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

Quail Park of West Seattle, LLC
Quail Park Memory Care Residences of West Seattle
4515 41st Ave SW
Seattle, WA 98116

RE: Quail Park Memory Care Residences of West Seattle License # 2458

Dear Administrator:

This letter addresses Compliance Determination(s) 46667 (Completion Date 09/05/2024) and 43095 (Completion Date 07/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/05/2024 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-2160

The Department staff who did the on-site verification:
Lisa Hauk, Complaint Investigator

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

Sincerely,

Jamie Singer

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Quail Park Memory Care Residences of West Seattle
License/Cert.#: 2458
Compliance Determination #: 43095
Investigator: Lisa Hauk
Investigation Date(s): 06/24/2024 through 07/03/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 132482
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
A Named Resident (NR) at the Assisted Living Facility (ALF) was left unattended for 5 to 6 hours because ALF staff were unaware the NR had returned from the hospital.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Administration Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies Staff training records

Investigation Summary:
Staff at the ALF assisted the NR to her apartment upon return from the hospital on the evening shift and was helped to bed. The night shift at the ALF was aware of the NR's return and checked on her and assisted her throughout the night. The last time the NR was assisted was 5:30 or 6:00 AM. Day shift caregivers did not receive communication that the NR had returned to her apartment. The NR did not receive medications or breakfast on the day shift. Violation of regulations identified. See written citation WAC

388-78-2160.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site complaint investigation on 06/24/2024 and 06/24/2024 of:

Quail Park Memory Care Residences of West Seattle
4515 41st Ave SW
Seattle, WA 98116

This document references the following complaint number(s): 132482, 135105

The following sample was selected for review during the unannounced on-site visit: 2 of 44 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

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

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

Jamie Singer
Residential Care Services

7/8/2024
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.

Statement of Deficiencies	License #: 2458	Compliance Determination # 43095
Plan of Correction	Quail Park Memory Care Residences of West Seattle	Completion Date
Page 2 of 3	Licensee: Quail Park of West Seattle, LLC	07/03/2024

Administrator (or Representative) 7/9/2024 Date

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement the Negotiated Service Agreement (NSA) for 1 of 2 sampled residents (Resident 1) when it was not communicated to caregiving staff that the resident had returned from the hospital the previous evening. This failure resulted in Resident 1 not receiving care and services until noon the following day, missing medications, and breakfast, experiencing incontinence, and placed them at risk of harm.

Findings included...

Record review of an undated Resident Face Sheet showed the ALF admitted Resident 1 on [redacted]/2022 with Alzheimer's Dementia (a type of dementia that affects memory, thinking and behavior. Symptoms eventually grow severe enough to interfere with daily tasks) and Hypertension (High Blood Pressure). An NSA, dated 04/11/2024, showed the ALF escorted Resident 1 to the dining room and provided cueing at meals to maintain adequate intake, provided stand-by assistance with toileting, grooming, dressing and assistance with medications.

Record review of a progress note (PN), dated [redacted]/2024 at 08:46 PM, showed the Hospital admitted Resident 1 at 8:46 PM. Review of a PN, dated [redacted]/2024 at 6:30 PM, showed Collateral Contact 1 (CC1 – Resident 1's Family Representative) transported Resident 1 from the hospital, back to the ALF where an ALF staff assisted CC1 to propel Resident 1's wheelchair to her apartment and prepare Resident 1 for bed at 6:30 PM. The PN stated evening and night shift caregivers were informed of Resident 1's weak status and the need for staff to check Resident 1 often.

In interview, on 06/24/2024 at 12:05 PM, Staff A (Health and Wellness Director) stated that on [redacted]/2024, Resident 1 received care from the night shift, but there was a miscommunication between night shift and day shift. Day shift staff were unaware of Resident 1's return from the hospital until CC1 arrived at the ALF to check on Resident 1.

In interview, on 06/25/2024 at 12:54 PM, CC1 stated that she came to the ALF to check on

Administrator (or Representative) Date

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In interview, on 06/24/2024 at 12:05 PM, Staff A (Health and Wellness Director) stated that on [redacted] 2024, Resident 1 received care from the night shift, but there was a miscommunication between night shift and day shift. Day shift staff were unaware of Resident 1's return from the hospital until CC1 arrived at the ALF to check on Resident 1.

In interview, on 06/25/2024 at 12:54 PM, CC1 stated that she came to the ALF to check on

Resident 1 on [redacted]/2024 at lunch time the day after she returned from the hospital. CC1 stated day shift caregivers stopped CC1 in the hallway to tell her that Resident 1 was in the hospital. CC1 informed the caregivers that Resident 1 returned to the ALF the evening prior. CC1 and day shift caregivers entered the apartment together and found Resident 1 still in bed and had been incontinent, was wet, and laying in feces. CC1 stated that because the care staff did not know Resident 1 had returned to the ALF she had also missed her medications and breakfast. CC1 stated, "She wouldn't leave her room without being prompted and needs to be led for most tasks."

Record review of an electronic Medication Administration Record for May 2024 showed seven of Resident 1's morning medications, including medications for Dementia and HTN were not given on the day shift [redacted]/2024.

In interview, on 06/26/2024 at 09:31 AM, Staff A confirmed the last time Resident 1 received care was from night shift staff on [redacted]/2024 between on 5:30 AM and 06:00 AM. Staff A stated that because Resident 1's return to the ALF was missed by the day shift staff, Resident 1 received no morning care and was not toileted on day shift of [redacted]/2024 until noon resulting in incontinence without assistance with cleaning. Staff A stated Resident 1 also did not receive her medications or breakfast on [redacted]/2024.

This deficiency was previously cited on 08/30/2021.

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, Quail Park Memory Care Residences of West Seattle is or will be in compliance with this law and / or regulation on (Date) ~~8/21/2024~~ 8/17/2024

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

Administrator (or Representative) — Date: 7/8/2024

Resident 1 on [redacted]2024 at lunch time the day after she returned from the hospital. CC1 stated day shift caregivers stopped CC1 in the hallway to tell her that Resident 1 was in the hospital. CC1 informed the caregivers that Resident 1 returned to the ALF the evening prior. CC1 and day shift caregivers entered the apartment together and found Resident 1 still in bed and had been incontinent, was wet, and laying in feces. CC1 stated that because the care staff did not know Resident 1 had returned to the ALF she had also missed her medications and breakfast. CC1 stated, "She wouldn't leave her room without being prompted and needs to be led for most tasks."

Record review of an electronic Medication Administration Record for May 2024 showed seven of Resident 1's morning medications, including medications for Dementia and HTN were not given on the day shift [redacted]2024.

In interview, on 06/26/2024 at 09:31 AM, Staff A confirmed the last time Resident 1 received care was from night shift staff on [redacted]2024 between on 5:30 AM and 06:00 AM. Staff A stated that because Resident 1's return to the ALF was missed by the day shift staff, Resident 1 received no morning care and was not toileted on day shift of [redacted]2024 until noon resulting in incontinence without assistance with cleaning. Staff A stated Resident 1 also did not receive her medications or breakfast on [redacted]2024.

This deficiency was previously cited on 08/30/2021.

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, Quail Park Memory Care Residences of West Seattle is or will be in compliance with this law and / or regulation on (Date)_____ .

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Administrator (or Representative) | Date