STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Kirkland Partners LLC
Madison House
12215 NE 128th St
Kirkland, WA 98034

RE: Madison House License # 2436

Dear Administrator:

This letter addresses Compliance Determination(s) 42860 (Completion Date 06/18/2024) and 39742 (Completion Date 04/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/18/2024 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-2483-1, WAC 388-78A-2483-2, WAC 388-78A-2483, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2484

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for an unannounced on-site follow-up on 04/15/2024, 04/15/2024, 04/16/2024, and 04/15/2024 of:

Madison House
12215 NE 128th St
Kirkland, WA 98034

This document references the following SOD dated: 04/18/2024

The following sample was selected for review during the unannounced on-site visit: 10 of 61 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Laurie Anderson — Residential Care Services

04/26/2024 — 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) 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

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 1 of 2 sampled staff (Staff E) was tested for tuberculosis. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 02/14/2024, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 03/30/2024.

Review of the facility's undated policy titled, "Tuberculosis Testing", showed the facility followed the Washington Administrative Code (WAC) on tuberculosis (TB) testing requirements. The policy showed the facility required all employees be tested for TB.

STAFF E
Review of the facility's Employee Roster showed the facility hired Staff E on 10/01/2021 as a Resident Assistant. Review of Staff E's personnel file showed that Staff E completed a two-step TB skin test, the first step completed on 02/29/2020 and the second completed on 03/07/2020. The two-step TB skin tests showed negative results. There was no documentation that showed Staff E completed a one-step TB skin test when hired on 10/01/2021, as required.

During an interview on 04/15/2024 at 1:40 PM, Staff A, Executive Director, stated that they were responsible for maintaining the TB documentation in the personnel files for all employees. Staff A stated that they reviewed the TB documents for all employees as their plan of correction to the full inspection. Staff A stated that they were unaware the staff with a history of a negative result from a previous two step skin test required to have one TB

test. Staff A stated that they did not complete a one-step TB test for Staff E.

This is an uncorrected deficiency previously cited on 02/14/2024.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 5.29.24 .

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

Administrator (or Representative) 5.3.24 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

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 2 sampled staff (Staff V) for tuberculosis (TB), as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 02/14/2024, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 03/30/2024.

Review of the facility's undated policy titled, "Tuberculosis Testing", showed the facility followed the Washington Administrative Code (WAC) on TB testing requirements. The policy showed the facility required all employees be tested for TB.

STAFF V
Review of the facility's Employee Roster showed that the facility hired Staff V, Director of

test. Staff A stated that they did not complete a one-step TB test for Staff E.

This is an uncorrected deficiency previously cited on 02/14/2024.

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

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

Administrator (or Representative) Date

WAC 388-78A-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

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 2 sampled staff (Staff V) for tuberculosis (TB), as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 02/14/2024, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 03/30/2024.

Review of the facility's undated policy titled, "Tuberculosis Testing", showed the facility followed the Washington Administrative Code (WAC) on TB testing requirements. The policy showed the facility required all employees be tested for TB.

STAFF V
Review of the facility's Employee Roster showed that the facility hired Staff V, Director of

Resident Services, on 04/01/2024. Review of Staff V's personnel records showed that the facility completed one TB test on 04/05/2024, with a negative result. The records showed the TB test was completed five days after Staff V was hired. There was no documentation that showed Staff V required no skin testing or only one test.

During an interview on 04/15/2024 at 1:40 PM, Staff A, Executive Director, confirmed that the facility hired Staff V on 04/01/2024. Staff A stated that the facility completed the first step of the two-step skin test for Staff V on 04/05/2024.

This is an uncorrected deficiency previously cited on 02/14/2024.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 5.29.24 .

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

Administrator (or Representative) 5.3.24 Date

Resident Services, on 04/01/2024. Review of Staff V's personnel records showed that the facility completed one TB test on 04/05/2024, with a negative result. The records showed the TB test was completed five days after Staff V was hired. There was no documentation that showed Staff V required no skin testing or only one test.

During an interview on 04/15/2024 at 1:40 PM, Staff A, Executive Director, confirmed that the facility hired Staff V on 04/01/2024. Staff A stated that the facility completed the first step of the two-step skin test for Staff V on 04/05/2024.

This is an uncorrected deficiency previously cited on 02/14/2024.

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

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 01/30/2024, 01/30/2024, 02/02/2024, 02/12/2024 and 02/02/2024 of:
Madison House
12215 NE 128th St
Kirkland, WA 98034

The following sample was selected for review during the unannounced on-site visit: 7 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

Residential Care Services _____ Date _____

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

Administrator (or Representative) Date

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 2 of 2 sampled pets (Pet 1 and Pet 2) received regular examinations and were certified by a veterinarian to be free of disease transmittable to humans. These failures placed all residents at risk of contracting illnesses spread by pets.

Findings included…

Review of the facility's undated policy titled, "Pet Ownership", showed that the facility permitted small pets to live on the premises. The policy showed the facility required pet owners to provide the pet and veterinary records that included proof of licensing and registration, current rabies vaccination record, negative results of a flea "dip" test, and record of other vaccines as required.

Review of the facility's pet records showed that Pet 1 and Pet 2 were current with their rabies vaccinations. There was no documentation that showed Pet 1 and Pet 2 were examined by a veterinarian. There was no documentation that showed Pet 1 and Pet 2 were certified by a veterinarian to be free of infectious diseases.

Observation on 02/01/2024 at 1:35 PM showed a dog (Pet 2) walked around inside Apartment [redacted]. Observation of the apartment showed a dog dish and a dog bed inside the bathroom. During an interview at this time, Resident 6 stated that Pet 2 was their pet.

During an interview on 01/30/2024 at 3:30 PM, Staff S, Business Office Manager, stated that two pets Pet 1 and Pet 2 resided in the assisted living facility. Staff S stated that they maintained the pet records. Staff S stated that they were unaware of the WAC regulation for pets living in the assisted living facility. Staff S stated that they maintained only the rabies vaccination for Pet 1 and Pet 2 and ensured the pets' rabies vaccination statuses were valid. Staff S stated that they did not request the other pet records for Pet 1 and Pet 2. Staff

S stated that they were unaware if Pet 1 and Pet 2 received regular veterinarian examination. Staff S stated that they were unaware if the pets were certified by a veterinarian to be free of human transmittable diseases.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility failed to submit the Washington state name and date of birth background check for 3 of 26 sampled staff (Staff C, Staff N, and Staff Q) and 1 of 1 sampled contracted staff (Staff T) within one business day after their start date. This failure placed all residents as risk for abuse and neglect from caregivers and staff persons with unknown background.

Findings included…

Review of the facility's undated background check policy showed that the facility maintained a personnel file for each employee. The policy showed that the personnel file included the employee's employment start date and end date and their background check documents. The policy showed that the facility maintained all employee file records for at least twelve months after the employee's last date of employment or service.

STAFF C
Review of the facility's Employee Roster showed that the facility hired Staff C on 04/04/2023 as a Resident Assistant. Review of Staff C's employee record showed that on 03/31/2023, Staff C completed and signed a Department of Social and Health Services (DSHS) Background Check Authorization form. There was no documentation that showed

the facility submitted the background check within one day of Staff C starting work. The records showed that on 09/08/2023, the facility completed the Washington State name and date of birth background check (BGI), 157 days after Staff C started work.

STAFF N
Review of the facility's Employee Roster showed that the facility hired Staff N on 07/22/2023 as a Culinary Aide. Review of Staff N's employee records showed no documentation that the facility submitted a background check within one day of Staff N starting work. The records showed that on 09/11/2023, the facility completed a Washington State name and date of birth BGI, 51 business days after Staff N started work.

STAFF Q
Review of the facility's Employee Roster showed that the facility hired Staff Q on 10/01/2021 as a Licensed Nurse. Review of Staff Q's employee record showed no documentation that the facility submitted a background check within one day of Staff Q starting work. The records showed that on 09/18/2023, the facility completed a Washington State name and date of birth BGI, 717 days after Staff Q started work.

STAFF T
Review of the facility's Nurse Delegation documents showed that Staff T, Registered Nurse Delegator, provided nurse delegation services at the Assisted Living Facility between April 2023 and February 2024. There was no documentation that showed the facility completed a Washington State name and date of birth BGI for contracted Staff T.

During an interview on 01/31/2024 at 12:15 PM, Staff S, Business Office Manager, confirmed that the hire date was considered the start date of work for all employees. Staff S stated that they were unaware of why the facility did not submit the background check authorizations to DSHS for Staff C, Staff N, or Staff Q within one business day of hire. Staff S stated that they were unaware background checks were not completed on-time and that the facility was out of compliance with the Washington State Administrative Codes for Assisted Living Facilities.

During an interview on 02/02/2024 at 1:30 PM, Staff A, Executive Director, stated that the facility hired Staff T as the Registered Nurse Delegator with the start date 10/12/2021. Staff A stated that Staff T worked continuously between 10/12/2021 and 02/02/2024. Staff A stated that Staff T's responsibilities included resident assessments and supervision of delegated Medication Technicians (unlicensed staff who dispenses and administers medications). Staff A stated that Staff T had unsupervised access to residents when they provided nurse delegation services to residents. Staff A stated that they were unaware there was a contracted Nurse Delegation agreement between Staff T and the ALF. Staff A stated that they were unaware the facility was responsible to complete a BGI for contracted staff. Staff A stated that the facility did not submit and complete a background check for Staff T when the facility hired them.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Madison House is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State name and date of birth background check (BGI) every two years for 9 of 26 sampled staff (Staff E, Staff H, Staff I, Staff J, Staff K, Staff M, Staff O, Staff P, and Staff R). This failure placed all residents at risk of abuse, neglect, or exploitation from caregivers and staff persons with unknown backgrounds.

Findings included…

Review of the facility’s undated background check policy showed that the facility maintained a personnel file for each employee. The policy showed that the personnel file included the employee’s start date and end date of employment and background check documents. The policy showed that the facility maintained all employee file records for at least 12 months after any employee’s last date of employment or service.

STAFF E
Review of the facility's Employee Roster showed the facility hired Staff E on 10/01/2021 as a Resident Assistant. Review of Staff E's employee records showed their previous Washington state name and date of birth BGI expired on 08/13/2021. The records showed that the facility submitted and completed a BGI on 10/28/2023, 76 days after the previous BGI expired.

STAFF H
Review of the facility's Employee Roster showed the facility hired Staff H on 10/11/2021 as a Physical Plant Director. Review of Staff H's employee records showed their previous Washington state name and date of birth BGI expired on 10/13/2023. The records showed that the facility submitted and completed a BGI on 11/02/2023, 20 days after the previous BGI expired.

STAFF I
Review of the facility's Employee Roster showed the facility hired Staff I on 05/24/2021 as a Resident Assistant. Review of Staff I's employee records showed their previous Washington state name and date of birth BGI expired on 05/21/2023. The records showed that the facility submitted and completed a BGI on 10/28/2023, 160 days after the previous BGI expired.

STAFF J
Review of the facility's Employee Roster showed the facility hired Staff J on 08/12/2019 as a Licensed Nurse. Review of Staff J's employee records showed their previous Washington state name and date of birth BGI expired on 01/22/2023. The records showed that the facility submitted and completed a BGI on 10/28/2023, 279 days after the previous BGI expired.

STAFF K
Review of the facility's Employee Roster showed the facility hired Staff K on 03/11/2021 as a Server. Review of Staff K's employee records showed their previous Washington state name and date of birth BGI expired on 03/11/2023. The records showed that the facility submitted and completed a BGI on 06/23/2023, 104 days after the previous BGI expired.

STAFF M
Review of the facility's Employee Roster showed the facility hired Staff M on 07/20/2021 as a Utility Staff. Review of Staff M's employee records showed their previous Washington state name and date of birth BGI expired on 07/15/2023. The records showed that the facility submitted and completed a BGI on 10/28/2023, 105 days after the previous BGI expired.

STAFF O
Review of the facility's Employee Roster showed the facility hired Staff O on 04/28/2021 as a Resident Assistant. Review of Staff O's employee records showed their previous Washington state name and date of birth BGI expired on 04/28/2023. The records showed that the facility submitted and completed a BGI on 06/08/2023, 41 days after the previous BGI expired.

STAFF P
Review of the facility's Employee Roster showed the facility hired Staff P on 06/16/2021 as a Resident Assistant. Review of Staff P's employee records showed their previous

Washington state name and date of birth BGI expired on 06/15/2023. The records showed that the facility submitted and completed a BGI on 10/28/2023, 134 days after the previous BGI expired.

STAFF R
Review of the facility's Employee Roster showed the facility hired Staff R on 08/04/2021 as a Medication Technician. Review of Staff R's employee records showed their previous Washington state name and date of birth BGI expired on 01/27/2024The records showed that the facility submitted and completed a BGI on 02/02/2024, six days after the previous BGI expired, during the licensing inspection.

During an interview on 01/31/2024 at 12:15 PM, Staff S, Business Office Manager, stated that they were responsible for completion of the staff background checks for all employees. Staff S stated that when they were hired in September 2023, they were unaware there were expired staff BGIs. Staff S stated that they were aware the facility was required to maintain a valid background checks for all staff.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Madison House is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-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

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 2 of 7 sampled staff (Staff C and Staff E) was screened and tested for tuberculosis. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the facility's undated policy titled, "Tuberculosis Testing", showed the facility followed the Washington Administrative Code (WAC) on tuberculosis (TB) testing requirements. The policy showed the facility required all employees be tested for TB.

STAFF C
Review of the facility's Employee Roster showed the facility hired Staff C on 04/04/2023 as a Resident Assistant. Review of Staff C's personnel records showed documentation that on 05/16/2022, Staff C completed a one-step TB skin test, with a negative result, 11 months prior to Staff C's hire date. There was no documentation that showed Staff C completed another one-step test when hired, as required.

STAFF E
Review of the facility's Employee Roster showed the facility hired Staff E on 10/01/2021 as a Resident Assistant. Review of Staff E's personnel file showed that Staff E completed a two-step TB skin test, the first step completed on 02/29/2020 and the second completed on 03/07/2020. The two-step TB skin tests showed negative results. There was no documentation that showed Staff E completed a one-step TB skin test when hired on 10/01/2021, as required.

During an interview on 01/31/2024 12:15 PM, Staff S, Business Office Manager, stated that they were responsible for maintaining the TB documentation in the personnel files for all employees. Staff S stated that they were unfamiliar with the TB testing requirements per the WAC. Staff S stated that when they were hired as the Business Office Manager in September 2023, Staff E was already employed at the facility. Staff S stated that they did not check employee records for staff already employed. Staff S stated that they were unaware Staff C and Staff E did not complete a one-step TB test within three days of employment, when they were hired.

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

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-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

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to screen and test 5 of 5 sampled staff (Staff G, Staff H, Staff I, Staff L, and Staff P) for tuberculosis (TB), as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the facility's undated policy titled, "Tuberculosis Testing", showed the facility followed the Washington Administrative Code (WAC) on TB testing requirements. The policy showed the facility required all employees be tested for TB.

STAFF G
Review of the facility's Employee Roster showed that the facility hired Staff G on 04/26/2023 as an Environmental Aide. Review of Staff G's personnel records showed no documentation that Staff G was screened for tuberculosis.

During an interview on 02/02/2024 at 12:09 PM, Staff G stated that they started in the caregiver position at the facility in April 2023. Staff G stated that they provided direct care to residents. Staff G stated that when the facility hired them, the facility did not screen and test them for TB. Staff G stated that they thought they provided the facility a chest x-ray with negative result to the facility at hire. Staff G stated that they previously tested for TB, with negative results. Staff G stated that they always tested negative for TB.

STAFF H
Review of the facility's Employee Roster showed the facility hired Staff H on 10/11/2021 as a Physical Plant Director. Review of Staff H's personnel records showed that Staff H completed a two-step TB skin test, step one on 10/28/2021 and step two on 11/16/2021. The tests results were negative. The records showed the facility screened Staff H for TB 17 days after Staff H started employment at the facility.

STAFF I
Review of the facility's Employee Roster showed the facility hired Staff I on 05/24/2021 as a Resident Assistant. Review of Staff I's personnel records showed that on 06/26/2019, Staff I took an Quantiferon-TB Gold Plus test (an Interferon Gamma Release Assays [IGRA], a blood test for TB) with negative results. The records showed no documentation that staff I was screened and tested for TB within three days of hire, as required.

STAFF L

Review of the facility's Employee Roster showed the facility hired Staff L on 11/01/2023 as a Resident Assistant. Review of Staff L's personnel records showed documentation that on 11/03/2023, Staff L completed a one-step TB skin test with a negative result. The records showed no documentation that Staff L completed the second TB skin test, as required. There was no documentation that showed a history of any other TB test results.

STAFF P
Review of the facility's Employee Roster showed the facility hired Staff P on 06/16/2021 as a Resident Assistant. Review of Staff P's personnel records showed that Staff P completed a two-step TB skin test, the first step completed on 06/28/2021 and the second step completed on 07/20/2021. The two-step TB skin tests showed negative results. The records showed the facility screened Staff P for TB 12 days after Staff P started employment at the facility.

During an interview on 01/31/2024 12:15 PM, Staff S, Business Office Manager, stated that they were responsible for maintaining the TB documentation in the personnel files for all employees. Staff S stated that they were unfamiliar with the TB testing requirements per the WAC. Staff S stated that when they were hired as the Business Office Manager in September 2023, Staff C, Staff G, Staff H, Staff I, and Staff P were already employed at the facility. Staff S stated that they were unaware there was no TB documentation for Staff G. Staff S stated that they were unaware staff was required to be screened for TB within three days of employment. Staff S stated that they did not complete the TB test for Staff H and Staff P on time. Staff S stated that since Staff I took an IGRA two years prior to their date of hire, Staff S did not know TB screening was still required. Staff S stated that they did not know why Staff L's second skin test was not completed.

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

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 1 of 1 sampled staff (Staff D) were screened for tuberculosis. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the facility's undated policy titled, "Tuberculosis Testing", showed the facility followed the Washington Administrative Code (WAC) on TB testing requirements. The policy showed the facility required all employees be tested for TB.

Review of the facility's Employee Roster showed the facility hired Staff D on 03/13/2023 as a Resident Assistant. Review of Staff D's personnel records showed that on 07/11/2022, Staff D received a chest x-ray with a positive result "indicating the possibility of active TB" and that Staff D was referred by health care provider to the TB clinic for follow-up treatment. There was no documentation that showed Staff D followed up with the health care provider's recommendation to complete the therapy for TB. There was no documentation that showed Staff D was evaluated for signs and symptoms of TB. There was no documentation that showed Staff D completed a chest X-ray within seven days of hire.

During an interview on 01/31/2024 12:15 PM, Staff S, Business Office Manager, stated that they were responsible for maintaining the TB documentation in the personnel files for all employees. Staff S stated that they were unfamiliar with the TB testing requirements per the WAC. Staff S stated that they were aware that in July 2022, Staff D tested positive for active TB. Staff S stated that they were unaware if Staff D received treatment for active TB. Staff S stated that they did not realize the facility was required to screen Staff D for TB.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during

employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to maintain the continuing education training records for 2 of 2 sampled Staff (Staff E and Staff U). This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the facility's Resident Assistant Job Description showed that the facility required Resident Assistant staff to be certified as a Certified Nursing Assistant (CNA) within 120 days of hire. The document showed that the Resident Assistant staff were required to follow the CNA certification requirements in accordance with the Washington state regulations that included maintaining Continuing Education (CE) and licensure requirements.

Review of the facility's Employee Schedules showed that Staff E, Resident Assistant, and Staff U, Resident Assistant, worked in December 2023 and January 2024.

STAFF E
Review of the facility's Employee Roster showed that the facility hired Staff E on 10/01/2021 as a Resident Assistant. The roster showed Staff E's birth month was October. Review of Staff E's employee record showed that Staff E's Nursing Assistant Certification was in active status. The record showed between October 2022 and October 2023, Staff E completed a total of 5.75 CE hours of the Washington state Department of Social and Health Services (DSHS) approved Continuing Education. Staff E was 6.25 hours short of the required 12 CE hours.

STAFF U
Review of the facility's Employee Roster showed that the facility hired Staff U on 05/25/2015 as a Resident Assistant. The roster showed Staff U's birth month was June. Review of Staff U's employee record showed Staff U's Nursing Assistant Certification was in active status. The records showed no CE documentation for Staff U.

During an interview on 02/02/2024 at 1:30 PM, Staff A, Executive Director, stated that they maintained Staff E and Staff U's credential and training documents in the employee records. Staff A confirmed that the facility hired Staff E and Staff U as Resistant Assistant. Staff A stated that Staff E and Staff U were a CNA, and their credential status was active.

Staff A stated that they thought Staff E and Staff U completed the continuing education courses since Staff E and Staff U's credentials were in active status. Staff A stated that they were unaware the facility was required to maintain the staff's CE certification documents. Staff A stated that they were unaware the staff did not submit their CE certificates for the facility's personnel records.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) 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 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess 3 of 3 sampled residents (Resident 4, Resident 7, and Resident 9) for their ability to use a medical device. This failure placed Resident 4, Resident 7, and Resident 9 at risk for possible entrapment and injury.

Review of the facility's document titled, "Side Rail Policy", dated 01/18/2021, showed a physical therapy evaluation for bedrail or side rail assessment or least restrictive therapeutic device for safety and or positioning would be obtained. The document showed that ongoing assessments would be done on all residents with bedrails or side rails. The document showed a bedrails algorithm (a process followed in calculations) to determine if a resident was appropriate for a bedrail or side rail. The document also showed a "Bedrail Risk Assessment" would be filled out when a resident used bedrails or side rails.

RESIDENT 4
Review of the facility's characteristic roster showed that the facility admitted Resident 4 in [redacted] 2017.

Observation of Resident 4's apartment on 02/02/2024 at 8:38 AM, showed a hospital bed with an alternating pressure relieving mattress on top of the regular mattress. At the head of the bed, there were two half-length side rails on each side. Observation showed that the side rails were secured to the frame of the bed with a bracket. The side rails were loose which allowed the side rails to bend outward away from the mattress with zero to minimal pressure. When the side rails were used, the pressure created a gap greater than four inches between the side rail and the mattress.

Review of Resident 4's Service Plan, dated 10/13/2023, showed that Resident 4 required two-person extensive assistance with repositioning and transfers. The service plan showed Resident 4 used a hospital bed with half-length side rails to assist staff with repositioning or transfers.

Review of Resident 4's records showed that on 01/26/2024, Resident 4 signed a consent form to use a bedrail or side rail enabler. The form showed that Resident 4 understood the risks involved when side rails were used for repositioning. The consent form showed Resident 4 had no cognitive impairment that affected their ability to use the side rails.

Review of Resident 4's records showed no documentation that a physical therapist completed an assessment for bedrails or side rails. There was no assessment completed to determine if the side rails were safe to use, were correctly secured, and if the space between the mattress and side rail prevented any possible entrapment.

RESIDENT 7
Review of the facility's characteristic roster showed that the facility admitted Resident 7 in [redacted] 2022.

Observation of Resident 7's apartment on 02/01/2024 at 8:08 AM, showed a hospital bed in the bedroom. There were two half-length side bed rails attached to the bed, one on each side at the head of the bed. Observation showed the side rails were secured to the frame of the bed with a bracket. The attached side rails were sturdy. Observation of the living room showed a metallic transfer pole securely mounted to the floor and ceiling. The transfer pole was next to a recliner. During an interview at this time, Resident 7 stated that they used the bed rails for transfers between the wheelchair and the bed and repositioning in bed. Resident 7 stated that they used the transfer pole for transfers between the wheelchair and the recliner every day. Resident 7 stated that they bought the transfer pole and notified the facility for installation. Resident 7 stated that the facility staff installed the transfer pole for them. Resident 7 stated that they were unaware the bed rails and transfer pole required a regular assessment and maintenance.

Review of Resident 7's records showed that on 01/26/2024, Resident 7 signed a consent form to use a bedrail or side rail enabler. Resident 7 signed a consent form to use a transfer pole. The forms showed that Resident 7 understood the risks involved when the side rails and transfer pole were used for repositioning and transfers.

Review of Resident 7's Assessment, dated 01/26/2024, showed that Resident 7 used the half-length side rails as enablers for bed mobility. There was no documentation that showed a physical therapist completed an assessment for bedrails or side rails. There was no documentation that showed the facility assessed Resident 7's ability to use the transfer pole.

RESIDENT 9
Review of the facility's characteristic roster showed that the facility admitted Resident 9 in [redacted] 2020.

Review of Resident 9's Assessment dated 01/31/2024, showed that Resident 9 used a hospital bed with half-length side rails attached.

Review of Resident 9's records showed that on 01/31/2024, Resident 9 signed a consent form to use a bedrail or side rail enabler. The form showed that Resident 9 understood the risks involved when side rails were used for repositioning. The consent form showed Resident 9 had no cognitive impairment that affected their ability to use the side rails.

Review of Resident 9's records showed no documentation that a physical therapist completed an assessment for bedrails or side rails. There was no assessment completed to determine if the side rails were safe to use, were correctly secured, and if the space between the mattress and side rail prevented any possible entrapment.

During an interview on 02/02/2024 at 10:30 AM, Staff B, Licensed Practical Nurse (LPN), Director of Resident Services, stated that the facility only used the consent form as the assessment for residents who used a medical device. Staff B stated that there was no separate policy or assessment for residents who used a transfer pole. Staff B confirmed that they did not complete medical device assessments for Resident 4, Resident 7, and Resident 9. Staff B stated that the corporation planned to update the policy and develop a new bedrail risk assessment tool to determine whether the use of a bedrail or side rail enabler device presented a risk of injury to the resident. During the interview Staff B stated that there was not a system in place for ongoing assessments.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

(6) The assisted living facility must require that whenever a resident's family provides medication assistance or medication administration services, the resident's significant medications remain on the assisted living facility premises whenever the resident is on the assisted living facility premises.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete a written family medication assistance plan for 4 of 4 sampled residents (Resident 2, Resident 9, Resident 10, and Resident 11) and failed to keep Resident 2’s significant medications on-site. This failure placed Resident 2, Resident 9, Resident 10, and Resident 11 at risk for not receiving their medications as prescribed.

Findings included…

Review of the facility's document titled, "Family Assistance with Medications and/or Treatments Policy", dated 01/15/2021, showed that the facility followed Washington State Administrative Code 388-78A-2290. The policy showed that the resident’s family and/or responsible party must sign a written plan.

RESIDENT 2

Review of the facility's Characteristics Roster showed that the facility admitted Resident 2 in [redacted] 2021.

Observation on 02/01/2024 at 10:08 AM, showed a mediset sat on top of Resident 2's dining room table. The mediset (pill organizer labeled for each day of the week) had compartments labeled for each day of the week and for specific times of the day. Multiple compartments were filled with pills. Observation showed that Resident 2's significant medications were not on-site and were not available while Resident 2 was on the premises.

Review of Resident 2's Service Plan dated 01/31/2024 showed that Resident 2 "self-managed" their medications. The Service Plan did not show Resident 2 used a mediset to administer their medications. The service plan did not show who filled the mediset.

Review of Resident 2's record found no documentation of a family plan that showed who filled the mediset, the individual's contact information, the signatures of the responsible individuals, and the back-up plan for when the family member was unable to fill the mediset.

During an interview on 02/01/2024 at 10:08 AM, Resident 2 stated that a family member filled the mediset for them once a week. Resident 2 stated that their family member kept most of the medications with them and brought them in to fill the Medi-set.

During an interview on 02/02/2024 1:15 PM, Staff B, Licensed Practical Nurse, Director of Resident Services, stated that Resident 2's significant medications were not on-site. Staff B stated they would request Resident 2's family member to bring the medications back on-site.

RESIDENT 9
Review of the facility's Characteristics Roster showed that the facility admitted Resident 9 in [redacted] of 2020. An external email from Staff B, dated 02/08/2024, showed that Resident 9 moved from Independent Living to Assisted Living in [redacted] of 2021.

Review of Resident 9's Assessment dated 01/31/20240 showed that Resident 9 "self-managed" their own medications. The Assessment showed Resident 9's daughter filled the mediset. There was no documentation that explained who the backup person was and their contact information.

RESIDENT 10
Review of the facility's Characteristics Roster showed that the facility admitted Resident 10 in [redacted] of 2023.

Review of Resident 10's Service Plan dated 12/21/2023 showed that Resident 11 "self-managed" their medications. The plan showed that Resident 10 used a mediset. The plan

showed that Resident 10's son set-up the mediset and the son's best friend was the backup. The plan did not provide the identity of the best friend and their contact information for when the son was unavailable to fill the mediset.

Review of Resident 10's records showed there was no written plan for family assistance with medication that identified who filled Resident's 10 mediset, the emergency contact information, and the backup plan for when the responsible individual was unavailable to fill the mediset.

RESIDENT 11
Review of the facility's Characteristics Roster showed that the facility admitted Resident 11 in [redacted] of 2024.

Review of Resident 11's Service Plan, dated 01/29/2024, showed that Resident 11 "self-managed" their medications. The service plan showed that Resident 11's son filled the mediset.

Review of Resident 11's records showed that on 02/02/2024, a family medication assistance plan was completed.

During an interview on 02/02/2024 1:15 PM, Staff B, stated that there were other Assisted Living Residents who self-medicated and received family assistance with their medications. Staff B stated that they were unaware of any family plans for any of the residents who self-medicated with family assistance.

During an interview on 02/02/2024 at 1:15 PM, Staff B stated that the family medication assistance documents were not done prior to 02/02/2024 for Resident 2, Resident 9, Resident 10, and Resident 11.

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) 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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 1 sampled resident (Resident 1) received medications as prescribed in a safe manner. This failure placed Resident 1 at risk for compromised health and not receiving medications as prescribed.

Findings included…

Review of the facility's undated policy titled, "Medication Services", defined medication administration as when a resident is not physically able to ingest or apply medication independently or with assistance, staff legally authorized to administer medications provided the assistance. The policy showed that nursing services provided by the facility were planned and supervised. The policy showed that staff who provided medication administration assistance were appropriately trained and would document medication name, time, and dosage in resident's record.

RESIDENT 1
Review of Resident 1's Move-In Record showed the facility admitted resident on [redacted]/2022.

Review of Resident 1's Service Plan, dated 01/19/2023, showed the facility staff maintained all of Resident 1's medications. The plan showed that facility staff provided assistance with medication administrations and treatments.

Review of Resident 1's January 2024 and February 2024 electronic medication administration record (eMAR) showed an order for Voltaren 1% gel (topical pain ointment) two grams (gms)to be applied topically to affected knees, typically four times a day.

Observation and interview on 02/02/2024 at 11:12 AM, showed Staff F, Medication Technician, (Med Tech; unlicensed staff who dispense and administer medications) reviewed Resident 1's February 2024 eMAR. Staff F removed the box of Voltaren from the medication cart. From the Voltaren box, Staff F removed the measuring strip that was affixed to the medication instructions. Staff F stated that the strip was used to measure the amount of Voltaren to be applied. Observation showed Staff F held the measuring strip in a vertical position and held the tube of Voltaren with the other hand, then squeezed an unknown amount of the ointment into a medicine cup. Staff F looked at the medicine cup, picked-up the measuring strip, held it vertically and attempted to push the measuring strip down into the medicine cup to measure the amount of Voltaren ointment inside. Observation showed Staff F attempted several times to push the measuring strip into the ointment in the medicine cup. The strip was too wide to fit into the cup. Observation showed Staff F was unsure of how to measure the prescribed amount of the Voltaren. Observation showed Staff Q, Registered Nurse, walked over to Staff F to show Staff F how to correctly measure the Voltaren. Observation showed Staff Q discard the used medicine cup with the Voltaren inside. Staff Q laid the measuring strip flat on the cart. Staff Q then squeezed out to two gms of Voltaren ointment onto the measuring strip. Observation showed Staff Q removed the Voltaren ointment from the measuring strip and placed the ointment into a new medicine cup. Observation showed a second unmarked medicine cup for unidentified resident on top of the medicine cart with a similar ointment that looked like Voltaren. Staff F confirmed that the second cup of ointment was Voltaren for a different, unidentified resident.

During an interview on 02/02/2024 at 11:12 AM, Staff Q confirmed Staff F incorrectly dispensed the Voltaren and they would show Staff F how to measure the amount of Voltaren correctly.

During an interview on 02/02/2024 at 1:45 PM, Staff F stated that after Staff Q showed them the proper way to measure the Voltaren, they discarded the unidentified resident medication cup and remeasured the amount of Voltaren the correct way.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to obtain the written consent from the resident or their representative prior to nurse delegation for 1 of 1 sampled resident (Resident 8) and failed to assess and implement nurse delegation services for 1 of 1 sampled resident (Resident 1). These failures placed the residents at risk for medication errors and potential decline in their health when unqualified staff provide care.

Findings included…

DISCLOSURE OF SERVICES
Review of the facility's Disclosure of Services showed the facility used nursing assistants to administered drops, oral, and topical medications under delegation of a Registered Nurse.

Review of the facility's Medication Aide Assisted or Delegated document, dated 07/28/2022, showed that administered medications must be delegated by a Registered Nurse. The document showed that hand over hand was considered administrated and required nurse delegation.

RESIDENT 8
Review of the facility's Characteristic Roster showed that the facility admitted Resident 8 in [redacted] 2023 with a medical diagnosis of [redacted]

Review of the facility's nurse delegation records showed that on 04/17/2023, Staff T, Registered Nurse Delegator, initially delegated Medication Technicians (unlicensed staff who was delegated to administer medications) to administer blood sugar testing for Resident 8. The records showed that between 07/13/2023 and 01/31/2024, Staff T delegated Medication Technicians (unlicensed staff who dispense and administer medications) to administer blood sugar testing and topical medications for Resident 8. The records showed that as of 01/31/2024, Resident 8 or their representative did not sign and date the consent form for nurse delegation. There was no documentation that showed Resident 8, or their representative, provided verbal consent to the nurse delegation.

During an interview on 02/02/2024 at 8:40 AM, Staff B, Director of Resident Services, confirmed that between 04/17/2023 and 01/31/2024, Resident 8 received nurse delegation. Staff B stated that they maintained the nurse delegation documentation for Resident 8. Staff B stated that they did not find any Nurse Delegation consent form signed and dated by Resident 8 or their representative. Staff B stated that they did not find

documentation that showed Resident 8 or their representative provided verbal consent for nurse delegation.

RESIDENT 1
Review of Resident 1's Move-In Record showed the facility admitted resident on [redacted]/2022.

Review of Resident 1's Service Plan, dated 01/19/2023, showed a diagnosis of [redacted] and the facility staff maintained all of Resident 1's medications. The plan showed the facility staff assisted with medication administration and treatments. There was no documentation that showed Resident 1 received nurse delegation services for medication administration.

Review of Resident 1's January 2024 and February 2024 electronic medication administration records (eMAR) showed that Resident 1 received prescription medications and over the counter medications. The eMARs showed staff signed off when medications were administered. The eMARs showed an order "may crush medication" for Vitamin D3 tabs 25 micrograms.

Observation on 02/01/2024 at 2:29 PM, showed Resident 1 sat in a recliner in their apartment. Observation showed Staff F, Medication Technician administered Resident 1's medications, crushed in applesauce, with a spoon.

During an interview on 02/02/2024 at 10:00 AM, Staff F stated that they crushed most of Resident 1's medications and mix them in applesauce. Staff F stated that they explained to Resident 1 what they were doing and what medications were being administered. Staff F stated that they gave Resident 1 a drink of water, then used a spoon to place the crushed medications into Resident 1's mouth. Staff F stated that they used a spoon to place the uncrushed pills, potassium, and gabapentin, into Resident 1's mouth. Staff F stated that they give Resident 1 plenty of water to swallow the medications. Staff F stated that Resident 1 had difficulty swallowing.

During the exit conference on 02/02/2023 at 2:30 PM, Staff B, stated that they were unaware that the Med Techs administered Resident 1's medications. Staff B stated that Resident 1 needed to have nurse delegation for medication administration.

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

02/21/2024

Kirkland Partners LLC
Madison House
12215 NE 128th St
Kirkland, WA 98034

RE: Madison House # 2436

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/14/2024 and found that your facility does not meet the Assisted Living Facility requirements.

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

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately;
• Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

• Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  o Sign and date the enclosed report;
  o For each deficiency, indicate the date you have or will correct each deficiency;
  o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

The Assisted Living Facility failed to ensure that 2 of 14 sampled kitchen staff and caregivers (Staff E and Staff F) maintained a current food handlers' card. Review of the facility job description for caregivers showed all caregivers were required to have a current food handlers' card. On 01/31/2024, Staff E and Staff F completed online food handler training.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:
• Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure