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) 41787 (Completion Date 05/28/2024) and 36058 (Completion Date 03/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-1-b, WAC 388-78A-2630-1-a, WAC 388-78A-2160, WAC 388-78A-2450-2-e

The Department staff who did the on-site verification:
Michelle Mcglon, 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Mukilteo Memory Care
Provider Type: Assisted Living Facility
License/Cert.#: 2426
Compliance Determination #: 36058
Intake ID: 112401
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/30/2024 through 03/28/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) was involved in a Resident-to-Resident altercation at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:
Total residents: 59
Resident sample size: 17
Closed records sample size:

Observations:
Identified resident
Residents
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Family members

Record Reviews:
State reporting log
Incident investigation
Facility policies
Resident Records

Investigation Summary:

1. Record review showed the NR had a history of resident-to-resident altercations. Review of the incident showed the NR began hitting the resident, when asked to leave the apartment. The ALF made all the appropriate notifications including a call to the NR's family representative. The ALF failed to implement the negotiated service agreement to provide monitoring and supervision the of the NR, resulting in other resident-to-resident altercations to occur.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Mukilteo Memory Care
Provider Type: Assisted Living Facility
License/Cert.#: 2426
Compliance Determination #: 36058
Intake ID: 115447
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/30/2024 through 03/28/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) was involved in a Resident-to-Resident altercation at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:
Total residents: 59
Resident sample size: 17
Closed records sample size:

Observations:
Identified resident
Residents
Resident to resident interactions
Staff to resident interactions

Interviews:
Identified resident
Nursing staff
Family members

Record Reviews:
State reporting log
Incident investigation
Facility policies
Resident Records

Investigation Summary:

1. Record review showed the NR had a history of resident-to-resident altercations. Review of the incident showed the NR began hitting the resident, when asked to leave the apartment. The ALF made all the appropriate notifications including a call to the NR's family representative. The ALF failed to implement the negotiated service agreement to provide monitoring and supervision the of the NR, resulting in other resident-to-resident altercations to occur.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Mukilteo Memory Care
Provider Type: Assisted Living Facility
License/Cert.#: 2426
Compliance Determination #: 36058
Intake ID: 120459
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/30/2024 through 03/28/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Staff (NS) deliberately threw medications in the garbage for 15 memory care residents.

Investigation Methods:

Sample:
Total residents: 59
Resident sample size: 17
Closed records sample size:

Observations:
Residents
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Identified staff
Nursing staff
Family members

Record Reviews:
State reporting log
Incident investigation
Facility policies
Resident Records
Staff training records

Investigation Summary:

1. Interview and record review showed the NS intentionally threw the medications for 14 residents in to the garbage. The NS confirmed that she threw the medications in the garbage. The Assisted Living Facility (ALF) failed to ensure the NS had the required crendentials to provide care and services and administered medications to residents. The ALF failed to ensure medication systems were in place to promote safe medications services. The ALF failed to report to Department, when the NS threw medications in the garbage placing the residents at risk for harm.

Conclusion / Action:

[X] Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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 # 36058
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 1 of 11	Licensee: HSP - Harbour Point LLC	03/28/2024

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 an unannounced on-site complaint investigation on 01/30/2024 and 01/30/2024 of:

Mukilteo Memory Care
4686 Pointes Dr
Mukilteo, WA 98275

This document references the following complaint number(s): 112401, 115447, 116162, 118183, 120459

The following sample was selected for review during the unannounced on-site visit: 17 of 59 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, 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

4/4/2024
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) 4/10/2024 Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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.

WAC 388-78A-2210 Medication services.

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure 14 of 14 sampled residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) received medications when an uncredentialed Medication Technician intentionally threw away medications instead of administering them as prescribed. This failure resulted in Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14 to not receive their prescribed medications and placed them at risk for significant health complications.

Findings included...

NOTE: According to Washington Administrative Code (WAC) 388-78A-2020 – Definitions - Medication Administration means the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the resident's body by an individual legally authorized to do so. Medication Assistance means assistance with self-administration of medication rendered by a nonpractitioner to a resident of an assisted living facility in accordance with chapter 246-888 WAC.

Review of a Medication Error Report (MER), dated 02/20/2024 and documented by Staff C (Director of Wellness), showed Staff D (Medication Technician) intentionally threw away the medications ordered for Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14 at 6:30

AM, 7:00 AM, 7:30 AM, 8:00 AM, 1:00 PM, and 2:00 PM instead of administering them. The MER stated that all the missed medications were found in the trash by another staff member. The MER stated that all of the medications thrown in the trash were fraudulently documented in the Medication Administration Records (MAR) as given.

Record review of www.doh.wa.gov.pcs, on 03/12/2024 4:30 PM, showed Staff D's Nursing Assistant Certification credential, expired on 11/21/2023. For further details see 388-78A-2450 in this Statement of Deficiencies.

Resident 1
Record review of an undated Face Sheet showed the ALF admitted Resident 1 on [redacted]/2022 with multiple medical diagnoses, including [redacted]. Record review of an Assessment, dated 12/07/2023, showed Resident 1 required medication administration and crushed medications.

Record review of February 2024 Physician's Orders showed at 6:30 AM Resident 1 was to receive levothyroxine (used to treat hypothyroidism), acetaminophen (used for fever and pain), amlodipine (used to treat high blood pressure and chest pain), metoprolol tartrate (used to treat high blood pressure, chest pain, and heart failure). Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 1. However, these medications were found in the garbage.

Resident 2

Record review of an undated Face Sheet showed the ALF admitted Resident 2 on [redacted]/2022, with multiple medical diagnoses including [redacted]. Record review of an Assessment, dated 10/25/2023, showed Resident 2 required medication administration.

Record review of February 2024 Physician's Orders showed at 8:00 AM Resident 2 was to receive acidophilus (used to treat vaginal inflammation and digestive disorders) and Balanced B Complex (supplement). Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 2. However, these medications were found in the garbage.

Resident 3
Record review of an undated Face Sheet showed the ALF admitted Resident 3 on [redacted]/2021 with multiple medical diagnoses including [redacted]. Record review of an Assessment, dated 10/25/2023, showed Resident 3 required medication administration and crushed medications.

Record review of February 2024 Physician's Orders showed at 7:00 AM Resident 3 was to

receive senna (used to treat occasional constipation), venlafaxine HCL (used to treat depression), acetaminophen, aripiprazole (used to treat mental disorders and depression), aspirin (used to treat fever, pain, and low the risk of a heart attack), docusate sodium (stool softener), finasteride (used to treat enlarged prostrate and urinary retention), gabapentin (used to treat seizures and pain), and losartan potassium (used to treat used treat high blood pressure). At 1:00 PM, Resident 3 was to received acetaminophen. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 3. However, these medications were found in the garbage.

Resident 4
Record review of an undated Face Sheet showed the ALF admitted Resident 4 on [redacted]/2020, with multiple medical diagnoses including [redacted] and [redacted]. Record review of an Assessment, dated 09/01/2023, showed Resident 4 required medication assistance.

Record review of February 2024 Physician's Orders showed at 7:00 AM Resident 4 was to receive amlodipine, donepezil (used to improve memory, awareness, and ability to function), lisinopril (used to treat high blood pressure), pantoprazole sodium (used to treat heartburn and acid reflux), prenatal vitamin (supplement), quetiapine fumarate (used to treat mental disorders and depression), and vitamin B1 (supplement). Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 4. However, these medications were found in the garbage.

Resident 5
Record review of an undated Face Sheet showed the ALF admitted Resident 5 on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted]. Record review of an Assessment, dated 11/30/2023, showed Resident 5 required medication assistance.

Record review of February 2024 Physician's Orders showed at 8:00 AM Resident 5 was to receive amlodipine, benazepril HCL (used to treat high blood pressure), ferrous sulfate (treat and prevent iron deficiency anemia), isosorbide mononitrate (used to prevent chest pain), sertraline HCL (used to treat depression) and, vitamin D(supplement). Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 5. However, these medications were found in the garbage.

Resident 6
Record review of an undated Face Sheet showed the ALF admitted Resident 6 on [redacted]/2020 with multiple medical diagnoses including [redacted] and [redacted]. Record review of an Assessment, dated 02/07/2024, showed Resident 6 required medication administration and crush medications.

Record review of February 2024 Physician's Orders showed at 7:00 AM Resident 6 was to receive acetaminophen and losartan potassium. At 1:00 PM Resident 6 was to receive acetaminophen. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 6. However, these medications were found in the garbage.

Resident 7
Record review of an undated Face Sheet showed the ALF admitted Resident 7 on [redacted]/2021 with multiple medical diagnoses including [redacted] and [redacted]. Record review of an Assessment, dated 01/20/2024, showed Resident 7 required medication administration and crushed medications.

Record review of February 2024 Physician's Orders showed at 8:00 AM Resident 7 was to receive levothyroxine, memantine (used improve memory), quetiapine fumarate, and sertraline. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 7. However, these medications were found in the garbage.

Resident 8
Record review of an undated Face Sheet showed the ALF admitted Resident 8 on [redacted]/2021 with multiple medical diagnoses including [redacted]. Record review of an Assessment dated, 12/27/2023, showed Resident 8 required medication administration and crushed medication.

Record review of February 2024 Physician's Orders showed at 7:30 AM and 8:00 AM Resident 8 was to receive acetaminophen, acidophilus, nitrofurantoin (antibiotic used to treat and prevent urinary tract infections), and senna. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 8. However, these medications were found in the garbage.

Resident 9
Record review of an undated Face Sheet showed the ALF admitted Resident 9 on [redacted]/2023 with multiple medical diagnoses including and [redacted] and [redacted] Record review of an Assessment, dated 02/12/2024, showed Resident 9 required medication administration.

Record review of February 2024 Physician's Orders showed at 8:00 AM resident 9 was to receive levothyroxine, losartan potassium, metformin ER (used to treat type 2 diabetes), and Vitamin D3. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 9. However, these medications were found in the garbage.

Resident 10
Record review of an undated Face Sheet showed the ALF admitted Resident 10 on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted]. Record review of an Assessment, dated 11/30/2023, showed Resident 10 required medication assistance.

Record review of February 2024 Physician's Orders showed at 8:00 AM Resident 10 was to

receive memantine and quetiapine fumarate. At 2:00 PM, Resident 10 was to receive another dose of quetiapine fumarate. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 10. However, these medications were found in the garbage.

Resident 11
Record review of an undated Face Sheet showed the ALF admitted Resident 11 on [redacted]/2020, with multiple medical diagnoses including [redacted], [redacted], and [redacted]. Record review of an Assessment, dated 11/13/2023, showed Resident 11 required medication assistance.

Record review of February 2024 Physician's Orders showed at 7:00 AM Resident 11 was to receive acetaminophen, aspirin, clopidogrel (used to prevent stroke, heart attack, and other heart problems), ferrous sulfate, lisinopril, memantine, metoprolol tartrate, pantoprazole, sertraline, vitamin B-12, and vitamin B1. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 11. However, these medications were found in the garbage.

Resident 12
Record review of an undated Face Sheet showed the ALF admitted Resident 12 on [redacted]/2022 with multiple medical diagnoses including [redacted]. Record review of an Assessment, dated 10/25/2023, showed Resident 12 required medication assistance and crushed medications.

Record review of February 2024 Physician's Orders showed at 7:00 AM Resident 12 was to receive divalproex sodium (used to treat seizures and mental health disorders) and quetiapine fumarate. At 1:00 PM, Resident 12 was to receive another dose of quetiapine fumarate. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 12. However, these medications were found in the garbage.

Resident 13
Record review of an undated Face Sheet showed the ALF admitted Resident 13 on [redacted]/2024 with multiple medical diagnoses including [redacted] and [redacted]. Record review of an Assessment, dated 12/15/2023, showed Resident 13 required medication assistance and crushed medications.

Record review of February 2024 Physician's Orders showed at 7:30 AM Resident 13 was to receive Synthroid (used to treat hypothyroidism). At 8:00 AM, Resident 13 was to receive citalopram (used to treat depression), digoxin (used to treat heart failure and irregular heartbeat), Eliquis (used to treat and prevent blood clots), Invokana (used to treat type 2 diabetes), losartan potassium, spironolactone (used to treat high blood pressure, heart failure, and swelling). Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 13. However, these medications were found in the garbage.

Resident 14
Record review of an undated Face Sheet showed the ALF admitted Resident 14 on [redacted]/2021 with multiple medical diagnoses including [redacted]. Record review of an Assessment, dated 01/20/2024, showed Resident 14 required medication administration and crushed medications.

Record review of February 2024 Physician's Orders showed at 8:00 AM Resident 14 was to receive bisacodyl (used to treat constipation), lamotrigine (used to treat seizures and mental health disorders), senna. Staff D initialed in the MAR, on 02/20/2024, that she administered the above medications to Resident 14. However, these medications were found in the garbage.

In an interview, on 03/06/2024 at 10:40 AM, Staff D admitted to throwing away Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14's medications instead of giving them as ordered. Staff D stated that she felt overwhelmed when she threw the medications the garbage.

This deficiency was previously cited on 05/25/2023.

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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/17/2024 12.

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

[signature] 4/10/2024

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed notify the Department of Social and Health Services (DSHS) complaint hotline when 1 of 2 sampled staff (Staff D) intentionally threw away medications instead of administering them as

ordered. This placed 25 of 25 residents at risk of further abuse and neglect.

Findings included...

NOTE: According to Washington Administrative Code (WAC) 388-78A-2020 – Definitions "Neglect" means: (1) A pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident; or (2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

Review of a Medication Error Report (MER), dated 02/20/2024 and documented by Staff C (Director of Wellness), showed Staff D (Medication Technician) intentionally threw away the medications ordered for Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14 at 6:30 AM, 7:00 AM, 7:30 AM, 8:00 AM, 1:00 PM, and 2:00 PM instead of administering them. The MER stated that all the missed medications were found in the trash by another staff member. The MER stated that all of the medications thrown in the trash were fraudulently documented in the Medication Administration Records (MAR) as given. For further details see WAC 388-78A-2210 in this Statement of Deficiencies.

Review of the Departments Secured Tracking and Reporting System, on 03/27/2024, showed there was no record the ALF reported the incident of Staff D throwing away resident medications to the Department.

In an interview, on 03/06/2024 at 11:35 AM, Staff A (Executive Director) confirmed she did not notify the Department.

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) 5/17/2024 12.

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

Administrator (or Representative) 4/10/2024 Date

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to implement the Negotiated Service Agreement (NSA) to monitor 1 of 1 sampled resident (Resident 1), who had a pattern of multiple behavior issues including physical assault toward other residents. This resulted in Resident 1 physically assaulting other residents and placed 25 of 25 residents at risk of abuse.

Findings included...

Record review of an undated Face sheet showed the ALF admitted Resident 1 on [redacted]/2023 with multiple medical diagnoses including [redacted]. Review of a Temporary Care Plan (adjunct to an NSA), dated 01/07/2024, titled "Resident to Resident Altercation" showed Resident 1 required interventions that included: monitor resident for signs of agitation notify LN (Licensed Nurse)/MT (Medication Technician), keep resident away from other residents, and redirect resident if wandering towards another residents room.

Review of a Resident Incident/Unusual Occurrence Report (IUO) showed that on 01/17/2024, Resident 1 entered Resident 2's apartment and physically assaulted them. Another IUO showed that on 11/29/2023, Resident 1 had entered Resident 4's apartment and poured water on them. Another IUO showed that on 01/07/2024, Resident 1 had entered Resident 5's apartment and physically assaulted them, resulting in the resident being found on the floor with an abrasion to their right elbow. Another IUO showed that on 11/22/2023, Resident 1 entered Resident 6's apartment and pushed them down to the floor, resulting in the resident hitting her head.

Observation, on 01/30/2024 at 12:05 PM, showed Resident 1 was in the activity room standing next to Resident 3. There were no staff in the activity room monitoring Resident 1 at this time.

In an interview, on 01/30/2024 at 1:40 PM, Staff B (Resident Care Coordinator) stated that the staff were monitoring and redirecting Resident 1 to keep them from harming other residents in the unit. When told that Resident 1 was just observed alone with another resident, without monitoring or supervision, Staff B stated, "We monitor when we can, we cannot afford more staff."

This deficiency was previously cited on 05/25/2023

Statement of Deficiencies	License #: 2426	Compliance Determination # 36058
Plan of Correction	Mukilteo Memory Care	Completion Date
Page of 11	Licensee: HSP - Harbour Point LLC	03/28/2024

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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/7/2024 12.

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

Administrator (or Representative) — Date: 4/10/2024

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure credentials were active for 1 of 1 sampled staff (Staff D) while they provided care and medication services to residents. This failure placed 25 of 25 residents at risk of harm related to receiving care and medication administration from an uncredentialed staff.

Findings included...

Record review showed the ALF hired Staff D (Medication Technician) on 11/08/2022.

In an interview on 03/06/2024 at 10 :40 AM, Staff D stated that she provided medication administration to 25 memory care residents. Staff D stated that she provided care when other care staff were on break.

Record review of a February Medication Administration Record (MAR) showed Staff D had initialed administering medications to memory care residents.

Record review of www.doh.wa.gov.pcs, on 03/12/2024 4:30PM, showed Staff D's Nursing Assistant Certification, expired on 11/21/2023. Staff D provided care and services to memory care resident for 113 days with expired credentials.

Statement of Deficiencies	License #: 2426	Compliance Determination # 36058
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In an interview, on 03/13/2024 at 10:13 AM, Staff C (Director of Wellness) confirmed that Staff D was currently providing care and services at the ALF. Staff C stated that she was not aware that Staff D's credentials had expired.

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) 5/17/2024 12.

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

Administrator (or Representative) — Date: 4/10/2024