was aware of the risks and benefits of side rail use.

In an interview, on 05/24/2023 at 12:19 PM, Staff G (Administrator) confirmed Residents 3's assessment was completed prior to her admission and was not completed within 14 days of Resident 3's move-in date to reflect current care requirements.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Legacy of Bothell is or will be in compliance with this law and / or regulation on (Date) July 7, 2023

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

Sheree O-Keefe — Administrator (or Representative)

6/14/2023 — Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to update assessments for 1 of 7 sampled residents (Residents 2) who had a change of condition. In addition, the ALF failed to ensure a system was in place to annually update assessments for 2 of 7 sampled residents (Residents 4 and 5). This failure placed the residents at risk for not receiving needed care.

Findings included...

Resident 2

Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]2023 with multiple medical diagnoses.

Review of an Assessment, dated 12/18/2022 (prior to Resident 2's move-in date) showed "reviewed" and "no change" had been hand written by Staff G (Administrator) and dated 01/07/2023. The Assessment showed Resident 2 to be independent with bed mobility, walking and transfers. Review of the nutrition and eating section of the Assessment showed Resident 2 to be independent with eating and required minimal supervision with meals.

Observation, on 05/24/2023 at 11:00 AM, showed Resident 2 in bed and unable to respond to questions.

Review of a Physical Therapy Visit Note, dated 04/24/2023, stated Resident 2 showed limited movements during therapy and concluded resident may be ready to transition to hospice (care provided to the terminally ill) due to observed decline.

Interview, on 05/24/2023 at 9:05 AM, Staff I (Lead Caregiver) stated Resident 2 was no longer getting out of bed. Staff I stated Resident 2's change of condition began over three months ago and now required assistance with eating and two staff to assist with his mobility needs. Staff I stated due to Resident 2's decline, he had not eaten for several days and would likely start hospice care.

Resident 4

Review of a Face Sheet showed the ALF admitted Resident 4 on [redacted]21 with multiple medical diagnoses to include [redacted]. Review of the Resident Characteristic Roster (RCR), updated on 05/23/2023, showed Resident 4 received assistance from the ALF to include medication management.

Review of Resident 4's Assessment, dated 03/11/2022, showed no review or update in the past 14 months.

Resident 5

Review of a Face Sheet showed the ALF admitted the Resident 5 on [redacted]2020 with multiple medical diagnoses to include [redacted]. Review of the RCR, updated on 05/23/2023, showed Resident 5 received assistance from the ALF to include medication management and some activities of daily living.

Review of Resident 5's Assessment, dated [redacted]2020, showed no review or update since 04/02/2022.

In an interview, on 05/23/2023 at 09:45 AM, Staff G stated that she was responsible for all resident assessments and updates.

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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Theresa A. Fugle
Administrator (or Representative)

06/14/2023
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:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure instructions for care staff were included in the Negotiated Service Agreement (NSA) for 1 of 2 sample residents (Resident 7) who had an indwelling urinary catheter (A catheter which is inserted into the bladder, via the urethra, and remains to drain urine). This failure placed Resident 7 at risk for infection and decreased quality of life.

Findings included...

An observation and interview with Staff H (Caregiver), on 05/24/2023 at 10:05 AM, showed Resident 7 in her apartment, sitting in a wheelchair. There was a catheter tube extending from under the blanket on her lap to a urinary collection bag hanging off the side of her wheelchair. Staff H stated that the care staff emptied the bag and reported the fluid output to the medication technician. Staff H stated that she wasn't sure what else she needed to know for care of Resident 7's urinary catheter, but all the instructions for catheter care was located in Resident 7's Negotiated Care Plan (NCP is equivalent to the NSA). Staff H stated, "If I need to know what to do, I look there."

Record review of Resident 7's NCP, updated on 08/01/2022, showed a handwritten note stating, "8/2/20 – has F/C [Foley Catheter] – dependent on peri-care (involves cleaning the private areas of a patient) + foley needs." Note was signed by Staff G (Administrator). Underneath, a handwritten note stated, "8/2/21 – no changes." Note was signed by Staff G. Under that entry was another handwritten note that stated, "8/1/22 – No changes." Note was signed by Staff G. The NCP had a column titled, "What Provider/Caregivers/Support Person Does/When & How." For incontinence, the column stated "CG [caregiver] to check on resident frequently for toileting needs and redirect to the bathroom." There was no mention of emptying the catheter bag, no instruction regarding what complications to observe and report to the nurse, or what to do in the event of bag leakage or an emergency.

In an interview, on 05/24/2023 at 12:45 PM, Staff G stated that she would be going through and updating NCP's.

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Sheree A. Trujillo — Administrator (or Representative)

06/14/2023 — Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on interview and record reviews, the Assisted Living Facility (ALF) failed to ensure the residents, or their representatives signed the Negotiated Service Agreement (NSA) at least annually for 4 of 7 sampled residents (Residents 1, 3, 4, and 5). This placed Residents 1, 3, 4, and 5 at risk for receiving care, or not receiving care and services that had been agreed upon.

Findings included...

Review of a Face Sheet showed the ALF admitted Resident 1 on [redacted] 2022 with multiple diagnoses. Review of Resident 1's undated Negotiated Care Plan (NCP– equivalent to a Negotiated Service Agreement) showed no signature from the resident or the resident representative.

Review of a Face Sheet showed the ALF admitted Resident 3 on [redacted] 2023 with multiple diagnoses. Review of Resident 3's undated NCP showed no signature from the resident or the resident representative.

Review of a Face Sheet showed the ALF admitted Resident 4 on [redacted] 2021 with multiple diagnoses. Review of Resident 4's undated NCP showed no resident, or representative, signature since 03/10/22.

Review of a Face Sheet showed the ALF admitted Resident 5 on [redacted] 2023 with multiple diagnoses. Review of Resident 5's undated NCP showed no signature from the resident or the resident representative.

In an interview, on 05/24/2023 at 10:50, Staff G (Administrator) stated that she usually called, or mailed, the NCPs to resident representabves for a signature. Staff G stated, "I

think I've been a little 'lax' [relaxed] about that lately."

Plan/Attestation Statement

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Administrator (or Representative) 06/14/2023 Date

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

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

This requirement was not met as evidenced by:

Based on interview and staff record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff members (Staff B and D) completed the required one step tuberculin skin test (TST). This placed 30 residents at risk of exposure to a communicable disease.

Findings included...

Record review showed the ALF hired Staff B (Caregiver) on 05/04/2023. Record review showed Staff B had prior documentation of a negative skin test on 02/22/2023. Staff B did not have a second step TST within three days of hire date.

Record review showed the ALF hired Staff D (Caregiver) on 01/07/2023. Record review showed Staff D had prior documentation of two negative skin tests on 08/28/2023 and 09/15/2023. Staff D did not have a second step TST within three days of hire date.

In interview, on 05/23/2023 at 3:40 PM, Staff G (Administrator) stated she thought the TST requirement was waived and confirmed she would have the employees tested.

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

Sheree C. Engle — Administrator (or Representative)

06/14/23 — Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff members (Staff A and C) completed the required two-step tuberculin skin test (TST). This placed 30 residents at risk of exposure to a communicable disease.

Findings included...

Review of records showed the ALF hired Staff A (Caregiver) on 01/07/2023. Record review showed Staff A did not have the two-step TST completed.

Review of records showed the ALF hired Staff C (Caregiver) on 03/28/2023. Record review showed Staff C did not have the two-step TST completed.

In interview, on 05/23/2023 at 3:40 PM, Staff G (Administrator) confirmed Staff A and C did not complete the first or second TST. Staff G stated she thought the TST requirement was waived and stated she would have the employees tested.

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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Theresa D. Fujita — Administrator (or Representative)

06/14/2023 — Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(v) Alternative resident accommodations;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and maintain a current disaster plan detailing an alternative resident accommodation. This placed all of the residents at risk of harm in the event of an internal or external disaster or emergency situation.

Findings included...

On 05/23/2023 upon the entrance conference, the disaster manual was requested for review. Staff F (Administrator) provided a copy of a disaster manual to manage emergencies including fire, illness, containment and resident relocation.

Review of the ALF's disaster manual, "Disaster and Emergency Manual for Assisted Living and Residential Care", on 05/24/2023 at 11:45 AM, showed no specific location designated for resident relocation in the event of an emergency or natural disaster. On the page titled, "Temporary Relocation Sites", there were no facilities or locations listed.

In an interview, on 05/24/2023 at 12:17 PM, Staff G (Administrator) confirmed there were no written agreements with other facilities only a verbal agreement with a nearby school.

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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WAC 388-78A-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law:

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure their Nurse Delegation (ND) program was updated in accordance with requirements of state regulations. This failure placed 4 of 7 sample residents (Resident 2, 4, 5, and 7) at risk for receiving unsafe, or mismanaged, medications.

Findings included...

Note: The ND Program, under Washington State Law, allows nursing assistants and Home Care Aides working in community-based care settings to perform certain tasks such as administration of prescription medications such as insulin injections and blood sugar testing, which are normally performed by licensed nurses. A registered nurse must teach and supervise the nursing assistant as well as provide nursing assessments of the resident's condition. Nurse Delegation is specific to each resident, each caregiver, and each task and is not transferrable. Documentation must be specific and include all required information as listed in Washington Administrative Code (WAC) 246-840.

In an interview, on 05/23/2023 at 9:15 AM, Staff G (Administrator) stated that the ALF utilized a ND program for all residents. Staff G stated that she was the Registered Nurse Delegator (RND) who supervised the program. Staff G stated, "my delegation is out of date, I know that."

Record review of Resident 2's "Nurse Delegation Nursing Visit" (DSHS 14-484) showed Staff G reviewed and supervised the individualized medication management for the resident on 01/07/2023. Further review showed the RND was to perform a return visit for updates on, or before, 04/07/2023. There was no documentation to show Staff G had updated Resident 2's information.

Record review of Resident 4's "Nurse Delegation Nursing Visit" (DSHS 14-484) showed Staff G reviewed and supervised the individualized medication management for the resident on 11/01/2022. Further review showed the RND was to perform a return visit for updates on, or before, 02/01/2023. There was no documentation to show Staff G had updated Resident 4's information.

Record review of Resident 5's "Nurse Delegation Nursing Visit" (DSHS 14-484) showed Staff G reviewed and supervised the individualized medication management for the resident on

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11/21/2022. Further review showed the RND was to perform a return visit for updates on, or before, 02/01/2023. There was no documentation to show Staff G had updated Resident 5's information.

Record review of Resident 7's "Nurse Delegation Nursing Visit" (DSHS 14-484) showed Staff G reviewed and supervised the individualized medication management for the resident on 11/01/2022. Further review showed the RND was to perform a return visit for updates on , or before, 02/01/2023. There was no documentation to show Staff G had updated Resident 7's information.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Legacy of Bothell is or will be in compliance with this law and / or regulation on (Date) July 7, 2023

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

Sharon O. Kyle — Administrator (or Representative)

06/14/2023 — 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, and interview, the Assisted Living Facility (ALF) failed to ensure the water temperature measured between 105 Fahrenheit (F) and 120 F for 5 of 8 common bathrooms (3 common bathrooms in Legacy 1 Building and 2 common bathrooms in Legacy 2 Building). This failure placed 30 of 30 residents at risk for injury or decreased infection control.

Findings included...

Observation during the

environmental tour, on 05/23/2023 at 9:22 AM, with Staff G (Administrator) showed the following bathrooms were out of standard temperature range: The northeast common bathroom in Legacy 1 was 128.8 F, the southeast common bathroom in Legacy 1 was 126.8, the southwest common bathroom in Legacy 1 was 124.5 F, the northeast common bathroom in Legacy 2 was 102.8 F, and the southwest common bathroom in Legacy 2 was 101.8 F.

In an interview, on 05/23/2023 at 9:30 AM, Staff G stated that the residents did not have bathrooms in their rooms, and the common bathrooms were used by residents. Staff G stated that she knew the temperatures should be below 120 F, and that Legacy 1 Building and Legacy 2 Building had their own water heating systems. Staff G stated that water temperatures were checked regularly but had no documentation of water temperature checks.

Plan/Attestation Statement

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

Sheree O. Fuzzell — Administrator (or Representative)

06/14/2023 — Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow their Respiratory Protection Program (RPP) to ensure 6 of 6 sampled staff (Staff A, B, C, D, E, and F) had a medical clearance and were fit-tested for the appropriate respirator mask to wear during an infectious outbreak. This failure placed 30 of 30 residents at risk for exposure to COVID-19 (an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in

severe cases difficulty breathing that could result in severe impairment or death).

Findings included...

Note: Review of a "Dear Administrator" letter, dated 04/30/2021, showed the Department informed ALF's of their responsibility to develop and maintain an RPP. An RPP is defined by the Department of Health (DOH) as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALF were required to provide initial fit-tests for each Health Care Workers (HCW) with the same model, style, and size respiratory that the HCW would be required to wear for protection against COVID-19 and airborne hazards. The ALF were required to provide fit-tested respirators, such as N95, to all HCW's with the potential to have contact with residents with known or suspected COVID-19.

Note: Washington Administrative Code 296-842-12005 is a Washington State Department of Labor and Industries (L&I) rule that requires employers to develop a written RPP to safeguard employees from airborne hazards.

Record review of the ALF's, undated, RPP showed no individualized plan for the ALF. The forms for fit-testing staff and record for model, style, and size were all blank.

In an interview, on 05/24/2023 at 10:55 AM, Staff G (Administrator) stated that the RPP policy was purchased online, and she had not been able to go through it yet. Regarding fit-testing for staff, Staff G stated that she had tried to contact a company to fit test the staff, but the company had not returned her call.

Statement of Deficiencies	License #: 2411	Compliance Determination # 24404
Plan of Correction	The Legacy of Bothell	Completion Date
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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Legacy of Bothell is or will be in compliance with this law and / or regulation on (Date) July 7, 2023

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

Sheree O. Trigg — Administrator (or Representative)

06/14/23 — Date