STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

RP Operations, LLC
Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

RE: Rose Pointe Assisted Living License # 2452

Dear Administrator:

This letter addresses Compliance Determination(s) 46189 (Completion Date 08/26/2024) and 45082 (Completion Date 08/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/26/2024 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-2730-1-b

The Department staff who did the off-site verification:
Joy Pipgras, LTC Surveyor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 08/01/2024 and 08/01/2024 of:
Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

This document references the following SOD dated: 08/01/2024

The following sample was selected for review during the unannounced on-site visit: 5 of 90 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Joy Pipgras, LTC Surveyor
Brian Zbylski, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Michelle R. Closner
Residential Care Services

08/08/2024
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)

8.12.24
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were fit tested with an N95 respirator (is a protective device designed to achieve a close facial fit and efficient filtration of airborne particles) for 5 of 5 sampled staff (Staff A, B, C, D and E). This failure placed residents at risk for exposure to respiratory infection.

Findings Included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (test completed by specially trained personnel to ensure N95 respirator seal effectively reducing chance of exposure to respiratory viruses), and provide effective training before employees are assigned duties that may require the use of respirators.

Per WAC 296-842-15005, facilities must conduct fit testing before employees are assigned duties that may require the use of respirators.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to "follow regulations pertaining to respiratory protection" including respirator fit testing for long term care workers.

Review of the facility's respiratory protection program (RPP) showed that KN95 respirator (model 9502+) were used for staff fit testing.

Review of Staff A's, Executive Director, undated personnel file showed it did not contain records for the required National Institute for Occupational Safety and Health (NIOSH) approved N95 respirator fit test.

Review of Staff B's, Med Tech, undated personnel file showed it did not contain records for the required NIOSH approved N95 respirator fit test.

Review of Staff C's, Caregiver, undated personnel file showed it did not contain records for the required NIOSH approved N95 respirator fit test.

Review of Staff D's, Caregiver, undated personnel file showed it did not contain records for the required NIOSH approved N95 respirator fit test.

Review of Staff E's, Med Tech, undated personnel file showed it did not contain records for the required NIOSH approved N95 respirator fit test.

In an interview on 08/01/2024 at 4:07 PM, Staff A, Executive Director, stated that they had been fit testing their staff with KN95 respirator. In an observation at that time, Staff A provided the department with a sample respirator that did not show a NIOSH approval on the respirator or the packaging.

This is an uncorrected deficiency previously cited on 06/18/2024.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8-17-24.

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

Administrator (or Representative) 8.12.24 Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 131901
Compliance Determination #: 42717
Region/Unit #: RCS Region 1 / Unit B
Investigator: Patty Ford
Investigation Date(s): 06/06/2024 through 06/18/2024
Complainant Contact Date(s): 06/25/2024

Allegation(s):

1. Resident was quarantined
2. Non-availability of medications
3. Lack of resident care
4. Care plans not updated
5. Staff credential
6. Food service

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 18 Closed records sample size: 0
Observations:	identified residents sample residents staff to resident interactions medpass
Interviews:	Identified residents sample residents Nursing staff Residents
Record Reviews:	Identified residents facility records Identified residents Medical records Identified residents Hospital records Sample residents facility records Personnel files facility policies Staff training records shower schedules Disclosure of services Characteristics Roster

Investigation Summary:

1. Reporter stated that named resident was quarantined to their room when not

necessary. Resident went to the emergency room for shortness of breath, was positive for Covid 19 and went back to the facility and placed in isolation for 5 days. Hospital had called the facility to advise of positive COVID results. Review of records showed positive COVID test results from the hospital, resident interviewed and had no complaints about isolation policy. No failed practice identified.
2. Reporter stated that the resident went without necessary medications. Interviewed resident stated there were times when their medications were not available. Staff stated that medications were supposed to be ordered prior to running out. Record review of the medication administration records showed that resident had gone without their ordered medications. Failed practice identified and cited under Nonavailability of medications WAC 388-78A-2240.
3. Reporter stated that showers were not being provided per care plan agreement. Identified resident was interviewed and stated they preferred to take their showers by themselves. Identified resident appeared clean and groomed. Care staff were interviewed and confirmed that identified resident had taken showers on their own and repeatedly refused assistance for showers by staff. Residents interviewed did not report concerns regarding shower assistance and showers were given as scheduled. No failed practice identified.
4. Reporter stated that care plans were not updated and staff did not have access to them. Record reviews of sampled resident records showed all care plans were updated. Interviewed staff stated that care plans are available in the residents electronic and paper charts. No failed practice identified.
5. Reporter stated that unqualified staff were passing medications. Interviewed staff stated they had received training to pass medications. Review of sampled staff records showed that staff had received required training and credentials to pass medications. Interviewed residents did not report any concerns regarding the training of MedTech's. No failed practice identified.
6. Reporter stated that residents did not get milk when requested. Residents interviewed did not have complaints about snacks offered when they were hungry or requested. Staff stated that residents were given snacks when requested. Snacks and beverages were observed to be available for residents. No failed practice identified.

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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

RP Operations, LLC
Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

RE: Rose Pointe Assisted Living # 2452

Dear Administrator:

This document references the following complaint numbers 133555, 132996, 132858, 132596, 131901, 131914, 130244.

The Department completed a full inspection of your Assisted Living Facility on 06/18/2024 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:

Stephanie Jenks, Field Manager

Residential Care Services
Region 1, Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• 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-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

Staff record reviews showed that sampled staff had current Washington name and date of birth background checks. During the staff record review, it was discovered that the facility was not checking the Washington name and date of birth background checks every two years. Record review showed the facility was checking background checks every four years. The business office manager stated that moving forward they would implement a plan and verify that background checks were completed every two years.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

Staff records showed that some staff had not received a facility orientation when they were initially hired. During the inspection, the facility began reviewing the facility orientation with staff that did not have it. The business office manager stated they would review the facility orientation in the next staff meeting, and moving forward would implement the orientation into all new hire 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 (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 and complaint investigation on 06/06/2024, 06/07/2024, 06/11/2024, 06/13/2024 and 06/17/2024 of:

Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

This document references the following complaint numbers: 133555, 132986, 132858, 132596, 131901, 131914, 130244.

The following sample was selected for review during the unannounced on-site visit: 18 of 90 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Patty Ford, LTC Surveyor
Carla Rose, NCI Community Licensor
Veronica Jackson, Assisted Living Facility Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 06/25/2024 Date

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 and complaint investigation on 06/06/2024, 06/07/2024, 06/11/2024, 06/13/2024 and 06/17/2024 of:

Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

This document references the following complaint numbers: 133555, 132996, 132858, 132596, 131901, 131914, 130244.

The following sample was selected for review during the unannounced on-site visit: 18 of 90 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Patty Ford, LTC Surveyor
Carla Rose, NCI Community Licensor
Veronica Jackson, Assisted Living Facility Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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: 6.27.24

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the primary healthcare provider of high blood pressures and low heartrate for 1 of 9 sampled residents (Resident 3). This failure placed the resident at risk of health complications.

Findings included...

Review of Resident 3's negotiated service agreement, signed on 06/07/2024, showed the resident moved into the facility on [redacted]/2018 with a diagnosis of [redacted]) and required assistance with medication administration that included taking their blood pressure daily. Further review showed the resident required assistance with completing all activities of daily living including dressing, grooming, transferring, and showering.

Review of Resident 3's medication administration records (MARs) for April 2024, May 2024, and June 2024, showed an order to "notify the RN/PCP [Registered Nurse and Primary Care Provider] if systolic blood pressure [top number] was over 200 or diastolic blood pressure [DBP, bottom number] was over 90 or under 50. Notify PCP/LN [licensed nurse] if pulse [heart rate] is over 90 or under 60." Review of the MAR showed on the following days the provider should have been notified by the licensed nurse for DBP over 90: 04/02/2024, 04/16/2024, 04/18/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/24/2024, 04/25/2024, 04/27/2024, 04/30/2024, 05/02/2024, 05/07/2024, 05/11/2024, 05/23/2024, 05/27/2024, 05/28/2024, 06/02/2024, 06/04/2024. Further review showed the residents pulse was below 60 and the PCP should have been notified on the following dates: 04/09/2024, 04/09/2024, 04/11/2024, 04/12/2024, 04/15/2024, 04/16/2024, 04/17/2024, 04/15/2024, 04/20/2024, 05/05/2024, 05/28/2024, 06/02/2024, 06/04/2024.

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-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the primary healthcare provider of high blood pressures and low heartrate for 1 of 9 sampled residents (Resident 3). This failure placed the resident at risk of health complications.

Findings Included...

Review of Resident 3's negotiated service agreement, signed on 06/07/2024, showed the resident moved into the facility on [redacted]/2018 with a diagnosis of [redacted] ([redacted]) and required assistance with medication administration that included taking their blood pressure daily. Further review showed the resident required assistance with completing all activities of daily living including dressing, grooming, transferring, and showering.

Review of Resident 3's medication administration records (MARs) for April 2024, May 2024, and June 2024, showed an order to "notify the RN/PCP [Registered Nurse and Primary Care Provider] if systolic blood pressure [top number] was over 200 or diastolic blood pressure [DBP, bottom number] was over 90 or under 50. Notify PCP/LN [licensed nurse] if pulse [heart rate] is over 90 or under 60." Review of the MAR showed on the following days the provider should have been notified by the licensed nurse for DBP over 90: 04/02/2024, 04/16/2024, 04/18/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/24/2024, 04/25/2024, 04/27/2024, 04/30/2024, 05/02/2024, 05/07/2024, 05/11/2024, 05/23/2024, 05/27/2024, 05/28/2024, 06/02/2024, 06/04/2024. Further review showed the residents pulse was below 60 and the PCP should have been notified on the following dates: 04/03/2024, 04/09/2024, 04/11/2024, 04/12/2024, 04/15/2024, 04/16/2024, 04/17/2024, 04/15/2024, 04/20/2024, 05/05/2024, 05/28/2024, 06/02/2024, 06/04/2024.

In an interview on 06/11/2024 at 11:30 AM, Staff F, Executive Director, stated the provider was not notified of any blood pressures during April 2024, May 2024, or June 2024.

In an interview on 06/17/2024 at 12:00 PM, Staff A, Health and Wellness Director/LPN, stated they did not know Resident 3 had an order to notify the primary care provider if blood pressure and pulse were out of parameters. Staff A further stated they were not aware of the instances that should have been reported to the primary care provider.

This is a reoccurring deficiency previously cited on 12/01/2022.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7-9-24

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

Administrator (or Representative) — Date: 6.27.24

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that resident privacy was protected, food was served with appropriate dinnerware, carpets were cleaned throughout the facility, adequate seating was available, a homelike setting was provided, and that care was provided with dignity for 7 of 19 sampled residents (Residents 2, 6, 14, 16, 17, 18, and 19). This failure resulted in resident dissatisfaction and placed the residents at risk of decreased quality of life and diminished sense of dignity.

Findings included...

<Privacy>

In an interview on 06/11/2024 at 11:30 AM, Staff F, Executive Director, stated the provider was not notified of any blood pressures during April 2024, May 2024, or June 2024.

In an interview on 06/17/2024 at 12:00 PM, Staff A, Health and Wellness Director/LPN, stated they did not know Resident 3 had an order to notify the primary care provider if blood pressure and pulse were out of parameters. Staff A further stated they were not aware of the instances that should have been reported to the primary care provider.

This is a reoccurring deficiency previously cited on 12/01/2022.

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, Rose Pointe Assisted Living 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

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that resident privacy was protected, food was served with appropriate dinnerware, carpets were cleaned throughout the facility, adequate seating was available, a homelike setting was provided, and that care was provided with dignity for 7 of 19 sampled residents (Residents 2, 6, 14, 16, 17, 18, and 19). This failure resulted in resident dissatisfaction and placed the residents at risk of decreased quality of life and diminished sense of dignity.

Findings included…

<Privacy>

Observation on 06/06/2024 at 1:22 PM, showed two medication carts stationed in the resident television (TV) lounge to have unattended facility laptops with resident information visible on each monitor.

Observation on 06/17/2024 at 10:05 AM, showed two medication carts stationed in the resident TV lounge to have unattended facility laptops with resident information visible on each monitor.

Observation on 06/17/2024 at 10:10 AM, showed Resident 2 in the TV room next to the medication carts had received an injection of insulin (injectable medication to lower blood sugar) from the MedTech. Resident 2 had to pull their shirt off their shoulder for the injection. During this medication administration, there were four other residents and one staff member present for an activity that was taking place less than four feet from Resident 2.

In an interview on 06/17/2024 at 10:25 AM, Resident 2 stated that they could only have the insulin administration in their arm because they were uncomfortable getting the injection anywhere else on their body due to the lack of privacy in the TV room. Resident 2 further stated they felt uncomfortable when other residents walked in and saw their abdomen exposed.

<Dinnerware>

In an interview on 06/06/2024 at 09:30 AM, Staff H, Director of Dining Service, stated the facility had been using disposable dinnerware “for a while.”

In an interview on 06/11/2024 at 1:50 PM, Resident 6 stated that they did not like having their food served on disposable dinnerware. When the department asked how long the facility had been using disposable dinnerware, Resident 6 stated “it feels like two years, since before COVID.”

Observation on 06/13/2024 at 12:08 PM, of the memory care unit’s lunch service showed residents meals had been served on disposable dinnerware and the residents were attempting to cut their food with plastic utensils. Resident 19 was unable to use the utensils to cut their food and used their fingers instead.

In an interview on 06/17/2024 at 9:30 AM, Resident 2 stated they frequently had difficulty cutting their food at mealtimes with plastic knives and often the plastic fork tines broke while they are eating. The resident stated they could not remember the last time “real” utensils and dishes were used for meals.

In an interview on 06/13/2024 at 11:50 AM, Resident 14 stated they had been eating on

plastic dinnerware for over a year and missed eating on “real” dinnerware.

<Carpets>

Observation on 06/13/2024 at 10:40 AM, showed the carpet in Resident 6’s apartment had large grey and black stains throughout.

Observation on 06/13/2024 at 11:50 AM, showed the carpet in Resident 14’s apartment had a large two foot by two foot brownish stain on the carpet as well as other areas of various sized stains that were dark brown.

Observation on 06/17/2024 at 09:30 AM, during an environmental walk through showed the carpet in the hallway for resident rooms 1-24 and rooms 27-42 had dark stains varying in sizes, throughout the length of the hallway. Further observation showed the carpet in the hallway in front of resident rooms 53-55 had multiple dark stains varying in sizes.

Observation on 06/17/2024 at 11:03 AM, showed the carpet in Resident 2’s apartment had large grey and black stains throughout and a large spot approximately eight inches by 11 inches of a black sticky substance.

Observation on 06/17/2024 at 11:48 AM, showed the carpet in Resident 16’s apartment had large grey and black stains throughout.

Observation on 06/17/2024 at 11:50 AM, showed the carpet in Resident 12’s apartment had large grey and black stains throughout.

In an interview on 06/06/2024 at 10:14 AM, Staff I, Maintenance Director, stated that the carpet cleaner had broken two weeks prior.

In an interview on 06/11/2024 at 2:36 PM, Staff K, Owner, stated that the carpet tiles in the hallway were new and could easily be replaced.

In an interview on 06/13/2024 at 10:40 AM, Resident 6 stated that they had the same carpet since they moved into their apartment six years ago. Resident 6 further stated that the carpet in their room needed to be cleaned.

In an interview on 06/13/2024 at 11:50 AM, Resident 14 stated their carpet needed to be cleaned and no one had offered to clean the carpet since they moved in five years ago.

In an interview on 06/13/2024 at 11:57 AM, Resident 12 stated that the carpet in their room was dirty and needed to be either cleaned or replaced.

In an interview on 06/17/2024 at 11:52 AM, Resident 16 stated their carpet needed to be cleaned and had not been cleaned since they moved in five years ago.

<Adequate seating>

Observation on 06/06/2024 at 9:15 AM, during the environmental tour, showed a TV room with one dining room chair and no living room furniture for residents to sit on while watching television. There was a small game table placed against the wall with two wheelchairs blocking it which had an additional wheelchair footrest on top. Further observation showed a large wheelchair scale was placed in the walkway, two medication carts were placed in half of the room along with a shelving unit which contained dog treats and medical supplies (oxygen tanks, medication cutters, blood pressure cuffs), a shower schedule, and staffs' personal items.

Observation on 06/11/2024 at 2:06 PM, showed one chair on the covered patio adjacent to the dining room. There were no other places for non-smoking residents to sit outdoors.

In an interview on 06/17/2024 at 9:30 AM, Resident 2 stated that they wished there were more comfortable places to sit throughout the facility. Resident 2 further stated they liked to sit outside but they had to sit on two bricks because there was nowhere else to sit in a non-smoking area. Resident 2 also stated there was not enough comfortable seating throughout the facility to visit with others or in the lobby while they waited for transportation to appointments.

In an interview on 06/13/2024 at 11:57 AM, Resident 12 stated they wished there was seating outside now that there was nice weather for them and their visitors to sit. The resident stated the only seating available was in the covered smoking area, and that they did not smoke.

<Homelike setting>

Observation on 06/06/2024 at 09:30 AM, showed poorly lit resident hallways and no homelike decor on the walls.

Observation on 06/17/2024 at 09:35 AM, showed the view from the windows of resident apartments 38, 39, and 40 were in direct line of sight of an outdoor area used for storage of equipment. The area had six metal racks, a BBQ grill, a five-gallon bucket filled with a dark liquid, a small damaged trash can, multiple extension cords, nine full trash bags, a rake, an extension ladder, and an industrial kitchen mixer covered by a black trash bag.

<Dignity>

Observation on 06/11/2024 at 1:33 PM, showed a resident sitting in their wheelchair in the uncleaned dining room of the memory care unit, their head on the table, and in the dark by themselves. When asked by the department if the resident wanted to be in there, they nodded their head to indicate no, and stated "They left me."

In an interview on 06/11/2024 at 1:35 PM, Staff C, Caregiver, stated they were busy with other residents and had not gone back to the resident left alonein the dining room yet.

Observation on 06/13/2024 at 12:10 PM, showed Resident 18 was brought to the dining room and seated approximately 18 inches from the table. The resident's chair was not scooted towards the table, they strained to reach their meal, and dropped numerous food items on their lap. Staff N, MedTech, and Staff O, Resident Care Coordinator, were observed in the dining room and did not assist.

This is a recurring deficiency previously cited on 10/26/2023 for subsections (1).

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7-15-24.

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

Administrator (or Representative) — Date: 6-27-24

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the resident or their representative for 5 of 12 residents (Resident's 2, 3, 4, 11, and 15) sampled for signatures on service agreements. This failure placed residents at risk of unmet care needs and receiving services that were not agreed

<Dignity>

Observation on 06/11/2024 at 1:33 PM, showed a resident sitting in their wheelchair in the uncleaned dining room of the memory care unit, their head on the table, and in the dark by themselves. When asked by the department if the resident wanted to be in there, they nodded their head to indicate no, and stated “They left me.”

In an Interview on 06/11/2024 at 1:35 PM, Staff C, Caregiver, stated they were busy with other residents and had not gone back to the resident left alonein the dining room yet.

Observation on 06/13/2024 at 12:10 PM, showed Resident 18 was brought to the dining room and seated approximately 18 inches from the table. The resident’s chair was not scooted towards the table, they strained to reach their meal, and dropped numerous food items on their lap. Staff N, MedTech, and Staff O, Resident Care Coordinator, were observed in the dining room and did not assist.

This is a recurring deficiency previously cited on 10/26/2023 for subsections (1).

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, Rose Pointe Assisted Living 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-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the resident or their representative for 5 of 12 residents (Resident’s 2, 3, 4, 11, and 15) sampled for signatures on service agreements. This failure placed residents at risk of unmet care needs and receiving services that were not agreed

upon.

Findings included…

<Resident 2>

Review of Resident 2's negotiated service agreement (NSA), updated 01/08/2024, showed it did not contain a signature by the resident and/or their representative to show agreement to the plan.

In an interview on 06/13/2024 at 11:35 AM, Staff A, Health and Wellness Director/LPN, stated the last time Resident 2 signed their NSA was on 01/05/2023.

<Resident 3>

Review of Resident 3's NSA, updated on 12/27/2023, showed the agreement was not signed until 06/07/2024, the day the department requested a signed copy.

<Resident 4>

Review of Resident 4's NSA, updated 02/20/2024, showed it did not contain a signature by the resident and/or their representative to show agreement to the plan.

In an interview on 06/07/2024 at 3:10 PM, Staff F, Executive Director, stated that they did not have a signed NSA for Resident 4.

<Resident 11>

Review of Resident 11's NSA, updated on 12/27/2023, showed it did not contain a signature by the resident and/or their representative to show agreement to the plan.

In an interview on 06/11/2024 at 10:20 AM, Resident 11 stated that the facility did not review their NSA with them.

In an interview on 06/13/2024 at 11:35 AM, Staff A stated they did not have a signature from Resident 11 or their representative to show agreement to the plan.

<Resident 15>

Review of Resident 15's NSA, updated on 12/06/2023, showed the agreement was not signed until 06/13/2024, the day the department requested a signed copy.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6.15.24.

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

Administrator (or Representative) — Date: 6-27-24

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a respiratory protection program as required and failed to ensure staff were fit tested for 5 of 5 sampled staff (Staff A, B, C, D, and E). This failure placed residents at risk for respiratory infection.

Findings included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (test completed by specially trained personnel to ensure N95 masks seal effectively reducing chance of exposure to respiratory viruses), and provide effective training before employees are assigned duties that may require the use of respirators.

Per WAC 296-842-15005, facilities must conduct fit testing before employees are assigned duties that may require the use of respirators.

Record review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to "follow regulations pertaining to respiratory protection" including respirator fit testing for long term care workers.

Review of Resident 15's NSA, updated on 12/06/2023, showed the agreement was not signed until 06/13/2024, the day the department requested a signed copy.

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, Rose Pointe Assisted Living 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-2730 Licensee's responsibilities.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a respiratory protection program as required and failed to ensure staff were fit tested for 5 of 5 sampled staff (Staff A, B, C, D, and E). This failure placed residents at risk for respiratory infection.

Findings Included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (test completed by specially trained personnel to ensure N95 masks seal effectively reducing chance of exposure to respiratory viruses), and provide effective training before employees are assigned duties that may require the use of respirators.

Per WAC 296-842-15005, facilities must conduct fit testing before employees are assigned duties that may require the use of respirators.

Record review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to "follow regulations pertaining to respiratory protection" including respirator fit testing for long term care workers.

Review of the facility policy and procedures binders showed they did not contain a respiratory protection program (RPP).

Review of Staff A's, Health and Wellness Director, undated personnel file showed it did not contain records for a medical evaluation or fit testing

Review of Staff B's, Medication Tech, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff C's, Resident Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff D's, Medication Tech, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff E's, Medication Tech, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of facility records showed Resident 3 was positive for COVID-19 (contagious respiratory virus) on 05/13/2024.

In an interview on 06/06/2024 at 8:30 AM, Staff F, Executive Director, stated that staff did not have their medical evaluation clearance for respirator use and staff were not current with their fit testing. Staff F further stated the facility did not have a respiratory protection program and they had recently received fit tester training materials from the Department of Health

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10-10-24 C

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

Administrator (or Representative) — Date: 6.27.24

Review of the facility policy and procedures binders showed they did not contain a respiratory protection program (RPP).

Review of Staff A's, Health and Wellness Director, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff B's, Medication Tech, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff C's, Resident Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff D's, Medication Tech, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff E's, Medication Tech, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of facility records showed Resident 3 was positive for COVID-19 (contagious respiratory virus) on 05/13/2024.

In an interview on 06/06/2024 at 9:30 AM, Staff F, Executive Director, stated that staff did not have their medical evaluation clearance for respirator use and staff were not current with their fit testing. Staff F further stated the facility did not have a respiratory protection program and they had recently received fit tester training materials from the Department of Health.

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, Rose Pointe Assisted Living 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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain an adequate supply of medications for 1 of 9 sampled residents (Resident 2). This failure resulted in multiple missed medications and placed the resident at risk of health complications due to not receiving their medications as ordered.

Findings included...

<Resident 2>

Review of Resident 2's negotiated service agreement, updated on 01/08/2024, showed the resident required medication assistance and had a diagnosis of [redacted] ([redacted]).

Review of Resident 2's medication administration records (MARs) for April 2024, May 2024, and June 2024, showed an order placed by the provider on 04/17/2024, for cinacalcet (used to lower parathyroid hormone as well as decrease calcium and phosphorus levels in the body) to be administered daily. Further review of the MARs showed the cinacalcet was documented as unavailable to administer until 06/03/2024.

Review of Resident 2's MARs for April 2024 and May 2024, showed an order for sevelamer (used to control high levels of phosphorus in people with chronic kidney disease) to be administered three times daily. Further review showed sevelamer was documented as unavailable to administer from 04/10/2024 through 05/23/2024.

Review of Resident 2's MAR for April 2024, showed sodium bicarbonate (used to neutralize the acid/base balance of the blood) was ordered twice daily and was documented as unavailable to administer from 04/17/2024 through 04/27/2024.

Review of Resident 2's MAR for May 2024, showed an order for brilinta (used to reduce blood clots, risk of heart attacks, and strokes) to be administered twice daily. Further review showed the medication was documented as unavailable to administer from 05/10/2024 to 05/12/2024, which resulted in missing four doses.

Review of Resident 2's MAR for May 2024, showed an order for ciprofloxacin (used to treat infection) to be given twice daily for seven days. Further review of the MAR showed ciprofloxacin was ordered on 05/03/2024 and was documented as not available to administer until 05/05/2024. This resulted in Resident 2 missing four doses.

In an interview on 06/17/2024 at 9:30 AM, Resident 2 stated that they were on dialysis (a filtration process used in place of kidney function) for kidney failure.

In an interview on 06/17/2024 at 10:55 AM, Staff M, Resident Care Coordinator, stated that Resident 2's cinacalcet and sevelamer were difficult to obtain. Staff M was unable to provide documentation to show the facility made consistent efforts to obtain the medications. Staff M further stated the brilinta was not re-ordered in time, and the antibiotic ciprofloxacin should have been placed as a rush order, but it was not done that way.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7-15-24.

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

Administrator (or Representative) — Date: 6-27-24

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 facility failed to ensure that staff were tested for tuberculosis within three days of employment and failed to ensure a second tuberculosis test was done within one to three weeks after the first test for 1 of 5 sampled staff (Staff C). This failure placed residents at risk of exposure to tuberculosis.

Findings included...

Review of Staff C's, Caregiver, personnel file showed they were hired on 11/02/2023. Further review showed the file contained a first step tuberculosis (TB) test dated 11/22/2023 and a second step TB test dated 12/28/2023.

In an interview on 06/17/2024 at 9:30 AM, Resident 2 stated that they were on dialysis (a filtration process used in place of kidney function) for kidney failure.

In an interview on 06/17/2024 at 10:55 AM, Staff M, Resident Care Coordinator, stated that Resident 2's cinacalcet and sevelamer were difficult to obtain. Staff M was unable to provide documentation to show the facility made consistent efforts to obtain the medications. Staff M further stated the brilinta was not re-ordered in time, and the antibiotic ciprofloxacin should have been placed as a rush order, but it was not done that way.

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-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 facility failed to ensure that staff were tested for tuberculosis within three days of employment and failed to ensure a second tuberculosis test was done within one to three weeks after the first test for 1 of 5 sampled staff (Staff C). This failure placed residents at risk of exposure to tuberculosis.

Findings included…

Review of Staff C's, Caregiver, personnel file showed they were hired on 11/02/2023. Further review showed the file contained a first step tuberculosis (TB) test dated 11/22/2023 and a second step TB test dated 12/28/2023.

In an interview on 06/11/2024 at 11:45 AM, Staff G, Business Office Manager, confirmed the dates listed above for Staff C and could not provide an explanation, and stated they were aware of the requirements. When asked about hire date versus start date, Staff G stated the hire date was the same day staff start working at the facility to begin orientation and training.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7-10-24 .

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

Administrator (or Representative) — Date: 6-27-24

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that the housekeeping cart with hazardous supplies and materials was locked and secured in the memory care unit for 1 of 1 memory care housekeeping carts. This failure placed the residents in the memory care unit at risk of harm.

Findings included...

Review of the facility's Characteristic Roster showed the memory care unit housed 23 residents (residents diagnosed with [redacted]).

Observation on 06/11/2024 at 1:30 PM, showed an unattended and unlocked housekeeping cart in the memory care unit hallway, which was next to the television (TV) room. Further observation showed there were no staff nearby. Inspection of the cart showed it contained: two spray bottles with pink liquid labeled "disinfecting acid bathroom

In an interview on 06/11/2024 at 11:45 AM, Staff G, Business Office Manager, confirmed the dates listed above for Staff C and could not provide an explanation, and stated they were aware of the requirements. When asked about hire date versus start date, Staff G stated the hire date was the same day staff start working at the facility to begin orientation and training.

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that the housekeeping cart with hazardous supplies and materials was locked and secured in the memory care unit for 1 of 1 memory care housekeeping carts. This failure placed the residents in the memory care unit at risk of harm.

Findings included…

Review of the facility's Characteristic Roster showed the memory care unit housed 23 residents (residents diagnosed with [redacted], [redacted]).

Observation on 06/11/2024 at 1:30 PM, showed an unattended and unlocked housekeeping cart in the memory care unit hallway, which was next to the television (TV) room. Further observation showed there were no staff nearby. Inspection of the cart showed it contained: two spray bottles with pink liquid labeled “disinfecting acid bathroom

cleaner", one can of Lysol disinfectant spray, and one container of powder bleach cleaner. Further observation showed 10 residents sat unattended in the TV room and another resident was walking in the hallway near the housekeeping cart, curiously touching multiple surfaces.

In an interview on 06/13/2024 at 10:12 AM, Staff J, Housekeeper, stated that the lock on the housekeeping cart was broken and that staff were to put the hazardous chemicals in a locked closet.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6.27.24

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

Administrator (or Representative) — Date: 6.27.24

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a covered area on the patio outside for 1 of 1 outdoor patio areas of the memory care unit. This failure placed the memory care residents at risk of exposure to weather elements, sunburns, and a decreased quality of life.

Findings included...

Review of the facility's Characteristic Roster showed the memory care unit housed 23 residents (residents diagnosed with [redacted]).

cleaner", one can of Lysol disinfectant spray, and one container of powder bleach cleaner. Further observation showed 10 residents sat unattended in the TV room and another resident was walking in the hallway near the housekeeping cart, curiously touching multiple surfaces.

In an interview on 06/13/2024 at 10:12 AM, Staff J, Housekeeper, stated that the lock on the housekeeping cart was broken and that staff were to put the hazardous chemicals in a locked closet.

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-2381 General design requirements for memory care.

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(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a covered area on the patio outside for 1 of 1 outdoor patio areas of the memory care unit. This failure placed the memory care residents at risk of exposure to weather elements, sunburns, and a decreased quality of life.

Findings included…

Review of the facility's Characteristic Roster showed the memory care unit housed 23 residents [redacted]).

Observation on 06/06/2024 at 9:15 AM, showed the memory care unit patio had no overhead coverings to protect the residents from the sun. One resident was observed asleep in direct sunlight.

In an interview on 06/06/2024 at 3:13 PM, Staff F, Executive Director, stated they had not found an awning that could be bolted down into the cement.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7-10-24.

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

Administrator (or Representative) — Date: 6-27-24

WAC 388-78A-2920 Area for nursing supplies and equipment.

(1) In each building, the assisted living facility must provide for the safe and sanitary storage and handling of nursing equipment and supplies appropriate to the needs of their residents, as well as for the soiled nursing equipment by providing:

(a) A "clean" utility area for the purposes of storing and preparing nursing supplies, or durable and disposable medical equipment equipped with:

(ii) A handwashing sink, with soap and paper towels or other approved hand-drying device;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide an appropriately equipped area to pass medications that included a hand-washing sink for 2 of 4 medication carts. This failure placed residents at increased risk of infection due to care staff passing medications without the ability to effectively clean their hands in between residents.

Findings included...

Observation on 06/07/2024 at 11:05 AM, showed two medication carts were placed in half of the resident's television (TV) lounge, along with a large wheelchair scale, and a shelving unit which contained medical supplies (oxygen tanks, medication cutters, blood pressure cuffs). Further observation showed there were no handwashing sinks in or adjacent to that room.

Observation on 06/06/2024 at 9:15 AM, showed the memory care unit patio had no overhead coverings to protect the residents from the sun. One resident was observed asleep in direct sunlight.

In an interview on 06/06/2024 at 3:13 PM, Staff F, Executive Director, stated they had not found an awning that could be bolted down into the cement.

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-2920 Area for nursing supplies and equipment.

(1) In each building, the assisted living facility must provide for the safe and sanitary storage and handling of nursing equipment and supplies appropriate to the needs of their residents, as well as for the soiled nursing equipment by providing:

(a) A "clean" utility area for the purposes of storing and preparing nursing supplies, or durable and disposable medical equipment equipped with:

(ii) A handwashing sink, with soap and paper towels or other approved hand-drying device;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide an appropriately equipped area to pass medications that included a hand-washing sink for 2 of 4 medication carts. This failure placed residents at increased risk of infection due to care staff passing medications without the ability to effectively clean their hands in between residents.

Findings included…

Observation on 06/07/2024 at 11:05 AM, showed two medication carts were placed in half of the resident's television (TV) lounge, along with a large wheelchair scale, and a shelving unit which contained medical supplies (oxygen tanks, medication cutters, blood pressure cuffs). Further observation showed there were no handwashing sinks in or adjacent to that room.

In an interview on 06/07/2024 at 2:15 PM, Staff M, Resident Care Coordinator, stated that the two medication carts were always stationed in the resident's TV lounge. Staff M further stated that the resident's TV lounge was the designated medication administration area.

In an interview on 06/13/2024 at 11:55 AM, Staff D, Medication Tech, stated that since they started working at the facility 12 years ago, the resident TV lounge had been the designated medication administration area.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7-17-24.

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

Administrator (or Representative) — Date: 6.27.24

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(2) If provided, locate outdoor smoking areas in accordance with Washington state law;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure smoking areas were 25 feet away from entrances and windows for 5 of 7 areas where residents smoked. This failure exposed residents and visitors to secondhand smoke.

Findings included...

Per RCW 70.160.075 - Smoking is prohibited within a presumptively reasonable minimum distance of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means.

Observations on 06/06/2024 at 9:15 AM, showed industrial grade outdoor ashtray receptables less than 25 feet from exits and windows at the following locations:

-Outdoor patio in the memory care unit, four feet from the dayroom door.

In an interview on 06/07/2024 at 2:15 PM, Staff M, Resident Care Coordinator, stated that the two medication carts were always stationed in the resident's TV lounge. Staff M further stated that the resident's TV lounge was the designated medication administration area.

In an interview on 06/13/2024 at 11:55 AM, Staff D, Medication Tech, stated that since they started working at the facility 12 years ago, the resident TV lounge had been the designated medication administration area.

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, Rose Pointe Assisted Living 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-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(2) If provided, locate outdoor smoking areas in accordance with Washington state law;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure smoking areas were 25 feet away from entrances and windows for 5 of 7 areas where residents smoked. This failure exposed residents and visitors to secondhand smoke.

Findings included…

Per RCW 70.160.075 - Smoking is prohibited within a presumptively reasonable minimum distance of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means.

Observations on 06/06/2024 at 9:15 AM, showed industrial grade outdoor ashtray receptables less than 25 feet from exits and windows at the following locations:

-Outdoor patio in the memory care unit, four feet from the dayroom door.

-Outside of the east wing under a tree, 15 feet from the entrance.
-Outside the north side of the building at the end of the wheelchair ramp/sidewalk, 10 feet from the building.
-Outside the northwest side of the building two inches from the exterior under a resident window.

Observation on 06/11/2024 at 1:50 PM, showed two residents smoking outside next to the south exit doorway. A metal coffee can, utilized as an ashtray, was located on the sidewalk at the doorway where the two residents were smoking.

Observation on 06/17/2024 at 9:40 AM, showed two residents smoking at the north side of the building obstructing the wheelchair ramp/sidewalk. Further observation showed there were no other wheelchair ramps/sidewalks to utilize for entry into the memory care unit.

In an interview on 06/11/2024 at 10:45 AM, Resident 13 stated that other residents smoke at the doorway located outside their apartment window. Resident 13 further stated that they were a non-smoker, and that the cigarette smoke bothered them because it came in through their apartment window.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6.26.24.

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

Administrator (or Representative) — Date: 6.26.24

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to keep a well maintained, safe and

-Outside of the east wing under a tree, 15 feet from the entrance.
-Outside the north side of the building at the end of the wheelchair ramp/sidewalk, 10 feet from the building.
-Outside the northwest side of the building two inches from the exterior under a resident window.

Observation on 06/11/2024 at 1:50 PM, showed two residents smoking outside next to the south exit doorway. A metal coffee can, utilized as an ashtray, was located on the sidewalk at the doorway where the two residents were smoking.

Observation on 06/17/2024 at 9:40 AM, showed two residents smoking at the north side of the building obstructing the wheelchair ramp/sidewalk. Further observation showed there were no other wheelchair ramps/sidewalks to utilize for entry into the memory care unit.

In an interview on 06/11/2024 at 10:45 AM, Resident 13 stated that other residents smoke at the doorway located outside their apartment window. Resident 13 further stated that they were a non-smoker, and that the cigarette smoke bothered them because it came in through their apartment window.

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, Rose Pointe Assisted Living 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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to keep a well maintained, safe and

sanitary interior and exterior environment. This failure placed all residents at risk of injury and decreased quality of life.

Findings included…

Observations on 06/06/2024 at 9:15 AM and 06/11/2024 and 1:50 PM, showed the following:

<Interior>

-Strong odor of urine in lobby bathrooms.
-Vents full of debris throughout the facility.
-Missing vent cover in memory care unit (MCU) bathroom, adjacent to the dining room.
-MCU shower room adjacent to the dining room was not in working order and contained two large plastic bins, a snow shovel, and a plumbing tool.
-MCU refrigerator and freezer had spilled food and food items that were not labeled with names and dates.
-MCU dining room steam tables had not been cleaned from the previous meal service.
-MCU doorway had two wall corners with visible damage and rough surfaces that could not be cleaned.
-The assisted living carpets in all halls had numerous black spills and stains.
-A large wheelchair accessible scale was located in the TV room walkway.
-Multiple doors and the doors kick plates were damaged throughout the building.
-In the ceiling located in the main lobby was a hole that measured about 18 by 18 inches.
-Numerous water stains on the ceiling located throughout the building.

<Exterior>

-No covered area in the MCU patio from weather elements.
-Pull cord for the call light on MCU patio was broken.
-Unsecured fire extinguisher located on the patio which was adjacent to the assisted living dining room.
-Thorney weeds, rocks, and bricks piled throughout the exterior of the building.
-Covered smoking area had ashes, cigarette butts and paper debris covering the floor and the cord from the call light was broken.
-Behind the covered smoking area was a bench and a coffee can with cigarette butts and numerous butts on the grass surrounding it.
-Between the covered smoking area and ramp from MCU there was a pile of materials left from a previous makeshift ramp, two hoses, sprinklers, planks of wood, broken plastic pieces, chicken wire, and other debris.
-At the base of the ramped walkway, a large chunk of broken cement was present.
-Next to the MCU was a variety of gardening items and debris.
-Numerous cable TV cords strung over the building and windows on the east and west side of the building with the cable boxes opened and exposed.
-Five hoses laying across the grass in various locations throughout the exterior.
-Five window screens on the ground under resident rooms 6, 8, and 14.

-A coffee can with cigarette butts was located three feet from the south exit door.
-The exterior patio located near their outdoor kitchen had numerous extension cords on the ground, nine black plastic garbage bags full of aluminum cans, five metal racks with food debris, a BBQ grill, a five-gallon bucket containing a black substance, garden tools, and a kitchen cart with an industrial mixer on top, in view of rooms 38, 39, and 40.

In an interview on 06/06/2024 at 9:15 AM, Staff I, Maintenance Director, stated that they were the only full-time staff in the maintenance department for the facility.

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6-27-24.

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

Administrator (or Representative) — Date: 6-27-24

WAC 388-78A-2450 Staff.

(2) The assisted living facility must.

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

(v) Policies, procedures, and equipment necessary to perform duties;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that all staff had keys to the memory care unit apartments for 1 of 5 sampled staff (Staff C). This failure placed the memory care residents at risk of harm due to staff not having access to assist them in case of an emergency.

Findings included...

Review the facility's policy titled, "Key Control," dated 12/2018, showed that the assisted living facility is to maintain a safe and secure environment, the Executive Director and Maintenance Director will have a "master key", and team members will have keys and access to areas as identified and approved by the Executive Director.

An observation on 06/11/2024 at 9:42 AM, showed Staff C, Caregiver, as the only staff person working at that time on the memory care unit.

-A coffee can with cigarette butts was located three feet from the south exit door.
-The exterior patio located near their outdoor kitchen had numerous extension cords on the ground, nine black plastic garbage bags full of aluminum cans, five metal racks with food debris, a BBQ grill, a five-gallon bucket containing a black substance, garden tools, and a kitchen cart with an industrial mixer on top, in view of rooms 38, 39, and 40.

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that all staff had keys to the memory care unit apartments for 1 of 5 sampled staff (Staff C). This failure placed the memory care residents at risk of harm due to staff not having access to assist them in case of an emergency.

Findings included…

Review the facility's policy titled, "Key Control," dated 12/2018, showed that the assisted living facility is to maintain a safe and secure environment, the Executive Director and Maintenance Director will have a "master key", and team members will have keys and access to areas as identified and approved by the Executive Director.

An observation on 06/11/2024 at 9:42 AM, showed Staff C, Caregiver, as the only staff person working at that time on the memory care unit.

In an interview on 06/11/2024 at 9:42 AM, Staff C stated that they could not open a resident room as they had forgot their keys at home. When the department inquired about what they would do if a resident needed assistance or if there was an emergency, Staff C stated they would have to leave the unit or use their own phone to call another staff member. When the department further questioned why they did not notify a supervisor of the need for keys, Staff C stated that there were no keys, and the maintenance staff didn't have time to make new keys.

In an interview on 06/11/2024 at 10:18 AM, Staff F, Executive Director, stated that every staff should have keys and if not, they would need to notify their supervisor.

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: 6 27.24

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Administrator (or Representative) Date