



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

102 Ave Bellevue LLC
Aegis of Bellevue
148 102nd Ave SE
Bellevue, WA 98004

RE: Aegis of Bellevue License # 2491

Dear Administrator:

This letter addresses Compliance Determination(s) 27975 (Completion Date 08/11/2023) and 25954 (Completion Date 06/29/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/11/2023 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, WAC 388-78A-2730-1-a

The Department staff who did the on-site verification:
Steven Garrett, LTC Licenser

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

Sincerely,

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

Statement of Deficiencies	License #: 2491	Compliance Determination # 25954
Plan of Correction	Aegis of Bellevue	Completion Date
Page 1 of 4	Licensee: 102 Ave Bellevue LLC	06/29/2023

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 06/28/2023 and 06/28/2023 of:

Aegis of Bellevue
148 102nd Ave SE
Bellevue, WA 98004

This document references the following SOD dated: 06/29/2023

The following sample was selected for review during the unannounced on-site visit: 4 of 78 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Steven Garrett, LTC Licenser
Angelica Ríos, ALF Licenser
Jane Hermano, NCI

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

07-05-2023

Date

Statement of Deficiencies	License #: 2491	Compliance Determination # 25954
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Page 2 of 4	Licensee: 102 Ave Bellevue LLC	06/29/2023

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)

7/7/2023

Date

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

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

(a) The operation of the assisted living facility;

(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 implement their policy for Respiratory Protection Program (RPP) for 11 of 46 staff who have direct contact with residents (Staff D, Care Manager 1, Staff E, Lead Care Manager, Staff F, Medication Care Manager, Staff T, Wellness Nurse, Staff V, Care Manager 2, Staff W, Associate Care Director, Staff MM, Medication Care Manager, Staff NN, Lead Care Manager, Staff SS, Care Manager 2, Staff TT, Care Manager 1, and Staff HHH, Lead Concierge). This failure placed 78 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

The Centers for Disease Control and Prevention (CDC), the national public health agency for the United States, developed guidelines for infection prevention and control practices in healthcare settings including assisted living facilities. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current infection control standards to prevent and control the spread of coronavirus disease 2019 (COVID-19) in healthcare settings.

Review of the CDC website, titled "Transmission-Based Precautions" (<https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>), showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission including a fit-tested National Institute for Occupational Safety and Health (NIOSH)-approved N95 or higher level respirator for healthcare personnel. Review of the DOH publication, titled "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31, 2022, showed specific guidelines for RPP that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and

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annual fit tests for any employee identified as potentially being exposed to respiratory hazard. The publication also stated that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

Review of the Dear Provider Letter titled "EMPLOYER RESPONSIBILITIES FOR RESPIRATORY PROTECTION PROGRAM AND PROVISION OF PERSONAL PROTECTIVE EQUIPMENT (PPE)," dated 04/30/2021, showed the guidelines for long-term care facilities (LTCF), healthcare workers (HCWs), and employers on when to use certain types of PPE. The letter further described requirements of LTCFs that included initial fit-tests for each HCW with the respirator that the HCW would be required to wear for protection against COVID-19 and other airborne hazards.

Review of the facility's document titled "Respiratory Protection Program", dated 10/18/2021, showed that the General Manager was the Program Administrator responsible for administering the RPP. The Program Administrator responsibilities included ensuring fit testing was conducted upon hire (for those identified staff) and annually thereafter. The document showed that the facility would identify one Fit Testing Trainer/Coordinator responsible for ensuring the RPP was implemented. The Fit Testing Trainer/Coordinator responsibilities included ensuring that employees (including new hires) received appropriate training, and annual medical evaluation and fit test if duties involved use of a respirator. Further review of the document showed the purpose of the RPP was to ensure that all employees who were required to wear respirators when performing their job duties were protected from exposure to these airborne transmissible diseases. The document showed that respirators were required for those designated staff members who cared for residents who were exposed or who were confirmed positive for COVID-19. The employees who were required to wear respirators may include Associate Care Directors, Care Directors, Care Managers, Medication Care Managers, Housekeepers (at a minimum of 2), and Culinary (at a minimum of 2).

Review of the facility's undated "Employee List" showed that the facility hired Staff D on 06/01/2023, Staff E on 04/26/2023, Staff F on 06/07/2023, Staff T on 12/29/2022, Staff V on 04/16/2021, Staff W on 09/15/2020, Staff MM on 12/17/2018, Staff NN on 04/27/2015, Staff SS on 05/14/2019, Staff TT on 01/24/2017, and Staff HHH on 08/01/2021.

Review of the facility's undated document titled "respirator fit testing" showed that Staff D, Staff E, Staff F, Staff T, Staff V, Staff W, Staff MM, Staff NN, Staff SS, Staff TT, and Staff HHH had not completed the initial or any respirator fit test. Further review of the documentation showed that Staff D, Staff F, Staff T, Staff V, Staff W, Staff MM, Staff NN, Staff SS, and Staff TT had not completed the respirator medical clearance evaluation certificate, as required.

During an interview on 06/28/2023 at 11:00 AM, Staff A, General Manager, stated that they were the RPP Administrator. Staff A further stated that Staff C, Care Director, was the facility Fit Testing Trainer/Coordinator. Staff A stated that all care staff were fit-tested for respirators.

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During an interview on 06/28/2023 at 12:55 PM, Staff C stated that they were the Fit Testing Trainer/Coordinator trained to conduct N95 respirator fit-testing for facility staff. Staff C further stated that they were aware not all staff that were required to be fit-tested had completed all fit-testing requirements.

During an interview on 06/28/2023 at 1:05 PM, Staff A stated that they were aware some employees missed the required fit-testing. Staff A further stated that additional Fit Testing Trainers were contacted to assist in completing the required N95 respirator fit tests for facility staff.

This is an uncorrected deficiency previously cited on 03/08/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis of Bellevue is or will be in compliance with this law and / or regulation on (Date) 8/7/2023.

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

[Signature]
Administrator (or Representative)

7/7/2023
Date



Residential Care Services Investigation Summary Report

Provider/Facility: Aegis of Bellevue

Provider Type: Assisted Living Facility

License/Cert.#: 2491

Compliance Determination #: 20336

Intake ID: 70209

Investigator: Laurie Anderson

Region/Unit #: RCS Region 2 / Unit D

Investigation Date(s): 02/21/2023 through 03/08/2023

Complainant Contact Date(s):

Allegation(s):

Resident tested positive for COVID-19

Investigation Methods:

Sample:

Total residents: 79

Resident sample size: 10

Closed records sample size: 0

Observations:

Observed facility environment, Apartments of COVID positive residents, observed personal protective equipment and isolation supplies outside of COVID positive residences, observed signage on the apartment doors of COVID positive residents and on the main entrance. Observed Staff infection control practices and interactions with COVID positive residents.

Interviews:

Interviewed Alleged Victim and sampled COVID positive resident(s).
Interviewed Administration staff, Licensed Nurses, and care staff.

Record Reviews:

Reviewed Alleged Victim's records and expanded sampled COVID positive resident(s) medical records. Reviewed the facility's Repertory Protection Program, and infection control documents.

Investigation Summary:

Failed practice established. Facility failed to follow infection control policies and procedures, and Center for Disease Control recommendations, for COVID positive residents on isolation. Investigation completed with full inspection. See Statement of Deficiencies for the full inspection report.

Conclusion / Action:

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

AMENDED
04/08/2023

CERTIFIED MAIL

9489 0090 0027 6382 8690 64

102 Ave Bellevue LLC
Aegis of Bellevue
148 102nd Ave SE
Bellevue, WA 98004

RE: Aegis of Bellevue # 2491

Dear Administrator:

This document references the following complaint numbers 70209.

The Department completed a full inspection of your Assisted Living Facility on 03/08/2023 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-2210 Medication services.

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
- (b) Develop and implement systems that support and promote safe medication service for each resident.

The facility failed to ensure that 2 of 4 Medication carts did not contain expired medications for three residents. The facility Medication Care Managers removed the expired medications during the medications system review.

WAC 388-78A-2600 Policies and procedures.

- (1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:
- (c) Safely operate the assisted living facility; and
- (2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:
- (i) To supervise and monitor residents, including accounting for residents who leave the premises;

The facility failed to follow two of their medication management policies, the undated "Medication Cart Audit Procedure" and the "Medication Care Manager Weekly Medication Audit," dated 06/18/2020, to ensure that 2 of 5 sampled Medication carts (4th floor medication cart and Memory Care Medication cart) did not contain expired medications for three residents. The "Medication Cart Audit Procedure" showed that all Medication Carts would undergo a weekly audit that used the "Medication Care Manager Weekly Medication Audit," form which showed the Medication Care Managers removed all expired and discontinued medications.

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

- (2) The licensee must:
- (b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

The facility failed to place the last full inspection report in a common area of the facility, accessible to anyone who wanted to review the report. During the licensing inspection, the facility placed the report in a clearly labeled binder on the bottom shelf of a console table near the entrance of the facility.

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.
- 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



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

Statement of Deficiencies	License #: 2491	Compliance Determination # 20336
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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 02/21/2023, 02/24/2023 and 02/24/2023 of:

Aegis of Bellevue
148 102nd Ave SE
Bellevue, WA 98004

This document references the following complaint numbers: 70209.

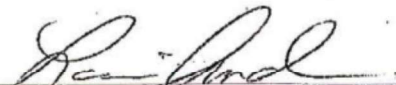
The following sample was selected for review during the unannounced on-site visit: 10 of 79 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor
Laurie Anderson, Community Field Manager

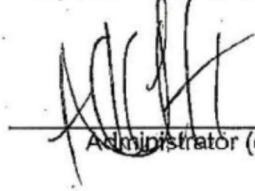
From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

04-06-2023
Date

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



Administrator (or Representative)

4/22/2023

Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement 1 of 1 infection control policy related to the Coronavirus disease (COVID-19). This failure placed all 79 residents and 74 staff at risk of contracting and spreading a potentially life-threatening virus.

Findings included...

Review of the facility's policy titled "WA Infection Control Guidelines", dated 12/27/2021, showed that the facility followed universal precautions for infection control. The policy showed that the facility "incorporated personal protective equipment and safe work practices to protect staff from potentially infectious material and prevent the spread of infection within our workplace. It includes hand hygiene, use of gloves, facial protection, respiratory hygiene, and environmental precautions." In addition, the policy showed that "in areas of high substantial to high community transmission, ensure the HCP (Health Care Provider) interacting with residents (who are not suspected or confirmed to have SARS-COV-2 infection) are still wearing eye protection in addition to well-fitting source control." The policy also showed that "staff will wear a mask such as surgical or K95 and eye protection during resident contact which requires staff to be within 6 feet of the resident; i.e., for Care Managers, this will be the majority of their time on shift. (only in non-outbreak situations)." The policy showed that staff would remove all Personal Protective Equipment (PPE), except the respirator, before they left the infected resident(s) room. Further review of the policy showed that staff would remove the respirator after they left the room and closed the door.

On 02/13/2023 the facility reported a COVID-19 outbreak when a single resident, Resident 6 tested positive for COVID-19. On 02/21/2023 at 9:10 AM, Staff E, Health Services Director, informed the Department that a second resident, Resident 10, tested positive for COVID-19.

Review of the Centers for Disease Control (CDC) COVID Data Tracker Levels of Community Transmission website showed on 02/08/2023, the transmission level for the county where

the facility was located was high. The CDC guidance recommended that Long-term care facilities monitor the community transmission levels for a two-week period, and ensure the levels were at a substantial or lower level before implementation of less stringent source control practices.

EYE PROTECTION

Observation on 02/21/2023 at 9:05 AM, Staff HHH, Lead Concierge, sat at the main entrance in the main lobby. Observation showed Staff HHH interacted with several residents. During the resident interactions, Staff HHH did not wear eye protection.

Observations on 02/21/2023 at 9:10 AM, during the Department's entrance conference showed Staff F, Health Services Director, and Staff A, General Manager, did not wear eye protection. Observation showed Staff A in the lobby and spoke with residents. Observation showed Staff F greet residents in the lobby.

Observation on 02/21/2023 at 12:08 PM showed Staff EEE, Host/Hostess, Staff YY, Host/Hostess, Staff R, Host/Hostess, and Staff K, Culinary Service Director all interacted with residents in the facility's main dining room. Observation showed Staff EEE, Staff YY, Staff R and Staff K did not wear eye protection while they served meals to the residents.

Observation on 02/23/2023 at 2:12 PM showed Staff GGG, Marketing Director, in the marketing office. Observation showed Staff GGG interacted with Resident 13. Staff GGG did not wear eye protection during the interaction.

Observation on 02/24/2023 at 12:26 PM showed Staff EEE, Staff N, Host/Hostess, and Staff K, served residents food in the main dining room without wearing eye protection. The Department Representatives observed Staff EEE, Staff N, and Staff K donned (put on) eye protection when the Department Representatives were present.

FACE COVERINGS

Review of the State of Washington Department of Health "Secretary of Health Mask Order" document, with Amending Order 20-03-10 "Face Coverings- Statewide," stated "Every person in Washington State must wear a face covering that covers their nose and mouth when they are indoors in any of the following settings, subject to the exceptions and exemptions below: Health Care settings and Long-term care settings. The order further stated "for the purpose of this order, a face covering must: fit snugly against the sides of the face; completely cover the nose and mouth; be secured with ties, ear loops, elastic bands, or other equally effective method; and include at least one layer of tightly woven fabric without visible holes, although multiple layers are strongly recommended. A face covering may also be a mask or face covering that provides a higher level of protection than a cloth face covering, such as a medical procedure/surgical mask, a KN95 mask, a KF94 mask, or an N95 mask."

Review of the Aging and Long-Term Support Administration (ALISA) Residential Care Services (RCS) document titled "Community Program Infection Prevention and Control (IPC) Assessment Pathway" for Assisted Living Facilities, dated January 2023, showed that "HCP

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[Health Care Providers] are not allowed to wear cloth masks for source control. HCP must wear a medical grade procedure mask."

Observation on 02/21/2023 at 9:10 AM showed Staff EEE wore a cloth mask during the entrance conference and throughout the day. Observation showed Staff EEE wore the cloth mask when they interacted with residents.

Observation on 02/21/2023 at 12:08 PM showed Staff EEE, wore a cloth mask below their nose and mouth. Observation showed Staff EEE improperly wore the cloth mask while they served meals to the residents in the facility's main dining room. Additional observation on 02/24/2023 at 12:26 PM, showed Staff EEE still wore the mask below their nose.

Observation on 02/23/2023 at 10:39 AM showed Staff ZZ, Activity Assistant, walked down the second-floor hallway towards the staircase. Staff ZZ continued down the stairs to the first-floor lobby. Staff ZZ did not wear a mask or eye protection.

PERSONAL PROTECTION EQUIPMENT DOFFING

During an interview on 02/23/2023 at 1:25 PM, Staff Y stated they were not fit tested for any NIOSH respirator.

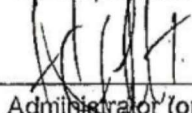
Observation on 02/24/2023 at 1:24 PM showed Staff Y, Registered Nurse (RN)/Wellness Nurse, entered Resident 10's apartment. Staff Y stated that they were there to perform a health check on both Resident 10 and their spouse (Resident 14). Observation showed signs posted above the PPE supply cart located outside the apartment. The signs showed the proper PPE donning and doffing (removal) procedures. Observation showed that Staff Y donned PPE, which included an N95 respirator, prior to entering the apartment. Observation outside of the isolation apartment showed an uncovered garbage can without a plastic bag liner. Observation showed that when Staff Y exited the apartment, Staff Y started to doff their gown outside of the apartment. Then observation showed Staff Y move the garbage can from the outside of the entry door to inside the apartment where Staff Y doffed their gown and gloves. Additional observation showed Staff Y left the apartment and doffed their eye protection outside of the apartment.

During an interview on 02/24/2023 at 1:30 PM, upon exiting the apartment, Staff Y asked the Department Representatives if they should remove their used PPE inside of the apartment. Staff Y then stated that the garbage can to discard used PPE was located outside of the apartment by the door. Staff Y stated that there was supposed to be a plastic bag liner inside the garbage can.

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, Aegis of Bellevue is or will be in compliance with this law and / or regulation on (Date) 4/22/23.

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



Administrator (or Representative)

4/22/23

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored;

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation and interview the facility Medication Care Manager failed to ensure 1 of 4 sampled medication carts (third floor medication cart) were locked. This failure placed the residents at risk for harm or illness if the medications were accessed and swallowed.

Findings Included...

Review of the facility's undated "Assisted Living Resident Characteristics Roster" showed that 61 residents resided in the unsecured Assisted Living section of the facility. The Roster identified 26 of the 61 residents with a diagnosis of "[REDACTED]".

On 02/22/2023 at 12:57 PM, the Department Representative, Staff P, Medication Care Manager in training, and Staff C, Associate Care Director/Medication Care Manager, walked past the third-floor medication cart. Observation showed the cart was unlocked. Observation showed the drawers to the medication cart were accessible and easily opened. When the unlocked cart was noticed, Staff C stated that Staff Q, Medication Care Manager, managed this medication cart. Staff C then radioed Staff Q who was on the fourth floor to come to the third floor.

Observation on 02/22/2023 at 12:58 PM, showed several Assisted Living residents independently ambulated along the third-floor hallway, past the unlocked medication cart.

Observation on 02/24/2023 at 9:34 AM, showed several Assisted Living residents ambulated back and forth along the hallway, past the fourth-floor locked medication cart.

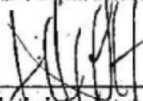
Observation showed Resident 12 approached the medication cart. Resident 12 stated that they were looking for their medications.

During an interview on 02/22/2023 at 1:01 PM, Staff Q stated that they were responsible for the third-floor medication cart. Staff Q admitted that they left the cart unlocked. Staff Q stated that it was not their standard practice to leave the medication cart unlocked when the cart was unattended.

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, Aegis of Bellevue is or will be in compliance with this law and / or regulation on (Date) 4/22/23.

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



Administrator (or Representative)

4/22/23

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 ensure residents received medications as prescribed for 4 of 9 sampled residents (Resident 3, Resident 4, Resident 7, and Resident 8). This failure placed the residents at risk for compromised health.

Findings included...

Resident 3

Review of the facility's "Resident Characteristics Roster", dated 02/21/2023, showed that the facility admitted Resident 3 in [REDACTED] of 2022. Review of Resident 3's "Face Sheet", dated 02/21/2023, showed that Resident 3's medical diagnoses included [REDACTED].

Review of Resident 3's "Individualized Service Plan (ISP)", dated 02/23/2023, showed that the facility provided Resident 3 with medication assistance. The ISP showed that facility staff were required to order Resident 3's medications.

Review of Resident 3's January 2023 electronic Medication Administration Record (eMAR) showed that Resident 3's prescriptions included Lactulose Solution (a drug to treat constipation), 30 Milliliters (equivalent to 20 Milligrams) to be given twice daily, and

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Miconazole Cream 2% (a drug to treat fungal infection on skin), to be used twice daily. The eMAR showed Lactulose Solution was unavailable for 8 days: 01/12/2023, 01/13/2023, 01/14/2023, 01/15/2023, 01/17/2023, 01/18/2023, 01/19/2023, and 01/20/2023. The eMAR also showed Miconazole Cream 2% was unavailable for 15 days, from 01/06/2023 through 01/20/2023.

During an interview on 02/23/2023 at 4:00 PM, Staff F, Health Services Director, stated that they were unaware Resident 3's medications were not available, and that Resident 3 missed some doses of their medications in January 2023. During a follow-up interview on 03/07/2023 at 3:17 PM, Staff F stated that the facility contacted the pharmacy when the two medications ran out. Staff F further stated that they were unaware Resident 3's medications were not delivered by their pharmacy in January 2023. Staff F stated that they failed to follow up with the pharmacy to ensure Resident 3's medications were delivered.

Resident 4

Review of the facility's "Resident Characteristics Roster", dated 02/21/2023, showed that the facility admitted Resident 4 in [REDACTED] 2018. Review of Resident 4's "Face Sheet", dated 02/21/2023, showed that Resident 4's medical diagnoses included [REDACTED] and [REDACTED].

Review of Resident 4's "Individualized Service Plan (ISP)", dated 02/23/2023, showed that the facility assisted Resident 4 with medication administration and management of oral medications.

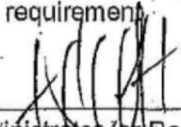
Review of Resident 4's February 2023 electronic Medication Administration Record (eMAR) showed that on 01/06/2023, the medical provider prescribed Resident 4 Acetaminophen (a drug to relieve pain), 975 Milligrams to be given three times daily, at 8:00 AM, noon and 8:00 PM. Further review of the eMAR showed the Acetaminophen medication was unavailable for the three doses on 02/16/2023, the noon dose on 02/17/2023, the noon dose on 02/18/2023, the 8:00 AM and noon doses on 02/19/2023, and the 8:00 AM dose on 02/20/2023.

During an interview on 02/23/2023 at 4:00 PM, Staff F, stated that they were unaware that Resident 4's medication was unavailable, and that Resident 4 missed some doses of their medications. During a follow up interview on 03/07/2023 at 3:17 PM, Staff F reported that Resident 4's Acetaminophen medication arrived in three separate packages, labeled for AM, noon, and PM doses. Staff F stated that staff did not follow the medication labels when they mistakenly popped out the AM and PM doses from the bubbles for the noon schedule. Staff F further stated that the facility ran out of the noon packaged Acetaminophen which resulted in several missed medication doses for Resident 4.

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, Aegis of Bellevue is or will be in compliance with this law and / or regulation on (Date) 4/22/23.

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


Administrator (or Representative)

4/22/23
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to post menus in common area or to provide written menus at least one week in advance to 79 of 79 residents. This failure placed 79 residents at risk for unmet nutritional needs and a decreased quality of life.

Findings included...

Observations on 02/21/2023 between 9:00 AM – 12:40 PM showed that there were no menus posted in any of the resident accessible areas within the assisted living premises. Additional observation showed that the facility used a resident newsletter, the "Bellevue Buzz", to inform residents of the daily menu. The facility placed the daily newsletter in flyer holders inside each elevator. Further observation showed that the flyer holders inside the two elevators were empty.

Review of the facility's "Daily Specials Menus", dated 01/29/2023 through 02/26/2023, showed that the menus for the dates, 01/31/2023, 02/06/2023, 02/20/2023, 02/21/2023, and 02/22/2023 were unavailable. Further review the menus showed that there were two daily menus dated 02/04/2023 and two daily menus dated 02/26/2023. The two menus dated 02/04/2023 and the two menus dated 02/26/2023 each listed different meals.

During an interview on 02/21/2023 at 12:40 PM, Staff K, Culinary Service Director, stated that the facility did not post a weekly menu to show their residents what foods would be served for a week. Staff K stated that they put the daily menu in the Assisted Living dining

room for those residents in the Assisted Living unit. Staff K stated that the facility never posted menus in the secured memory care unit for the residents. Staff K further stated that they were unaware the "Bellevue Buzz" with the daily menu for today was unavailable in the elevators.

Observation on 02/23/2023 at 7:30 AM of the assisted living dining room, the memory care unit dining room and the kitchen showed no menu posted for the day. Further observation of the common resident areas showed neither the daily menu nor the weekly menu was posted.

During an interview on 02/23/2023 at 7:30 AM, Staff V, Care Manager 2, stated that they were unable to locate the menu for the day in the assisted living dining room. Staff V stated that the kitchen staff knew where to find the daily menu. Staff V stated that they looked up the "Bellevue Buzz" placed at the front desk to find out what meals were served each day. During an interview with 02/23/2023 at 7:32 AM, Staff L, Cook, stated that they were unable find today's menu in the kitchen. Staff L stated that the menus were usually posted in the kitchen.

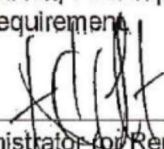
During an interview on 02/23/2023 at 7:45 AM, Staff U, Medication Manager in memory care unit, stated that the facility did not post menus in the memory care unit. Staff U stated that they were usually unaware what was on the daily menus. Staff U stated that when the meals arrived from the kitchen, then Staff U would know what the meal was to serve to the residents.

During an interview on 02/23/2023 at 1:15 PM, Staff A, General Manager, stated that they were unfamiliar with the regulations that required facilities to post weekly written menus in advance. Staff A also stated that they were unaware that the facility needed to provide the residents with a copy of the written menus for each week. Staff A stated that they posted the daily menu in the "Bellevue Buzz" which they delivered to the Assisted Living residents' rooms every day. Staff A further stated that the menus and "Bellevue Buzz" were not posted or provided to residents in the memory care unit.

Plan/Attestation Statement

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Administrator (or Representative)

4/22/23
Date

WAC 246-215-02120 Food worker cards.

(1) The permit holder and person in charge of the food establishment shall ensure that all food employees are in compliance with the provisions of chapter 69.06 RCW and chapter 246-217 WAC for obtaining and renewing valid foodworker cards.

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(a) At 135 F (57 C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400 (2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130 F (54 C) or above; or

(b) At 41 F (5 C) or less.

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain food temperature of the hot foods at or above 135 degrees Fahrenheit and food temperature of the cold foods at or below 41 degrees Fahrenheit, prior to serving the residents. The facility also failed to ensure 4 of 13 dietary staff (Staff L, Staff M, Staff N, and Staff O) have a valid Food Worker Card when those staff provided food services. These failures placed the 79 of 79 residents at risk for foodborne illnesses.

Findings included...

Review of the facility's "Resident Characteristic Roster", dated 02/21/2023, showed that the facility provided dietary service to 79 assisted living residents.

Review of the facility's document titled "Time and Temp Guidelines for Foods Transferred from Main Kitchen", dated 07/21/2015, showed that the facility's guidelines were consistent with the Washington Administrative Code (WAC). The document showed that the required holding temperature was 135 degrees Fahrenheit or above for hot food and the required holding temperature was 41 degrees Fahrenheit or below for cold food. The document also showed that the facility kept a daily food temperature log in the main kitchen and a second food temperature/time log traveled with the food to assure the time was monitored throughout the process.

During an interview on 02/21/2023 at 1:30 PM, Staff K, Culinary Service Director, stated that the facility prepared and cooked each meal in the main kitchen for all residents. Staff

K stated that they placed all meals ready to be served for Life's Neighborhood (LN) residents in an electric food warmer cart. The meals were transported in the food warmer cart to the LN unit. Staff K stated that the kitchen staff measured food temperatures at the kitchen. Staff K stated that since the kitchen and LN were located close together on the ground floor, food temperatures were not checked again prior to serving the LN residents.

HOT HOLDING

Observation on 02/22/2023 at 11:45 PM showed that Staff L, Cook, placed grilled chicken and French fries in covered dishes. Observation showed Staff L did not measure the food temperature after food was placed on the covered dishes. Staff L then placed the covered dishes into the electric food warmer cart. The cart was transported from the main kitchen to the Life's Neighborhood unit. Staff L measured the food temperature of the dishes inside the food warmer cart per the Department Representative's request. Observation of the thermometer used by Staff L showed that the food temperatures of two grilled chicken fillet samples measured 102 degrees Fahrenheit.

During the Resident Group Meeting on 02/22/2023 at 1:30 PM, five anonymous residents stated that they often received cold meals which were supposed to be hot. One of the five anonymous residents stated that about a week and a half ago, a pork chop meal served to the residents was cold and raw.

Observation on 02/23/2023 at 11:40 AM showed an unplugged electric food warmer cart in the LN unit dining room. Observation showed that the temperature indicator of the food warmer cart did not show any temperature readings. Observation showed that the staff took the meal trays out from the food warmer cart to serve the residents. Observation showed Staff R measured the food temperature per the Department Representative's request. Further observation showed the food temperatures of two grilled ham and cheese sandwiches samples were 98 degrees Fahrenheit and 102 degrees Fahrenheit.

During an interview on 02/23/2023 at 12:30 PM, Staff K stated that they were aware the food warmer cart was broken and unable to maintain the required food temperatures. Staff K stated that since the cart was broken, staff left the cart unplugged in the kitchen and in the LN dining room.

COLD HOLDING

Observation on 02/21/2023 at 12:50 PM showed a container of diced turkey and a container of diced ham sat on an uncovered holding station in the kitchen. Observation showed that residents were served the diced turkey and diced ham with salad for lunch. Observation showed that Staff R, Host/Hostess measured the food temperatures of the diced turkey and diced ham. The temperatures each measured 45 degrees Fahrenheit. Further observation showed that the diced turkey and diced ham were stored in the holding station on top of cold water. There was no ice used underneath the containers of to keep the food at the proper temperature.

During an interview on 02/21/2023 at 12:50 PM, Staff R stated that the kitchen staff measured the food temperature when they took the cold food items out of the refrigerator

prior to serving lunch. Staff R stated that they placed the cold food containers in the ice bed of the uncovered food holding station. Staff R stated that they were uncertain the required holding temperature for cold food in Washington state. Staff R then stated that they thought cold foods should be kept under 45 degrees Fahrenheit. Staff R stated that they only checked the cold food temperature when it came out of the refrigerator. Staff R stated that they did not continue to monitor the food temperature throughout the lunch hours. Staff R stated that they were unaware the holding station did not maintain the food temperature of the cold foods.

Observation on 02/23/2023 at 11:40 AM showed that the facility served potato salad at lunch for the LN residents. Observation showed that only the bottom half of the potato salad container sat on ice cubes in a large container. Further observation showed Staff R measured the food temperature of the potato salad, at three different spots in the salad. The temperature measured 44 degrees Fahrenheit.

During an interview on 02/23/2023 at 11:40 AM, Staff R stated that they brought the potato salad directly from the refrigerator to the LN unit. Staff R stated that they were unaware that the food temperature of the potato salad was above the required cold holding temperature.

FOOD WORKER CARDS

Review of the facility's document titled "Background Clearance and Training/Orientation Requirements for Washington", dated 08/23/2018, showed that the facility required a valid food handler's card for their dietary staff within 14 days of hire.

Review of the facility's "Employee Roster" showed that the facility hired Staff L, Cook, on 05/26/2022; Staff M, Dishwasher, on 10/06/2021; Staff N, Host/Hostess, on 08/16/2022; and Staff O, Cook, on 02/14/2022.

Review of the facility's personnel records showed that Staff L's Food Worker Card expired on 10/21/2022; Staff M's Food Worker Card expired on 02/01/2023; and Staff N's Food Worker Card expired 01/27/2023. Further review of the personnel records showed no initial Food Worker Card for Staff O. Records showed Staff O obtained their Food Worker Card on 02/21/2023, more than a year after being hired.

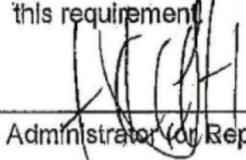
Review of the facility's Employee Schedule for dietary staff showed that Staff L worked between 01/31/2023 – 02/25/2023; Staff M worked between 02/01/2023 – 02/25/2023; Staff N worked between 01/29/2023 – 02/25/2023; and Staff O worked between 01/29/2023 – 02/25/2023.

Observations on 02/21/2023 between 11:15 AM – 1:05 PM showed that Staff L prepared food and cooked meals in the kitchen for the residents.

During an interview on 02/21/2023 at 2:00 PM, Staff K, Culinary Service Director, stated

the facility maintained the employees' Food Worker Cards in the Business Office. Staff K further stated that when they scheduled the four dietary staff to work, they were unaware Staff L, Staff M, and Staff N had expired Food Worker Cards. Staff K stated that when they schedule Staff O to work, they were unaware Staff O had no food worker card and only recently obtained a valid card.

During an interview on 02/21/2023 at 03:00 PM, Staff I, Business Office Manager, stated that they were familiar with the facility's Food Worker Card requirements. Staff I stated that the facility required cook, host/hostess, and dishwasher to obtain a valid food worker card within 14 days of hire. Staff I further stated that they were unaware of the invalid status for Staff L, Staff M, Staff N, and Staff O Food Worker Cards.

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)	<u>4/22/23</u> _____ Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

- (a) A Washington state name and date of birth background check; and
- (b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to obtain a Washington state name and date of birth background check for three contracted staff, Collateral Contact 1, (CC1) Collateral Contact 2, (CC2) and Collateral Contact 3 (CC3). This failure placed all the 79 residents at risk for harm from caregivers with unknown backgrounds.

Findings included...

Review of Resident 7's "Individualized Service Plan," (ISP) dated 02/21/2023, showed that Resident 7 had private caregivers hired through an outside agency that provided 24-hour care seven days a week.

Review of the facility's staff schedule for the week of 02/19/2023 showed that on 02/23/2023, four agency staff, which included CC 1, private caregiver, and CC 2, private caregiver, were scheduled to work the morning shift.

Observation on 02/23/2023 at 10:48 AM, showed CC 3, private caregiver, provided care for Resident 7.

During an interview on 02/23/2023 at 10:48 AM, Resident 7 stated that they utilized a private caregiver through an outside agency for 24-hour care seven days a week. Resident 7 stated that the nighttime caregiver worked each night of the week. Resident 7 stated that the agency caregivers assisted them with bathing, transfers, ambulation with a gait belt, and escorts in the community as needed.

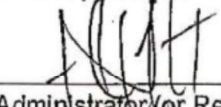
During the Department's on-site visit 02/23/2023 at 2:02 PM, Staff I, Business Office Manager, confirmed with an email that CC1 and CC2 were working the day shift of 02/23/2023 in the secured Memory Care. Staff I stated in the email that they would provide the completed Washington State name and date of birth background checks for CC1 and CC2 that were conducted through the Department of Social and Health Services.

During an interview on 03/07/2023 at 10:56 AM, Staff I stated that they were not able to obtain the background check results for CC1, one of three private caregivers for Resident 7. Staff I also stated that they were unable to provide the background checks for the two-agency staff, CC1 and CC2.

Plan/Attestation Statement

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Administrator (or Representative)

4/22/23

Date

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

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

(a) The operation of the assisted living facility;

(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 observation, interview, and record review the facility failed to implement their policy for Respiratory Protection Program for 46 of 74 staff who have direct contact with residents (Staff D, Care Manager, Staff G, Maintenance Director, Staff H, Housekeeper, Staff K, Culinary Service Director, Staff N, Host/Hostess, Staff P, Care Manager, Staff R, Lead Host/Hostess, Staff S, Care Manager, Staff T, Wellness Nurse, Staff U, Medication Care Manager, Staff V, Care Manager, Staff W, Associate Care Director, Staff X, Care Manager Coordinator, Staff Y, RN, Wellness Nurse, Staff Z, Care Manager, Staff AA, Medication Care Manager, Staff BB, Care Manager, Staff CC, Lead Care Manager, Staff DD, Care Manager, Staff EE, Medication Care Manager, Staff FF, Associate Care Director, Staff GG, Medication Care Manager, Staff HH, Care Manager, Staff II, Care Manager, Staff JJ, Care Manager, Staff KK, Care Manager, Staff LL, Wellness Nurse, Staff MM, Medication Care Manager, Staff NN, Lead Care Manager, Staff OO, Care Manager, Staff PP, Care Manager, Staff QQ, Associate Care Director, Staff RR, Care Manager, Staff SS, Care Manager, Staff TT, Care Manager, Staff UU, Care Manager, Staff VV, Care Manager, Staff WW, Housekeeper, Staff XX, Lead Housekeeper, Staff YY, Host/Hostess, Staff ZZ Life Enrichment Assistant, Staff AAA, Life Enrichment Assistant, Staff BBB, Life Enrichment Director, Staff CCC, Life Enrichment Assistant, Staff DDD, Life Enrichment Coordinator, and Staff FFF, Host/Hostess). This failure placed 79 residents and staff at risk of contracting and spreading a potentially life-threatening virus.

Findings included...

The Center for Disease Control (CDC), the national public health agency for the United States, in March 2020, identified Coronavirus disease (COVID-19) as a public health risk and established on-going public health guidance to monitor and control the spread of COVID-19. The CDC identified specific subgroups of persons thought to be at higher risk for severe illness or death from COVID-19 infection, which included persons over the age of 65 and persons with underlying chronic health conditions. The CDC identified the COVID-19 virus as an airborne, transmissible disease (a disease largely spread via small droplets expelled through the breath of an infected person, which can travel long distances in the air, and can infect other people when the virus is breathed in, per www.cdc.gov/coronavirus/2019-ncov, viewed 01/27/2022). The CDC encouraged on-going and strict adherence to previously established infection mitigation (cause to become less harsh or harmful) as outlined in their Standard Precautions and Transmission-Based Precautions. Within the CDC Transmission-Based Precautions (www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html, viewed 01/27/2022), the CDC recommended the use of Personal Protective Equipment (PPE) appropriately, to include a fit-tested NIOSH-approved (National Institute for Occupational and Health Safety) N95 or higher level respirator for healthcare personnel (per the online website for the Federal Drug Administration, www.fda.gov, viewed 01/27/2022, an N95 respirator is defined as a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles).

Review of the facility's undated document titled "Resident Characteristic Roster" showed that the facility provided care and services to 79 residents. Review of the facility's undated staff roster identified Staff A as the General Manager.

RESPIRATORY PROTECTION PROGRAM (RPP):

Review of the facility's document titled "Respiratory Protection Program"(RPP), dated 10/18/2021, showed that the General Manager was the program Administrator. The document showed the program administrator's responsibilities included "identifying situations requiring a mandatory use of respirators and ensuring the conduct of fit testing. The fit testing trainer or designee was responsible for ensuring that employees under their supervision (including new hires) have received appropriate training and annual medical evaluation and fit test if duties involve use of a respirator". The trainer/designee was responsible to ensure that respirators fit well and do not cause discomfort. Further review of the document showed "respirator will be required for those designated staff members who will care for residents who have been exposed or who have confirmed positive COVID-19. Employees who may be required to wear filtering facepiece respirators may include Associate Care Directors, Care Directors, Care Managers/Medication Care Managers, Housekeepers [minimum 2], Maintenance Director and/or Assistant, Life Enrichment, Culinary Servers [at a minimum 2 servers]". The document showed that employees required to wear tight-fitting respirators would be fit tested prior to being allowed to wear any tight-fitting respirator, tested annually and when there were changes in the employee's physical condition that could affect respirator fit. The document also showed that the Program Administrator would ensure fit tests were conducted in accordance with any appropriate and OSHA-approved protocol of the Respiratory Protection Standard.

Review of the facility's undated document titled Respiratory Protection Program fit test record showed that only eight of 44 Health Care staff, who had direct contact with residents, were fit tested for respirators. There were no records to show that the culinary staff, housekeeping staff, Life Enrichment staff, and Maintenance staff were fit tested for respirators per the facility's RPP.

During an interview on 2/23/2023 at 1:25 PM, Staff Y, Registered Nurse, Wellness Nurse and Staff LL, Registered Nurse, Wellness Nurse, both stated that they were not fit tested for an N95 mask or any equivalent mask. Staff LL stated that they unaware of what fit testing meant. Both Staff Y and Staff LL stated that they went into COVID-19 positive resident apartments, Resident 6 and Resident 10, during the Department's inspection. Staff Y and Staff LL stated that they both donned full Personal Protection Equipment (PPE), which included an N95 mask.

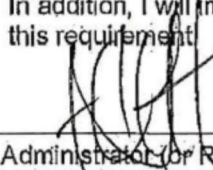
During an interview on 02/23/2023 at 2:54 PM, Staff FFF, Registered Nurse, Corporate Clinical Health Director, stated that the company was aware they were out of compliance with fit testing staff for N95 or equivalent respirators. Staff FFF stated that the company had not yet developed a fit test process. Staff FFF stated that it was in the development process.

Observation on 02/24/2023 at 1:20 PM, showed Staff Y donned full PPE, which included an N95 mask, prior to entering Resident 10's apartment.

Plan/Attestation Statement

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Administrator (or Representative)

4/22/23
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:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 administrative staff (Staff A) had completed the second step of the two-step Tuberculosis (TB) skin test. This failure placed residents at risk of contracting an infectious disease.

Findings included...

Record review of the facility's undated staff roster showed the facility hired Staff A on 09/14/2022. Review of the Facilities Management System (FMS) showed the facility established Staff A as the General Manager on 12/02/2022.

Record review of Staff A's personnel records at the facility showed that on 09/15/2022, Staff A signed and dated the facility document titled, "[Facility name] Mantoux (PPD) Skin Testing Questionnaire & Consent Form (WA only)" [Mantoux- a test used to screen for tuberculosis; PPD- purified protein derivative]. The form further indicated that a two-step TB test was required. The form showed that Staff A completed the first step on 09/15/2022. Further review of Staff A's personnel records showed there was no documentation that Staff A completed the second step of the test.

Observation during the full licensing inspection on 02/21/2023 through 02/24/2023, showed Staff A present in the facility. Further observations on these days showed Staff A interacted with the residents.

During an interview on 02/24/2023 at 2:30 PM, Staff A confirmed that they had not completed the second step of the TB screening.

During an interview on 02/27/2023 at 12:02 PM, Staff I, Business Office Manager, confirmed Staff A never completed the second step of the TB screening. Staff I also stated that Staff A restarted their TB testing during the full inspection and received the results of the first step of the skin test. Staff I further stated that Staff A planned to receive the

second TB skin test in about two weeks.

Plan/Attestation Statement

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[Signature]
Administrator (or Representative)

4/22/23
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 observation, interview, and record review, the facility failed to ensure that 1 of 1 staff (Staff D) with a positive test result for Tuberculosis (TB) completed a chest X-ray within seven days, evaluation of signs and symptoms of TB, and followed the recommendation of their health care provider. This failure placed residents at risk of contracting an infectious disease.

Findings Included...

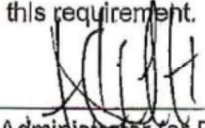
The Centers for Disease Control and Prevention (CDC) website (03/01/2023) defined, "Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain... If not treated properly, TB disease can be fatal." According to the CDC, "... Persons at risk for exposure to persons with TB disease include... Residents and employees of high-risk congregate settings (e.g., correctional facilities; homeless shelters, health care facilities)". The CDC (02/14/2023) further indicated the signs and symptoms of TB "depend on where in the body the TB bacteria are growing... TB disease in the lungs may cause such symptoms as a bad cough that lasts 3 weeks or longer, pain in the chest, coughing up blood or sputum (phlegm from deep inside the lungs). Other symptoms of TB disease are weakness or fatigue, weight loss, no appetite, chills, fever (and) sweating at night."

Record review of the facility's undated staff roster showed the facility hired Staff D on 06/07/2022 as a Care Manager. Review of the facility's document titled, "Care Manager I" showed Staff D signed and dated the document on 06/07/2022. The document showed the position summary involved providing "direct personal care to residents".

Record review of the facility document titled, "[Facility name] Mantoux (PPD) Skin Testing* Questionnaire & Consent Form (WA only)" [Mantoux- a test used to screen for tuberculosis; PPD- purified protein derivative], showed, "Any positive test (10 millimeters induration (size) or greater) will result in referral to an outside agency or your primary healthcare practitioner for follow-up and testing by chest X-ray." * The TB skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm. The result is a measurement or induration in millimeters of a hard raised area that forms on the skin.

Review of Staff D's TB skin test record showed the test was administered on 06/07/2022 and read on 06/09/2022. The result of the test read, "10+ mm induration". Further record review showed no documentation that Staff D received a chest X-ray within seven days, was evaluated for signs and symptoms of TB, or received and followed the recommendation of their health care provider. Observation on 02/23/2023 between 7:30 AM – 8:30 AM, showed Staff D was present in the facility. Further observation showed that Staff D provided direct care and services to residents.

During an interview on 02/24/2023, Staff I, Business Office Manager, stated that the facility had no additional TB records for Staff D.

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)	<u>4/22/23</u> _____ Date

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.

Statement of Deficiencies	License #: 2491	Compliance Determination # 20336
Plan of Correction	Aegis of Bellevue	Completion Date
Page 23 of 30	Licensee: 102 Ave Bellevue LLC	03/08/2023

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

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that 1 of 1 resident (Resident 11) in its memory care unit had independent access to their room. This failure placed Resident 11 at risk for a diminished quality of life.

Findings included...

Observation on 02/21/2023 at 12:09 PM, showed Resident 11 unable to open the door to their apartment within Life's Neighborhood, the memory care unit. Further observation showed the resident's room was out of view of the care staff who were in the memory care dining room. Observation also showed the resident approached the Department's Licenser and asked the Department Licenser for access to their room. Resident 11 informed the Department Licenser they wanted access their room to use the bathroom. During an interview at that time, Resident 11 was able to identify their full name, room number, and confirmed that they did not possess a room key.

During an interview on 02/21/2023 at 12:10 PM, Staff G, Maintenance Director, confirmed that memory care residents were not provided with room keys. Staff G further confirmed that Resident 11 had correctly identified their room. Staff G then unlocked Resident 11's door.

Observation on 02/24/2023 from noon until 12:06 PM, showed Resident 11's door was locked. Further observation of random resident room doors showed some doors were unlocked and some doors were locked.

During an interview on 02/24/2023 at 12:07 PM, Staff J, Care Manager, stated that they were supposed to keep the resident room doors locked for ease of managing residents who wandered. Staff J added that in the memory care unit, the residents were not provided their own room key. Staff J also stated some doors were probably unlocked because the residents had just left their room to go to lunch.

During an interview on 02/24/2023 at 1:04 PM, Staff F, Health Services Director, stated that he was unaware of the regulation that ensured residents had independent access to their own rooms.

During an interview on 03/01/2023 at 12:09 PM, Staff A, General Manager, stated that he also was unaware of the regulation that ensured residents had independent access to their own rooms. Staff A further stated that there was no facility policy that addressed

independent room accessibility for the Life's Neighborhood's residents.

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, Aegis of Bellevue is or will be in compliance with this law and / or regulation on (Date) 4/22/23.

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

[Signature]
Administrator (or Representative)

4/22/23
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:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 3 housekeeping carts (Cart 1) with potentially hazardous chemical supplies were inaccessible to residents or under staff supervision. This failure placed all the residents at risk of harm if the chemicals were accessed.

Findings included...

Record review of the facility's policy titled, "Housekeeping Cart Policy", dated 10/26/2016, showed, "keep carts locked at all times when not in use." The policy also showed the facility used nine different cleaning products. Review of the facility's policy titled "Housekeeping", dated 04/01/2001, showed that "chemicals must be kept within sight or in a secured location at all times".

Record review of the facility's undated document titled, "Resident Characteristic Roster", showed the facility identified 28 of 61 assisted living residents with diagnosis of [REDACTED]

Observation on 02/21/2023 between 10:55 AM – 11:27 AM, showed an unlocked housekeeping cart (Cart 1) on the second floor outside of a resident apartment. At times

Staff H, Housekeeper, came out of the apartment, exchanged the cleaning chemicals, or got the vacuum, and returned to the apartment. Further observation showed Staff H continued to leave the cart unlocked and unattended. During an interview at this time, Staff H confirmed that they left their cart unlocked before they re-entered the resident's apartment.

Observation on 02/21/2023 at 10:55 AM, showed Cart 1 contained numerous cleaning chemicals with warning labels. Some of the chemicals were colorful and sat next to two bottles of a sports drink of similar color. The labels on the cleaning chemicals included warnings such as "Do Not Drink"; "Keep Out of Reach of Children"; "Do Not Puncture. Use of Adequate Ventilation..."; "Causes Substantial Eye Damage... Avoid Contact with Skin"; "Inhaling Contents May Be Fatal". The cart contained a 32-ounce bottle of bathroom cleanser with a warning label that advised, "Always Wear Imperious Gloves; Causes Severe Skin Burns and Eye Damage... Wear Protective Clothing, Face Protection, Eye Protection." Additionally, the cart contained a squirt bottle of stainless-steel cleaner that advised the use of eye and face protection. Further observation at this same time also showed several residents independently walked up and down the hall past the unsecured, unsupervised cart.

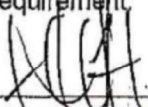
During an interview on 02/21/2023 between 10:55 AM – 11:27 AM, Staff G, Maintenance Director, confirmed that he supervised the housekeeping staff. Staff G stated that facility's policy required that while housekeepers cleaned the apartments, the housekeeping carts were to be locked.

During an interview on 02/21/2023 at 1:06 PM, Staff A, General Manager, confirmed that housekeeping carts needed to remain locked when unattended.

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Administrator (or Representative)

4/22/23

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;

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(i) A utility sink or equivalent means of obtaining and disposing of mop water, away from food preparation and service areas;

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, record review, the facility failed to ensure that 1 of 1 resident storage closet area and 1 of 1 resident-used parking garages were free from debris on the floor, obstacles including construction materials, and stacked furniture. The facility also failed to ensure that 1 of 1 laundry room air exchange vents within the memory care unit and 2 of 2 air exchange vents in the commercial laundry and adjacent mop sink utility room vented to the outside of the facility. This failure placed residents at risk of injury and a decreased quality of life.

Findings included...

Observation on 02/21/2023 at 11:46 AM of the memory care unit showed the laundry room air exchange vent did not work. Observation on 02/21/2023 at 12:45 PM of the commercial laundry room and adjacent utility room, which contained a wet mop sink, showed neither room's air exchange vent functioned.

During an interview on 02/21/2023 at 11:46 AM, Staff G, Maintenance Director, confirmed that the vent in the memory care unit's laundry room did not function. During an interview at 12:45 PM, Staff G confirmed that the vents in the commercial laundry room and utility room did not function. Staff G added that they failed to check the vents in the memory care laundry room and in the commercial laundry and utility rooms as part of their routine maintenance checks.

Observation on 02/21/2023 at 12:32 PM, showed there was a hallway in the facility with storage closets on either side. This area was accessible from the inside of the facility as well as through the garage. The hallway floor was littered with paper, cardboard, holiday decorations, plastic and metal objects, plastic wrap, cardboard boxes, plastic bins, a walker and a detached walker wheel, and various construction supplies. During an interview at the same time, Staff G stated that the storage closets were used by both residents and the facility.

Observation on 02/21/2023 at 12:35 PM – 12:37 PM of the garage, near the resident storage closets, showed a wide variety of stacked furniture and mattresses stored in the garage. Further observation showed construction/maintenance equipment, which included folded ladders leaning upright on other items, paint buckets, and cardboard boxes, stored in the garage. During an interview at the same time, Staff G confirmed that some residents used the garage for parking. Staff G stated that they were responsible to schedule the removal of the garbage in the garage. Staff G added that he was overdue with making the

request for garbage collection.

On 02/23/2023 at 8:18 AM and on 02/24/2023 at 8:09 AM, observations of the garage and storage closet hallway showed the same garbage, construction materials, and furniture as previously observed on 02/21/2023.

Observation on 02/23/2023 at 1:22 PM, showed a person standing at the first-floor elevators. Further observation showed the person pushed the elevator button to go down, which was the location of the garage. During a brief interview at the elevator, before they stepped into the elevator, the person confirmed they were a resident at the facility.

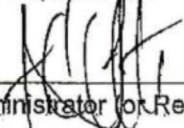
Review of the facility's undated document titled, "Preventative Maintenance Protocol" showed, "proper preventative maintenance is crucial in keeping our communities in excellent physical condition." Review of the facility's undated document titled, "Common Area Cleaning Protocol" showed, "Common areas should be kept in excellent condition."

During interviews on 02/24/2023 at 9:05 AM and 02/24/2024 at 2:40 PM, Staff A, General Manager, Staff A reported that six residents parked their cars in the garage, and 12 residents had storage closets within the structure of the garage. Staff A stated that the debris and furniture in garage were potentially a safety hazard. On 03/03/2023 at noon, Staff A stated that there was no facility policy specifically for maintenance and housekeeping of the garage.

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Administrator (or Representative)

4/22/23
Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

- (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 2 of 2 provisionally hired staff (Staff A and Staff E) were fingerprinted with results pending prior to have unsupervised access to residents. This failure also caused the facility not to obtain the completed national fingerprint background check within 120 days of hire. This failure placed the residents at risk of abuse, neglect, or exploitation from staff with unknown national background check results.

Staff A, General Manager

Review of the facility's undated staff roster showed the facility hired Staff A on 09/14/2022. Review of the Department's Facilities Management System (FMS) showed the facility established Staff A as the General Manager on 12/02/2022.

Review of Staff A's personnel records showed the facility completed a Washington name and date of birth background check, dated 09/16/2022. The results of the name and date of birth background check showed, "No background information was reported... no criminal or negative action records" were found. Staff A's personnel records showed Staff A signed the Department of Health and Social Services, "Fingerprint Background Check Notice" on 09/15/2022. There was no documentation that showed Staff A completed the fingerprint background check process. At the time of completion of the full licensing inspection on 03/08/2023, records showed Staff A was employed as the General Manager for 173 days, 53 days past the allowed time to complete the final national fingerprint background check.

Observation during the full licensing inspection on 02/21/2023 through 02/24/2023, showed Staff A present in the facility. Further observations on these days showed Staff A regularly interacted with the residents.

During an interview on 02/23/2023 at 12:50 PM, Staff A stated that there were no final fingerprint check results available. Staff A stated that they never completed final fingerprint background check result.

Staff E, Care Manager

Review of the facility's undated staff roster showed the facility hired Staff E on 01/24/2017.

Review of Staff E's personnel records showed the facility completed a Washington name and date of birth background check on 06/23/2021. The results of the name and date of birth background check showed, "No background information was reported... no criminal or negative action records" were found. Staff E's personnel records showed Staff E signed the Department of Health and Social Services "Fingerprint Background Check Notice" on 01/16/2017. There was no documentation that showed Staff E completed the fingerprints background check process.

Review of a facility document titled, "Care Manager II", signed and dated by Staff E, showed Staff E was hired into this position on 10/14/2022. Further review of the document showed the Care Manager II duties included work with individuals diagnosed with [REDACTED]

[REDACTED], [REDACTED], and [REDACTED]. Review of the Staff E's timecard at the facility showed that from 10/19/2022 – 01/20/2023, Staff E worked over 464 hours as a Care Manager. At the time of completion of the full licensing inspection on 03/08/2023, records showed Staff E was employed as the Care Manager for 145 days, 25 days past the allowed time to complete the national fingerprint background check.

During an interview on 02/24/2023 at 2:04 PM, Staff I, Business Office Manager, stated that Staff E was initially hired on 01/24/2017 as a housekeeper. Staff I stated that Staff E transitioned to a Care Manager on 10/19/2022. Staff I stated that Staff E worked directly with the residents on each of their shifts. Staff I also stated that Staff E never obtained fingerprints check as required.

Plan/Attestation Statement

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

[Signature]
Administrator (or Representative)

4/22/23
Date

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;

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

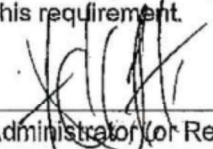
This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 2 Care Managers (Staff E) completed facility orientation prior to any interactions with residents. This failure placed residents at risk of a diminished quality of life from staff unfamiliar with the facility's setting and policies.

Findings included...

Record review of the facility's undated staff roster showed the facility hired Staff E on 01/24/2017. Further record review of Staff E's employee documents showed that Staff E did not complete the facility orientation. Review of the facility's timecard for Staff E, showed from 10/19/2022 - 01/20/2023, Staff E worked over 464 hours as a Care Manager.

During an interview on 02/24/2023 at 2:04 PM, Staff I, Business Office Manager, stated that Staff E was initially hired on 01/24/2017 as a housekeeper. Staff I stated that Staff E transitioned to a Care Manager on 10/14/2022. Staff I stated that Staff E worked directly with the residents on each of their shifts. Staff I also stated that Staff E never completed facility orientation.

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 _____ Administrator (or Representative)	<u>4/22/23</u> _____ Date