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

HSP - Harbour Point LLC
Mukilteo Memory Care
4686 Pointes Dr
Mukilteo, WA 98275

RE: Mukilteo Memory Care License # 2426

Dear Administrator:

This letter addresses Compliance Determination(s) 53039 (Completion Date 01/15/2025) and 49560 (Completion Date 11/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/15/2025 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-2240, WAC 388-78A-2410-7, WAC 388-78A-2060-1, WAC 388-78A-2060-2, WAC 388-78A-2060-3, WAC 388-78A-2060-4, WAC 388-78A-2060-5, WAC 388-78A-2060-6, WAC 388-78A-2060-7, WAC 388-78A-2060-8, WAC 388-78A-2060, WAC 388-78A-3100-2, WAC 388-78A-3100-1, WAC 388-78A-2480, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2140-1, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-d, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-3, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2305-1, WAC 388-78A-2400-2

The Department staff who did the on-site verification:

Faith Le, NCI
Judith Mellon, RN, Licensor
Erin Steinbrenner, Nursing Consultant Institutional

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

Sincerely,

Jamie Singer

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

Statement of Deficiencies	License #: 2426	Compliance Determination # 49560
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 1 of 20	Licensee: HSP - Harbour Point LLC	11/18/2024

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

The department completed data collection for the unannounced on-site full inspection on 11/07/2024 and 11/08/2024 of:

Mukilteo Memory Care
4686 Pointes Dr
Mukilteo, WA 98275

The following sample was selected for review during the unannounced on-site visit: 7 of 59 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Faith Le, NCI
Erin Steinbrenner, Nursing Consultant Institutional
Judith Mellon, RN, Licensor

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

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

Jamie Singer
Residential Care Services

12/2/2024
Date

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

Administrator (or Representative) 12/5/2024 Date

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

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to obtain 3 of 3 Memory Care Unit (MCU) sampled residents (Resident 2, 6 and 7) medications in a timely manner. This failure resulted in Resident 2, 6 and 7 not receiving medications as prescribed and placed them at risk for medical complications

Findings included...

Record review of the ALF's Medication Services policy and procedure, policy number 60.200 dated 04/01/2017, showed "all medications will be assisted with or administered at the designated times."

Resident 2

Record review showed Resident 2 was admitted into the MCU on [redacted] 2024 with multiple medical diagnosis including [redacted] and [redacted]

Review of Resident 2's Negotiated Service Agreement (NSA), dated 09/03/2024 showed Resident 2 needed total medication assistance.

Review of the September 2024 electronic Medication Administration Records (EMAR) showed Resident 2 was prescribed Eliquis (a type of medication that is a blood thinner and helps to block blood clots from forming). The EMAR showed Resident 2's Eliquis was not available for three days in September which resulted in a total of six missed doses.

In an interview on 11/08/2024 at 11:24 AM, Staff F (Wellness Director) stated that Resident 2 did not receive Eliquis for the six missed doses in September 2024 because the medication was not available in the ALF.

Administrator (or Representative) Date

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

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to obtain 3 of 3 Memory Care Unit (MCU) sampled residents (Resident 2, 6 and 7) medications in a timely manner. This failure resulted in Resident 2, 6 and 7 not receiving medications as prescribed and placed them at risk for medical complications.

Findings included...

Record review of the ALF's Medication Services policy and procedure, policy number 60.200 dated 04/01/2017, showed "all medications will be assisted with or administered at the designated times."

Resident 2

Record review showed Resident 2 was admitted into the MCU on [redacted]/2024 with multiple medical diagnosis including [redacted] and [redacted].

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In an interview on 11/08/2024 at 11:24 AM, Staff F (Wellness Director) stated that Resident 2 did not receive Eliquis for the six missed doses in September 2024 because the medication was not available in the ALF.

Resident 6

Record review of a Face Sheet, dated 10/06/2024, showed the ALF admitted Resident 6 into their MCU on [redacted] 2023 with diagnosis of [redacted] and [redacted].

Review of an Assessment, dated 09/17/2024, showed Resident 6 required facility assistance and support with medication management services.

Record review of Resident 6's September of 2024 EMAR showed the prescribed medication Lorazepam was not available on three occasions, the prescribed medication Senna was not available on one occasion.

Resident 7

Record review of a Face Sheet, dated 10/06/2024, showed the ALF admitted Resident 7 into their MCU on [redacted] 2024 with diagnosis of [redacted] and [redacted] and [redacted].

Record review of an Assessment, dated 10/142024, showed Resident 7 required facility assistance and support with medication management services.

Record review of Resident 7's September 2024 EMAR showed the prescribed supplement Coenzyme Q10 was not available on four occasions, the prescribed supplement Vitamin A was not available on nine occasions, and the prescribed inhaler Fluticasone Propionate was not available on one occasion.

In an interview on 11/08/2024 at 11:24 AM, Staff F stated that if a medication was not received in time the staff would request a hold on a medication order until they could get the medication. Review of medical records showed no physician holds on medications were placed on resident records.

This deficiency was previously cited on 04/11/2023.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2426	Compliance Determination # 49580
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 4 of 20	Licensee: HSP - Harbour Point LLC	11/18/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~11/18/2025~~ 1/2/2025

SB confirmed ammended POC date with provider on 12/9/2024.

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

[redacted] 12/5/2024

Administrator (or Representative) Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.

This requirement was not met as evidenced by:

Based on interviews and record, reviews the Assisted Living Facility (ALF) failed to document or maintain documentation when 1 of 1 sampled resident, (Resident 3) had multiple refusals to wear continuous oxygen. This failure placed Resident 3 at risk for medical complications related to oxygen care needs.

Findings included...

Record review showed Resident 3 was admitted to the ALF Memory Care Unit (MCU) on [redacted] 2022 with multiple medical diagnoses including [redacted] and [redacted]

Record review of Resident 3's medical record showed Resident 3 had received Hospice (care provided to the terminally ill) care services. Hospice level of care documentation showed Physician orders for prescribed medications and treatments. The Physician orders were electronically signed by the Physician and dated 09/05/2024. The Physician orders showed Resident 3 was prescribed a treatment for oxygen 2-3 LPM (liters per minute – a unit of measurement), continuously, for "air hunger" (a feeling of severe breathlessness) with a start date of 06/18/2024.

Review of Resident 3's electronic Medication Administration Record (EMAR) for

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

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

_____ _____
Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interviews and record, reviews the Assisted Living Facility (ALF) failed to document or maintain documentation when 1 of 1 sampled resident, (Resident 3) had multiple refusals to wear continuous oxygen. This failure placed Resident 3 at risk for medical complications related to oxygen care needs.

Findings included...

Record review showed Resident 3 was admitted to the ALF Memory Care Unit (MCU) on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted]

Record review of Resident 3's medical record showed Resident 3 had received Hospice (care provided to the terminally ill) care services. Hospice level of care documentation showed Physician orders for prescribed medications and treatments. The Physician orders were electronically signed by the Physician and dated 09/05/2024. The Physician orders showed Resident 3 was prescribed a treatment for oxygen 2-3 LPM (liters per minute – a unit of measurement), continuously, for "air hunger" (a feeling of severe breathlessness) with a start date of 06/18/2024.

Review of Resident 3's electronic Medication Administration Record (EMAR) for

September 2024 showed an oxygen treatment order with a start date of 06/21/2024 and a discontinued date of 10/10/2024. Resident 3's EMAR was signed showing oxygen treatment was refused 60 times for the month of September 2024.

Review of Resident 3's EMAR for October 2024 showed the EMAR was signed showing oxygen treatment was refused 17 times.

In an interview, on 11/08/2024 at 12:29 PM, Staff F (Wellness Director) stated she had talked to the Hospice Nurse several times about Resident 3's refusal to wear oxygen. Staff F stated, "we would normally notify the Physician by fax or notify the Hospice Registered Nurse if someone refused a treatment, and they usually get us the Physician directives or discontinuation orders the same day or within 24 hours." Staff F stated that she was not sure if there was any documentation of the Physician or of the Hospice Physician being notified of Resident 3's refusals to wear oxygen, or if documentation was purged (removed) from the medical record. No documentation was available when requested on Resident 3's medical record.

A second request was made by email on 11/13/2024 to Staff G, (Executive Director) for facility documentation, to show if there were any Physician or Hospice Physician notifications for Resident 3's multiple refusals to wear oxygen in September and October 2024. An email response from Staff G dated 11/15/2024 at 8:50 AM showed "we were not successful in finding any documentation."

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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) 1/3/2025. 1/2/2025

SB confirmed ammended POC date with provider on 12/9/2024.

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

Administrator (or Representative) — 12/5/2024 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;

September 2024 showed an oxygen treatment order with a start date of 06/21/2024 and a discontinued date of 10/10/2024. Resident 3's EMAR was signed showing oxygen treatment was refused 60 times for the month of September 2024.

Review of Resident 3's EMAR for October 2024 showed the EMAR was signed showing oxygen treatment was refused 17 times.

In an interview, on 11/08/2024 at 12:20 PM, Staff F (Wellness Director) stated she had talked to the Hospice Nurse several times about Resident 3's refusal to wear oxygen. Staff F stated, "we would normally notify the Physician by fax or notify the Hospice Registered Nurse if someone refused a treatment, and they usually get us the Physician directives or discontinuation orders the same day or within 24 hours." Staff F stated that she was not sure if there was any documentation of the Physician or of the Hospice Physician being notified of Resident 3's refusals to wear oxygen, or if documentation was purged (removed) from the medical record. No documentation was available when requested on Resident 3's medical record.

A second request was made by email on 11/13/2024 to Staff G, (Executive Director) for facility documentation, to show if there were any Physician or Hospice Physician notifications for Resident 3's multiple refusals to wear oxygen in September and October 2024. An email response from Staff G dated 11/15/2024 at 8:50 AM showed "we were not successful in finding any documentation."

Plan/Attestation Statement

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Administrator (or Representative) Date

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(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 interviews and record reviews the Assisted Living Facility (ALF) failed to complete a Preadmission Assessment for 2 of 7 sampled residents (Resident 2 and 7). This failure placed Resident 2 and 7 at risk for not receiving the appropriate care and services to ensure their safety and well-being.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2070 Timing of preadmission assessment, 1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility. (2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions. (3) For the purposes of this section, "emergency" means any circumstances when the prospective resident would otherwise need to remain in an unsafe setting or be without adequate and safe housing.

Resident 2

Resident 2 was admitted to the ALF Memory Care Unit (MCU) on [redacted] 2024 with multiple medical diagnoses including [redacted] and [redacted]

Review of Resident 2's medical record showed there was no Preadmission Assessment completed before Resident moved into the MCU.

In an interview, on 11/08/2024 at 11:24 AM, Staff F (Wellness Director) stated that she did not have a Preadmission Assessment for Resident 2. Staff F stated, "when I did the preadmission assessments, I didn't know we were supposed to use a form, and I did it on paper. I didn't know I was supposed to keep it, I got rid of it, I threw it away."

Resident 7

Record review of a Face Sheet, dated 10/08/2024, showed the ALF admitted Resident 7 into their MCU on [redacted] 2024 with diagnosis of [redacted] and [redacted] and [redacted]

Record review of Resident 7's medical record showed there was no Preadmission Assessment completed before Resident 7 moved into the MCU.

In a follow-up interview, on 11/08/2024 at 3:37 PM, Staff F confirmed Resident 7 did not have a Preadmission Assessment on file.

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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~11/3/2025~~ 1/2/2025

SB confirmed ammended POC date with provider on 12/9/2024.

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

Administrator (or Representative) — Date: 12/5/2024

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observations and interviews the Assisted Living Facility (ALF) failed to ensure personal care supplies were safely secured on the Memory Care Unit (MCU) for 2 of 2 sampled residents (Resident 3 and 6) or hand sanitizer, body lotion and wound cleanser were secured in the first floor nurses' station. This failure placed 59 of 59 dementia care residents at risk of harm from exposure to hazardous materials.

Resident 7

Record review of a Face Sheet, dated 10/06/2024, showed the ALF admitted Resident 7 into their MCU on [redacted] 2024 with diagnosis of [redacted] and [redacted] and [redacted].

Record review of Resident 7's medical record showed there was no Preadmission Assessment completed before Resident 7 moved into the MCU.

In a follow-up interview, on 11/08/2024 at 3:37 PM, Staff F confirmed Resident 7 did not have a Preadmission Assessment on file.

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

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observations and interviews the Assisted Living Facility (ALF) failed to ensure personal care supplies were safely secured on the Memory Care Unit (MCU) for 2 of 2 sampled residents (Resident 3 and 6) or hand sanitizer, body lotion and wound cleanser were secured in the first floor nurses' station. This failure placed 59 of 59 dementia care residents at risk of harm from exposure to hazardous materials.

Findings included...

Review of the ALF's Resident Characteristic Roster showed 59 residents were identified with a diagnosis of [redacted].

On 11/07/2024 at 10:25 AM during an initial tour of the MCU, on the first floor, showed an open nurses' station that allowed access to residents, staff or visitors. The nurse's station had an unlocked drawer with a bottle of hand sanitizer, a tube of body lotion and a spray bottle half full of liquid that was labeled wound cleanser.

In an interview, on 11/07/2024 at 10:35 AM, Staff G (Executive Director) stated that the hand sanitizer, body lotion and wound cleanser should be locked up in the far right cabinet and not left in the drawer.

Resident 3

Resident 3 was admitted to the MCU on [redacted]/2022 with multiple medical diagnoses including [redacted].

On 11/08/2024 at 1:46 PM, Resident 3's room was observed to have a shared bedroom. Resident 3's closet was unlocked and partially opened. A tube of Medline Remedy Clinical skin cream was on the shelf and within reach of residents.

In an interview, on 11/08/2024 at 1:48 PM, Staff F (Wellness Director) stated that the Medline Remedy Clinical skin cream should not be left in the resident's room and should be locked up.

Resident 6

Resident 6 was admitted to the MCU on [redacted]/2023 with multiple medical diagnoses including [redacted].

Observation of Resident 6's bathroom countertop, on 11/08/2024 at 9:23 AM, showed a tube of Medline Remedy Clinical skin cream and a stick of deodorant lying next to the sink. Both items had warning "External Use Only". The stick of deodorant showed, "Keep out of reach of children."

In an interview on 11/08/2024 at 1:58 PM, Staff F stated the skin cream and deodorant should be locked up.

This deficiency was previously cited on 04/11/2023.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 12/9/2024.

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

Mirell — Administrator (or Representative)

12/5/2024 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 5 staff members (Staff B and Staff C) initiated tuberculosis (TB) screening within three days of employment. This placed 59 residents at risk of exposure to a communicable disease.

Findings included...

Review of records showed the ALF hired Staff B (Caregiver) on 07/23/2024. Record review showed Staff B had a one-step completed greater than three days after date of hire on 08/08/2024.

Review of records showed the ALF hired Staff C (Caregiver) on 06/14/2024. Record review showed Staff C had a one-step completed greater than three days after date of hire on 06/25/2024.

In interview, on 11/08/2024 at 10:20 AM, Staff F (Wellness Director) confirmed Staff B and Staff C had worked in the community for greater than three days prior to initiating TB screening.

This deficiency was previously cited on 04/11/2023.

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

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Review of records showed the ALF hired Staff C (Caregiver) on 06/14/2024. Record review showed Staff C had a one-step completed greater than three days after date of hire on 06/25/2024.

In interview, on 11/08/2024 at 10:20 AM, Staff F (Wellness Director) confirmed Staff B and Staff C had worked in the community for greater than three days prior to initiating TB screening.

Statement of Deficiencies	License #: 2426	Compliance Determination # 43560
Plan of Correction	Mukilteo Memory Care	Completion Date
Page of 20	Licensee: HSP - Harbour Point LLC	11/18/2024

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 12/9/2024.

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

Mizell — Administrator (or Representative)

12/5/2024 — 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.

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(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;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, 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

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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(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;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, 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.

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(a) Exclusively for the individual resident; or

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

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement contained relevant interventions or information to meet the care and service needs for 4 of 7 residents (Resident 2, 5, 6, and 7). This placed Resident 2, 5, 6, and 7 at risk of harm by not having their care needs met.

Findings included...

Resident 2

Record review showed Resident 2 was admitted into the Memory Care Unit (MCU) on [redacted]/2024 with multiple medical diagnosis including [redacted] and [redacted].

Review of Resident 2's Service Plan (SP-equivalent to the Negotiated Service Agreement), dated 09/03/2024, showed Resident 2 required total medication assistance.

Review of Resident 2's September 2024 electronic Medication Administration Records (EMAR) showed Resident 2 was prescribed Eliquis (a type of medication that is a blood thinner and helps to block blood clots from forming).

Review of the SP, dated 09/03/2024, showed no information was available for Resident 2's medication, Eliquis, taken for anticoagulation therapy (also known as blood thinning). The SP did not identify any risks associated with taking Eliquis, such as bleeding, bruising or that skipping doses or stopping the medication could increase your risk of a blood clot or stroke.

In an interview, on 11/08/2024 at 11:24 AM, Staff F (Wellness Director) stated information from Resident 2's Assessment was supposed to transfer over to the SP. Staff F stated, "I didn't know how to add additional information into the SP, and I did not put anything about anticoagulation therapy (use of blood thinning drugs to prevent or treat blood clots) on it."

Resident 5

Review of a Face Sheet, dated 10/01/2024, showed the ALF admitted Resident 5 on [redacted] 2022 with multiple diagnosis to include [redacted] and [redacted]. Review of an Assessment, dated 10/01/2024, showed Resident 5 requires total assistance with medication management.

Record review of Resident 5's October and November 2024 EMAR showed a physician's order for once daily administration of Xarelto (an anticoagulant medication).

Record review of Resident 5's SP, dated 10/05/2024, showed no information and did not identify that Resident 5 was taking an anti-coagulant medication. There were no instructions for staff regarding what to observe, report, or monitor and the bleeding risks associated when caring for Resident 5 while taking an anti-coagulant.

Record review of the Resident Characteristic Roster, provided on 11/07/2024, showed Resident 5 had an indwelling catheter and received nursing services from a Home Health (HH) provider.

In interview, on 11/08/2024 at 9:25 AM, Resident 5 confirmed they had an indwelling catheter.

Record Review of Resident 5's SP, dated 10/05/2024, gave no mention that Resident 5 received HH care for catheter management or included instructions and information for staff regarding what to observe, report, or monitor for the catheter such as dislodgement or complications. Resident 5's SP gave no mention of clearly defined roles and responsibilities of the ALF staff or an alternative plan for providing care or services if the HH nurse was unavailable to meet the resident's catheter needs.

In interview, on 11/08/2024 at 9:35 AM, Staff F confirmed Resident 5's catheter was managed jointly by ALF nurses and HH nurses, depending on the assistance needed and the time it occurred. Staff F stated HH contact information and instructions were not included in Resident 5's SP and was only listed in a provider notebook.

Resident 6

Record review of a Face Sheet, dated 10/06/2024, showed the ALF admitted Resident 6 into the MCU on [redacted] 2023 with a primary diagnosis of [redacted]. Review of an Assessment, dated 09/17/2024, showed Resident 6 used of a Continuous Positive Airway Pressure (CPAP - a machine that gently blows air into your airway to keep it open while you sleep) machine and received hospice services (end of life care).

Observation, on 11/08/2024 at 9:20 AM, showed a CPAP on top of Resident 6's table next to his bed.

Record review of a SP, dated 10/17/2024, showed no information and did not identify Resident 6 used a CPAP or what care and services were required for the CPAP. There were no instructions for care staff on setting up, cleaning, and maintaining Resident 6's CPAP. The SP showed Resident 6 received hospice services but made no mention of name of the hospice, contact information, or a breakdown of the specific care provided.

In an interview, on 11/08/2024 at 1:48 PM, Staff F stated caregivers provided all care needs related to Resident 6's CPAP which included donning on/off, cleaning, maintenance and ensuring it was turned on while sleeping, and hospice services provided showers and wound care. Staff F confirmed instructions for managing CPAP and information about hospice services, including alternate plans, should be written on Resident 6's SP.

Resident 7

Record review of a Face Sheet, dated 10/06/2024, showed the ALF admitted Resident 7 into their MCU on [redacted]/2024 with diagnosis of [redacted] and [redacted].

Record review of Resident 7's September, October and November of 2024 eMAR showed a physician's order for twice daily administration of Eliquis.

Record review of an Assessment, dated 10/14/2024, showed Resident 7 was receiving physical therapy.

Record review of Resident 7's SP, dated 10/18/2024, showed no information and did not identify Resident 7 was taking an anti-coagulant medication. There were no instructions for staff regarding what to observe, report, or monitor and the bleeding risks associated when caring for Resident 7 while taking an anti-coagulant. The SP also showed no information and did not identify Resident 7 was receiving physical therapy.

In interview, on 11/08/2024 at 3:38 PM, Staff F confirmed there were no anti-coagulant safety monitoring instructions for staff on the SP, and that the risks of taking Eliquis should be included in Resident 2, 5 and 7's SPs. Staff F acknowledged Resident 7 was receiving physical therapy and confirmed it was not documented in the SP.

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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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date): ~~11/18/2024~~ 1/2/2025

SB confirmed ammended POC date with provider on 12/9/2024.

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

Administrator (or Representative) — 12/5/2024 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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete an ongoing assessment for use of side rails for 2 of 2 sampled residents (Resident 5 and Resident 6). This placed Resident 5 and 6 at risk for injury and unmet health needs.

Findings included:

Note. Washington Administrative Code 388-78A-2090 Full assessment topics - The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility .

Record review of the facility's "Use of Bed Mobility Devices" policy, dated 10/2017, showed the facility was "to assure that initial and periodic evaluations are made prior to, and during, the use of bed mobility devices, including half bed side rails, bed canes

Plan/Attestation Statement

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Administrator (or Representative) Date

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(2) The assisted living facility must:

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(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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete an ongoing assessment for use of side rails for 2 of 2 sampled residents (Resident 5 and Resident 6). This placed Resident 5 and 6 at risk for injury and unmet health needs.

Findings included:

Note: Washington Administrative Code 388-78A-2090 Full assessment topics - The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

Record review of the facility's "Use of Bed Mobility Devices" policy, dated 10/2017, showed the facility was "to assure that initial and periodic evaluations are made prior to, and during, the use of bed mobility devices, including half bed side rails, bed canes

or bed sticks in order to determine the necessity of such devices, identify possible alternatives, create awareness of potential risks and to promote independence."

Resident 5

Review of a Face Sheet, dated 10/01/2024, showed the ALF admitted Resident 5 on [redacted]/2022 with primary diagnosis of [redacted].

Observation and interview, on 11/08/2024 at 9:25 AM, showed Resident 5's hospital bed had a half-length side rail secured to the upper right side. The side rail measured 28 inches in length and 10 inches in height with vertical bars spaces two and a half inches apart. Resident 5 stated she was unsure if she needed the side rail.

Record review of Resident 5's Assessment, dated 10/01/2024, showed no mention of a side rail or transfer enabling device assessment.

In interview, on 11/08/2024 at 9:35 AM, Staff F (Wellness Director) confirmed an assessment to evaluate the risks and benefits of a side rail for Resident 5 had not been completed as she was unaware it was required for a bed with a single rail.

Resident 6

Record review of a Face Sheet, dated 10/06/2024, showed the ALF admitted Resident 6 into the MCU on [redacted]/2023 with diagnosis of [redacted] and [redacted].

Observation of Resident 6's bed, on 11/08/2024 at 9:20 AM, showed a half-length side rail attached on the upper left side. The steel side rail was loosely attached between the mattress and bed frame, with an eight-inch open space between the perimeter of the rail and the bed frame.

Record review of Resident 6's Assessment, dated 09/17/2024, showed no mention of a side rail.

In interview, on 11/08/2024 at 3:40 PM, Staff F stated the side rail was installed after Resident 6 admitted into the facility and confirmed an assessment for side rails had not been completed and should be completed to evaluate the risks and benefits.

This deficiency was previously cited on 5/23/2023.

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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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~11/1/2025~~ 1/2/2025

SB confirmed ammended POC date with provider on 12/9/2024.

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

Administrator (or Representative) — Date: 12/5/2024

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to have a system was in place for to ensure proper sanitizing of food prep surfaces and equipment and ensure ready-to-eat food were safe for Memory Care Unit (MCU) residents to consume. These failures placed 59 of 59 residents at risk for illness and increased health issues.

NOTE: According to the Washington State Food Workers Course at foodworkercard.wa.gov, cold food should be marked with the date if kept more than 24 hours. All refrigerated food should be served or discarded within seven days after opening. When you open or prepare refrigerated ready to eat food, mark the date immediately. Start with the day you open or prepare the food and add six days

Reference Washington Administrative Code (WAC) 246-215-03526 Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (Food and Drug Administration (FDA) Food Code 3-501.17). (1) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under 03540, and except as specified in subsections (5) and (6) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than twenty-four hours must be clearly marked to indicate the date or day by which the FOOD must be consumed on the PREMISES, sold, or discarded when held at a temperature of 41°F (5°C) or less for a maximum of seven days. The day of preparation must be counted as day one. (2) Except as specified in subsections (5) through (7) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT must be clearly marked, at the time the original container is

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to have a system was in place for to ensure proper sanitizing of food prep surfaces and equipment and ensure ready-to-eat food were safe for Memory Care Unit (MCU) residents to consume. These failures placed 59 of 59 residents at risk for illness and increased health issues.

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opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than twenty-four hours, to indicate the date or day by which the FOOD must be consumed on the PREMISES, sold, or discarded, based on the temperature and time requirements specified in subsection (1) of this section and: (a) The day the original container is opened in the FOOD ESTABLISHMENT is counted as day one; and (b) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety.

Record review of an undated Characteristic Roster, showed the ALF provided care and services for 59 residents residing in a locked MCU. Twenty-seven of the residents resided on the first floor. Thirty-two residents resided on the second floor.

Observation and interview, on 11/07/2024 at 12:47 PM, showed a refrigerator in the kitchenette near an elevator on the second floor. Observation of the contents of the refrigerator, showed a gallon of milk, with one-quarter remaining, had no label and date; whipped cream in a plastic piping bag, with a dried-out tip, had no label or date; an opened quart-sized yogurt showed a resident's name written on the lid, had no date; three plastic pitchers of juice had no label or date. Staff H (Director of Dining Services) reported contents in the refrigerator should have a label indicating the food item and an opened or prepared date.

Observation and interview, during the food service and kitchen tour with Staff H, on 11/07/2024 at 1:30 PM, showed a refrigerated sandwich prep table (SPT). Observation of the contents of the SPT showed an opened carton of scrambled egg mix had no open date; a gallon-sized tub of mayonnaise had no open date; a plastic container storing eight hard boiled eggs had no cover, label, or date; two pitchers of juice had no label or date. Staff H reported all opened food items should have a label and date.

NOTE: Reference WAC 246-215-03235 Specifications for receiving—Temperature (FDA Food Code 3-202.11). (5) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked to a temperature and for a time specified under 03400 through 03410 and received hot must be at a temperature of 135°Fahrenheit (F) (57°C) or above.

Observation during lunch service on the second floor, on 11/07/2024 at 11:54 AM, showed Staff H and Staff I plating and serving chicken and gnocchi with cream sauce (CS), sauteed kale and onions (KO), and baked beans. Observation showed Staff H taking the temperature of CS and KO. The temperature of the CS was 109 degrees F, and the temperature of the KO was 118 degrees F.

In interview, on 11/07/2024 at 11:57 AM, Staff H reported hot food should be kept at around 135 degrees F, and any hot food lower than 135 degrees F should not be served to residents.

NOTE: Reference WAC 246-215-03339 Preventing contamination from equipment, utensils, and linens--Wiping cloths, use limitation (FDA Food Code 3-304.14). (2) Cloths

in-use for wiping counters and other EQUIPMENT surfaces must be: (a) Held between uses in a chemical SANITIZER solution at a concentration specified under 04565; OR

NOTE: Reference WAC 246-215-04565 Equipment--Manual and mechanical warewashing equipment, chemical sanitization--Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 04710(3) must meet the requirements specified under 07220, must be used in accordance with the EPA-registered label use instructions, and must be used as follows: (3) A quaternary ammonium compound solution must: (a) Have a minimum temperature of 75°F (24°C); (b) Have a concentration as specified under 07220 and as indicated by the manufacturer's use directions included in the labeling; and (c) Be used only in water with 500 MG/L hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions; OR

NOTE: Reference WAC 246-215-07220 Chemicals--Sanitizers, criteria (FDA Food Code 7-204.11). Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACES must:
(1) Meet the requirements specified in 40 C.F.R. 180.940 Tolerance exemptions for active and inert ingredients for Use in Antimicrobial Formulations (food contact surface sanitizing food contact surface sanitizing solutions);

Observation, during the food service and kitchen tour, on 11/07/2024 at 2:02 PM, showed no sanitizing equipment available for staff to sanitize their instruments and workspace. Observation showed Staff H filled an empty bucket with sanitation solution. Staff H attempted to test the quaternary ammonium (QA) (a class of chemicals used for controlling bacteria, viruses, and other germs on surfaces.) concentration level of the sanitation bucket solution but was unable to find quat/chlorine (a way to measure the concentration of QA in sanitizer solutions.) test strips.

In interview, on 11/07/2024 at 2:07 PM, Staff H reported sanitation buckets should always be available for cleaning and sanitizing, and the QA concentration level should be tested regularly. Staff H stated the QA concentration level had not been tested today.

NOTE: WAC 246-215-03300 Preventing contamination by employees--Preventing contamination from hands (FDA Food Code 3-301.11). (2) Except when washing fruits and vegetables as specified under 03318 or as specified in subsections (4) and (5) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, SINGLE-USE gloves, or dispensing EQUIPMENT.

Observation during lunch service on the second floor, on 11/07/2024 at 11:54 AM, showed Staff H and Staff I (Cook) plating chicken and gnocchi in cream sauce with sauteed kale and onions, and baked beans to serve to residents. Staff H and Staff I were

observed wearing gloves while using serving utensils. Observation showed Staff H and Staff I retrieved dinner rolls from packaging and place them on the plates without using a utensil or changing out gloves. Staff H and Staff I went back and forth from handling serving utensils, touching drawer handles, touching countertops, and retrieving dinner rolls with their hands without washing their hands or changing gloves during and throughout the observation.

In interview, on 11/7/2024 at 1:47 PM, Staff H reported tongs should be used to handle dinner rolls, but the facility was short on serving utensils at that time.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 12/9/2024.

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

Administrator (or Representative) — 12/5/2024 Date

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

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

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure resident's medical records were protected and kept private. This failure placed 59 of 59 residents at risk for violation of their privacy and basic rights.

Findings included...

Observation, on 11/08/2024 at 12:17 PM, showed the nurse's station (NS) located in an open area on the second floor, with no doors or gate. Along the wall of the NS showed three unlocked wall cabinets, with one of the cabinets doors propped opened. Inside the cabinets were binders containing names and their medical information of residents. On top of the counter along the wall cabinets showed a binder labeled, "Second Floor service Plan." This binder contained various residents' name and their care plans. On top of the counter, opposite of the wall, showed another binder. Review of the binder showed various resident's names and the progress notes indicating their medical information.

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Findings included...

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Statement of Deficiencies	License #: 2426	Compliance Determination # 49560
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In interview, on 11/08/2024 at 1:54 PM, Staff F (Director of Wellness) stated the NS had no staffing during lunch hours. Facility staff should have locked up the cabinets and put away resident's confidential records before leaving for lunch.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 12/9/2024.

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

Administrator (or Representative) — 12/5/2024 — Date

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