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

Kirkland Memory Care LLC
Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

RE: Jefferson House Memory Care Community License # 2548

Dear Administrator:

This letter addresses Compliance Determination(s) 46055 (Completion Date 08/23/2024) and 42612 (Completion Date 06/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/23/2024 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-2420-1, WAC 388-78A-3000-1-a, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-b, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-2-a, WAC 388-78A-2610-2-a

The Department staff who did the on-site verification:
Jane Hermano, NCI
Steven Garrett, LTC Licensor

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

Sincerely,

Laurie Anderson

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

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

Statement of Deficiencies	License #: 2548	Compliance Determination # 42612
Plan of Correction	Jefferson House Memory Care Community	Completion Date
Page 1 of 13	Licensee: Kirkland Memory Care LLC	08/25/2024

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

The department completed data collection for the unannounced on-site full inspection on 06/12/2024 and 06/18/2024 of:
Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

The following sample was selected for review during the unannounced on-site visit: 7 of 39 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, Community Complaint Investigator
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

07/03/2024 — 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.

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

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Jefferson House Memory Care Community
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Kirkland, WA 98034

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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.

Residential Care Services

Date

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

Administrator (or Representative) 7/11/2024 Date

WAC 388-78A-2420 Record retention.

(1) The assisted living facility must maintain on the assisted living facility premises in a resident's active record(s) all relevant information and documentation necessary for meeting a resident's current assessed needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to retain resident's medication administration record for 16 of 16 residents (Resident 1 through Resident 16). This placed these 16 residents at risk for health complications due to unknown medication management history.

Findings included...

Review of the facility's undated document, titled "Resident Care Services – What to Keep in a Resident Healthcare Record", showed that the facility kept the last three months medication administration records (MARs) with the licensed nurse signature page in the residents' healthcare record. The document showed that old MARs, three months or older, were purged or removed from the residents' record. The resident's purged health records were filed into a file box in alphabetical order. The document showed the files were retained on-site for at least three years to allow the facility staff to access historical medical information when needed.

Review of the facility's Characteristics Roster showed that 16 residents resided on the third floor of the facility. The roster showed that 16 residents received medication administration assistance from facility staff.

Observation in the common dining area on 06/13/2024 between 10:15 AM and 10:36 AM, showed Staff I, Licensed Practical Nurse, assisted and administered medications to four residents. After each resident medication administration assistance provided, Staff I documented the action in each resident's MAR.

Review of the facility's medication records showed only the May 2024 and June 2024 MARs were available. There were no other MARs available for the months prior to May 2024.

During an interview on 06/17/2024 at 1:12 PM, Staff B, stated they were unable to find the April 2024 MARs for any of the residents on third floor. Staff B stated that the April 2024 MARs for residents on second floor were available. Staff B stated that they were unsure why the third-floor residents' April 2024 MARs were not in the residents' records.

Administrator (or Representative) Date

WAC 388-78A-2420 Record retention.

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This requirement was not met as evidenced by:

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Findings included…

Review of the facility's undated document, titled "Resident Care Services – What to Keep in a Resident Healthcare Record", showed that the facility kept the last three months medication administration records (MARs) with the licensed nurse signature page in the residents' healthcare record. The document showed that old MARs, three months or older, were purged or removed from the residents' record. The resident's purged health records were filed into a file box in alphabetical order. The document showed the files were retained on-site for at least three years to allow the facility staff to access historical medical information when needed.

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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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 8/9/24 .

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

Administrator (or Representative) — Date 7/11/2024

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

(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 9 of 9 rooms (three resident apartments on the second floor, two resident apartments on the third floor, one resident laundry room on the second floor, one resident laundry room on the third floor, one common bathroom on the third floor, and the housekeeping utility closet on the third floor) provided air flow and ventilation to the outside of the facility. This failure placed all residents at risk for diminished quality of life and potential respiratory illness from poor air circulation in the building.

Findings included...

NOTE: WAC 388-78A-3030 Toilet rooms and bathrooms stated (2) The assisted living facility must provide each toilet room and bathroom with: (e) Provide mechanical ventilation to the outside.
WAC 388-78A-3040 Laundry stated (5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off-site commercial laundry services.
WAC 388-78A-3090 Maintenance and housekeeping stated (2) The assisted living facility must provide housekeeping supply room(s): (c) Equipped with: (iv) Mechanical ventilation to the outside of the assisted living facility.

Observation during environmental tour with Staff A, Executive Director, on 08/12/2024 between 11:26 AM and 11:50 AM, showed non-functioning ventilation systems in the one common bathroom on the third floor, the housekeeping utility closet on the third floor, and the one resident laundry room on the second floor one resident laundry room on the third floor. Observation showed Staff A hoisted a pole with a tissue up the vent grille in each of the identified rooms to test the ventilation. The tissue did not move.

Observation on 08/17/2024 at 12:35 PM, showed the paper test failed in three resident

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

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

_____ _____

Administrator (or Representative) Date

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(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 9 of 9 rooms (three resident apartments on the second floor, two resident apartments on the third floor, one resident laundry room on the second floor, one resident laundry room on the third floor, one common bathroom on the third floor, and the housekeeping utility closet on the third floor) provided air flow and ventilation to the outside of the facility. This failure placed all residents at risk for diminished quality of life and potential respiratory illness from poor air circulation in the building.

Findings included…

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WAC 388-78A-3090 Maintenance and housekeeping stated (2) The assisted living facility must provide housekeeping supply room(s): (c) Equipped with: (iv) Mechanical ventilation to the outside of the assisted living facility.

Observation during environmental tour with Staff A, Executive Director, on 06/12/2024 between 11:26 AM and 11:50 AM, showed non-functioning ventilation systems in the one common bathroom on the third floor; the housekeeping utility closet on the third floor; and the one resident laundry room on the second floor one resident laundry room on the third floor. Observation showed Staff A hoisted a pole with a tissue up the vent grille in each of the identified rooms to test the ventilation. The tissue did not move.

Observation on 06/17/2024 at 12:35 PM, showed the paper test failed in three resident

apartments on the second floor and the two resident apartments on the third floor. The paper test showed there was no airflow exchange in any of these rooms.

During an interview, on 06/12/2024 at 11:48 AM, Staff A stated that the facility did not have a Maintenance Director. Staff A stated that they were unaware when the ventilation system was last checked. Staff A stated that they were unaware of when the air ducts were cleaned. Staff A stated that they were unaware the nine exchange vents did not work.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 8/9/24 .

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

Administrator (or Representative) — Date: 7/11/2024

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

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

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 residents (Resident 1 and Resident 2) or their representatives signed the current service plan. This failure placed Resident 1 and Resident 2 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included...

RESIDENT 1

Review of the facility's resident information document showed that the facility admitted Resident 1 on [redacted]/2021.

Review of Resident 1's Change of Condition Assessment and Service Plan, dated

apartments on the second floor and the two resident apartments on the third floor. The paper test showed there was no airflow exchange in any of these rooms.

During an interview, on 06/12/2024 at 11:46 AM, Staff A stated that the facility did not have a Maintenance Director. Staff A stated that they were unaware when the ventilation system was last checked. Staff A stated that they were unaware of when the air ducts were cleaned. Staff A stated that they were unaware the nine exchange vents did not work.

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

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

_____ _____

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 residents (Resident 1 and Resident 2) or their representatives signed the current service plan. This failure placed Resident 1 and Resident 2 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included…

RESIDENT 1

Review of the facility's resident information document showed that the facility admitted Resident 1 on [redacted]/2021.

Review of Resident 1's Change of Condition Assessment and Service Plan, dated

08/01/2024, showed no signatures by facility staff, resident, or the resident's representative.

RESIDENT 2

Review of the facility's resident information document showed that the facility admitted Resident 2 on [redacted]2024.

Review of Resident 2's Change of Condition Assessment and Service Plan, dated [redacted]/2024, showed no signatures by facility staff, resident, or the resident's representative.

During an interview on 08/18/2024 at 2:30 PM, Staff A, Executive Director, stated that they were aware the service plans required signatures from facility staff, residents, or the resident's representative annually and when a resident experienced a change of their condition. Staff A stated that they were aware that some of the service plans were not signed and dated by facility staff, residents, or their representatives, as required.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 8/9/24.

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

Administrator (or Representative) — Date: 7/11/2024

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;

(b) Basic;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

05/01/2024, showed no signatures by facility staff, resident, or the resident's representative.

RESIDENT 2

Review of the facility's resident information document showed that the facility admitted Resident 2 on [redacted]/2024.

Review of Resident 2's Change of Condition Assessment and Service Plan, dated [redacted]/2024, showed no signatures by facility staff, resident, or the resident's representative.

During an interview on 06/18/2024 at 2:30 PM, Staff A, Executive Director, stated that they were aware the service plans required signatures from facility staff, residents, or the resident's representative annually and when a resident experienced a change of their condition. Staff A stated that they were aware that some of the service plans were not signed and dated by facility staff, residents, or their representatives, as required.

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

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

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Administrator (or Representative) Date

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(a) Orientation and safety;

(b) Basic;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 6 staff (Staff B, Staff C, and Staff E) completed all required training to perform their job duties and responsibilities. This failure placed all the residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's personnel records showed the facility hired Staff B, Director of Resident Services, on 04/15/2024; Staff C, caregiver, on 02/23/2024; and Staff F, caregiver, on 08/19/2021.

ORIENTATION AND SAFETY TRAINING

Review of Staff B's personnel records showed there was no documentation that showed Staff B completed the required facility safety and orientation training.

Review of Staff C's personnel records showed there was no documentation that showed Staff C completed the required facility safety and orientation training.

BASIC TRAINING (SEVENTY HOURS)

Review of Staff C's undated personnel records showed no documentation that showed Staff C completed the required 70-hour basic training.

CARDIOPULMONARY RESUSCITATION AND FIRST AID

Review of Staff F's personnel records showed there was no documentation that showed Staff F completed the required cardio-pulmonary resuscitation (CPR) training with skills check and first aid training.

CONTINUING EDUCATION

Review of Staff F's personnel records showed there was no documentation that showed Staff F completed the required 12 hours of continuing education between their [redacted]/2023 and [redacted]/2024 birthday.

During an interview on 06/18/2024 at 3:26 PM, Staff A, Executive Director, stated that they were unaware Staff B and Staff C did not complete the orientation and safety training. Staff A stated that they were unaware Staff C did not complete the required basic training. Staff A stated that they were unaware Staff F did not complete cardio-pulmonary resuscitation,

Based on interview and record review, the facility failed to ensure 3 of 6 staff (Staff B, Staff C, and Staff E) completed all required training to perform their job duties and responsibilities. This failure placed all the residents at risk of unmet care needs from staff with incomplete training.

Findings included…

Review of facility's personnel records showed the facility hired Staff B, Director of Resident Services, on 04/15/2024; Staff C, caregiver, on 02/23/2024; and Staff F, caregiver, on 08/19/2021.

ORIENTATION AND SAFETY TRAINING

Review of Staff B's personnel records showed there was no documentation that showed Staff B completed the required facility safety and orientation training.

Review of Staff C's personnel records showed there was no documentation that showed Staff C completed the required facility safety and orientation training.

BASIC TRAINING (SEVENTY HOURS)

Review of Staff C's undated personnel records showed no documentation that showed Staff C completed the required 70-hour basic training.

CARDIOPULMONARY RESUSCITATION AND FIRST AID

Review of Staff F's personnel records showed there was no documentation that showed Staff F completed the required cardio-pulmonary resuscitation (CPR) training with skills check and first aid training.

CONTINUING EDUCATION

Review of Staff F's personnel records showed there was no documentation that showed Staff F completed the required 12 hours of continuing education between their [redacted]/2023 and [redacted]/2024 birthday.

During an interview on 06/18/2024 at 3:25 PM, Staff A, Executive Director, stated that they were unaware Staff B and Staff C did not complete the orientation and safety training. Staff A stated that they were unaware Staff C did not complete the required basic training. Staff A stated that they were unaware Staff F did not complete cardio-pulmonary resuscitation,

first aid training, or their continuing education requirements.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 8/9/24 .

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

Administratar (or Representative) 7/11/2024 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 6 staff (Staff A and Staff E) were screened for Tuberculosis (TB) within three days of hire, as required. This failure placed all the residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Review of the facility's personnel records showed the facility hired Staff A, Executive Director, on 03/27/2024. Review of the facility's personnel records showed the facility hired Staff E, caregiver, on 03/27/2023.

Review of the facility's staff schedule showed that from 03/27/2024 through 06/18/2024, Staff A worked at the facility providing oversight of the care and services for residents. Review of Staff A's personnel records showed documentation that Staff A completed the first step of the two-step skin test on 05/15/2024, 49 days after date of hire. There was no documentation that showed Staff A completed the second step of the TB testing.

Review of the facility's staff schedule showed that from 03/27/2023 through 06/18/2024, Staff E worked at the facility providing care and services for residents. Review of Staff E's

first aid training, or their continuing education requirements.

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

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Administrator (or Representative) Date

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(1) An initial skin test within three days of employment; and

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 6 staff (Staff A and Staff E) were screened for Tuberculosis (TB) within three days of hire, as required. This failure placed all the residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Review of the facility's personnel records showed the facility hired Staff A, Executive Director, on 03/27/2024. Review of the facility's personnel records showed the facility hired Staff E, caregiver, on 03/27/2023.

Review of the facility's staff schedule showed that from 03/27/2024 through 06/18/2024, Staff A worked at the facility providing oversight of the care and services for residents. Review of Staff A's personnel records showed documentation that Staff A completed the first step of the two-step skin test on 05/15/2024, 49 days after date of hire. There was no documentation that showed Staff A completed the second step of the TB testing.

Review of the facility's staff schedule showed that from 03/27/2023 through 06/18/2024, Staff E worked at the facility providing care and services for residents. Review of Staff E's

personnel records showed no documentation that Staff E completed any TB testing when hired.

During an interview on 06/18/2024 at 2:20 PM, Staff A stated that they were aware that they did not complete the TB test within 3 days of hire. Staff A stated that they were unaware that Staff E was not screened for TB within 3 days of hire.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 8/9/24.

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

Administrator (or Representative) — Date 7/11/2024

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2280 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 3 of 7 sampled

personnel records showed no documentation that Staff E completed any TB testing when hired.

During an interview on 06/18/2024 at 2:20 PM, Staff A stated that they were aware that they did not complete the TB test within 3 days of hire. Staff A stated that they were unaware that Staff E was not screened for TB within 3 days of hire.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 3 of 7 sampled

residents (Resident 2, Resident 3, and Resident 7) Negotiated Service Agreement (NSA), the care needs and interventions. This failure placed Resident 2, Resident 3, and Resident7 at risk for unmet care needs and potential for worsening medical condition.

Findings included...

RESIDENT 2
Review of Resident 2's Face Sheet showed the facility admitted Resident 2 on [redacted]/2024.

Review of Resident 2's April 2024, May 2024, and June 2024 medication administration record (MAR) showed that Resident 2 received 81 milligrams (mg) of Aspirin (medication used to prevent blood clots), one tablet twice a day by mouth. The MARs showed that Resident 2 received 40 milligrams (mg) of Fetzima (medication used to treat depression), one tablet once a day, by mouth.

Review of the Federal Drug Administration FETZIMA Boxed Warning label showed a possible increased risk of bleeding. The label showed "taking FETZIMA with aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), warfarin or blood thinners may add to this risk."

Review of Resident 2's assessment, dated 02/28/2024, and undated negotiated service plan (NSA), showed staff provided Resident 2 full assistance with medication management. Review of the assessment and NSA showed no documentation that Resident 2 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Aspirin, such as increased risk for bleeding and excessive bruising. There were no instructions for staff about what actions were needed if Resident 2 experienced any side effects.

RESIDENT 3
Review of Resident 3's Face Sheet showed the facility admitted Resident 3 on [redacted]/2024.

Review of Resident 3's April 2024, May 2024, and June 2024 medication administration record (MAR) showed that Resident 3 received five milligrams (mg) of Eliquis (medication used to prevent blood clots), one tablet by mouth, twice a day.

Review of Resident 3's assessment, dated 05/01/2024, and service plan (NSA), dated 05/01/2024, showed staff provided Resident 3 full assistance with medication management. Review of the assessment and NSA showed no documentation that Resident 3 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Eliquis, such as increased risk for bleeding and excessive bruising. There were no instructions for staff about what actions were needed if Resident 3 experienced any side effects.

RESIDENT 7

residents (Resident 2, Resident 3, and Resident 7) Negotiated Service Agreement (NSA), the care needs and interventions. This failure placed Resident 2, Resident 3, and Resident7 at risk for unmet care needs and potential for worsening medical condition.

Findings included…

RESIDENT 2
Review of Resident 2's Face Sheet showed the facility admitted Resident 2 on [redacted]/2024.

Review of Resident 2's April 2024, May 2024, and June 2024 medication administration record (MAR) showed that Resident 2 received 81 milligrams (mg) of Aspirin (medication used to prevent blood clots), one tablet twice a day by mouth. The MARs showed that Resident 2 received 40 milligrams (mg) of Fetzima (medication used to treat depression), one tablet once a day, by mouth.

Review of the Federal Drug Administration FETZIMA Boxed Warning label showed a possible increased risk of bleeding. The label showed "taking FETZIMA with aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), warfarin or blood thinners may add to this risk."

Review of Resident 2's assessment, dated 02/28/2024, and undated negotiated service plan (NSA), showed staff provided Resident 2 full assistance with medication management. Review of the assessment and NSA showed no documentation that Resident 2 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Aspirin, such as increased risk for bleeding and excessive bruising. There were no instructions for staff about what actions were needed if Resident 2 experienced any side effects.

RESIDENT 3
Review of Resident 3's Face Sheet showed the facility admitted Resident 3 on [redacted]/2024.

Review of Resident 3's April 2024, May 2024, and June 2024 medication administration record (MAR) showed that Resident 3 received five milligrams (mg) of Eliquis (medication used to prevent blood clots), one tablet by mouth, twice a day.

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RESIDENT 7

Review of Resident 7's Face Sheet showed the facility admitted Resident 7 on [redacted]/2021.

Review of Resident 7's May 2024 and June 2024 medication administration record (MAR) showed that Resident 7 received 81 milligrams (mg) of Aspirin, one tablet by mouth, every day with food.

Review of Resident 7's assessment, dated 03/23/2023, and NSA, dated 04/30/2024, showed staff provided Resident 7 full assistance with medication management. Review of the assessment and NSA showed no documentation that Resident 7 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Aspirin administration, such as increased risk for bleeding and excessive bruising. There were no instructions for staff about what actions were needed if Resident 7 experienced any side effects.

During an interview on 06/18/2024 at 12:40 PM, Staff B, Director of Resident Services, stated that Resident 2, Resident 3, and Resident 7 were unable to report any change of their condition to staff. Staff B stated they were unaware they needed to document a safety plan for medications with blood-thinning properties in the residents' assessment and service plan.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 8/9/24.

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

Administrator (or Representative) — Date 7/11/2024

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement infection control policies and requirements to protect 39 of 39 residents (Resident 1 through Resident 39) from the potential spread of an infectious illnesses. This facility placed all 39 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Review of Resident 7's Face Sheet showed the facility admitted Resident 7 on [redacted]/2021.

Review of Resident 7's May 2024 and June 2024 medication administration record (MAR) showed that Resident 7 received 81 milligrams (mg) of Aspirin, one tablet by mouth, every day with food.

Review of Resident 7's assessment, dated 03/23/2023, and NSA, dated 04/30/2024, showed staff provided Resident 7 full assistance with medication management. Review of the assessment and NSA showed no documentation that Resident 7 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Aspirin administration, such as increased risk for bleeding and excessive bruising. There were no instructions for staff about what actions were needed if Resident 7 experienced any side effects.

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Administrator (or Representative) Date

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Findings included...

TRANSMISSION-BASED PRECAUTIONS
Review of facility's policy titled, "Infection Control Contact Precaution", dated 10/19/2021, showed the facility's goal and responsibility was to keep the environment free from disease causing pathogens (organism causing disease). The policy showed that control of infectious disease was paramount in the health and well-being of the resident and staff. The policy showed isolation precautions were initiated for any residents with suspected or confirmed infectious disease. The policy showed that isolation supplies, such as gloves, gowns, and masks were maintained near the isolation apartment for use before staff entered the apartment.

Observation on 08/17/2024 at 12:24 PM, showed a precautionary sign for contact enteric (relating to intestine) precaution posted outside a resident's apartment. Observation showed a cart with personal protective equipment (PPE) was placed outside the resident's apartment. Observation showed an unidentified staff went inside the resident's apartment. Observation showed the staff did not put on a gown and glove before they entered the room. During an interview at this time, the staff stated they worked for an agency. The agency staff stated that they came to help the resident. The agency staff stated that they did not see the sign for contact precaution on the door of the apartment. The agency staff stated that they did not see the PPE cart outside the apartment. The agency staff stated that they were not informed about the facility's contact precaution policy.

During an interview on 08/17/2024 at 1:46 PM Staff B, Director of Residents Services, stated that a resident diagnosed with [redacted] was placed in quarantine within their apartment. Staff B stated that the agency staff was not informed about the contact precautions in place. Staff B stated that the facility posted a sign outside the apartment to alert staff to take additional precautions. Staff B stated that the sign instructed staff to wear appropriate protective clothing and gloves before they enter the apartment.

RESPIRATORY PROTECTION PROGRAM (RPP)
Review of the facility's policy titled, "Respiratory Protection", dated 08/29/2024, showed that the Director of Resident Services was the respiratory protection program administrator. The administrator was responsible for the program that monitored respiratory hazards and the annual program evaluation. The facility required that all staff use approved disposable National Institute for Occupational Safety and Health (NIOSH)-95 (N-95) respirators to protect against transmission of the SARS-COV-2 virus and other airborne diseases. The policy showed that all staff designated to use N-95 respirators would be fit tested before they used any respirator. The policy showed that the categories of the staff required to use respirators were licensed nurses and resident assistants. The policy showed that staff would be fit tested on an annual basis.

Review of the Department of Health (DOH) publication "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31,

Findings included…

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2022, showed specific guidelines for a Respiratory Protection Program (RPP) that included medical evaluation and fit testing for respirator use. The publication showed that long term care facilities (LTCF) were required to provide initial and annual fit tests for any employee identified as potentially being exposed to respiratory hazard. The publication showed that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process

Review of the Department of Social and Health Services (DSHS) Dear Provider Letter, "Provider Responsibilities for Provision of Personal Protective Equipment (PPE), Respiratory Protection Program (RPP), and changes to Department of Health RPP Resources", dated 09/14/2023, showed the guidelines for LTCF and employer responsibilities for respiratory protection and PPE. The letter showed that employers were responsible to identify respiratory hazards in the workplace, provide appropriate PPE to staff who provided care to residents with known or suspected communicable disease, and follow regulations pertaining to respiratory protection.

Review of the facility's staff records of fit testing documentation showed there were no staff currently fit tested for any of the N-95 respirators provided by the facility.

During an interview on 06/13/2024 at 1:56 PM, Staff B, Director of Resident Services, stated that the facility's Business Office Manager was trained to complete fit testing for the staff. Staff B stated that they were aware of the requirement to maintain an RPP program and to conduct N-95 fit testing, for an initial and an annual fit test for staff. Staff B stated that they were aware that staff who were required to provide care to residents did not complete the fit testing requirements.

RESIDENT LAUNDRY
Review of the facility's Infection Control Standards document provided staff instructions about how to handle soiled and clean linens. The document instructed staff to carry linens away from the staff's body and clothing. The document instructed staff that dirty linens were placed inside the dirty linen barrels and not on the floor. The document instructed staff to not shake dirty linens while changing the bed.

Review of Centers for Disease Control and Prevention website stated the best practice for linen (and laundry) handling included: use of reusable gloves before handling soiled linen, never carry the soiled linen against the body; carefully roll up the soiled linen to prevent contamination of the air, surfaces, and the cleaning staff; and place the soiled linen into a clearly labeled, leak-proof container in the care area.

Observation on 06/17/2024 at 11:07 AM, showed Staff J, Housekeeper, wore gloves and stripped the fitted and top sheets from the bed. Observation showed Staff J folded the comforter and sheets and carried them against their body. Staff J carried the dirty bedding linens outside the apartment and placed them on top of the housekeeping cart.

During an interview on 06/17/2024 at 1:00 PM, Staff A, Executive Director, stated that the

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During an interview on 06/17/2024 at 1:00 PM, Staff A, Executive Director, stated that the

housekeepers were trained by the Maintenance Director. Staff A stated that the facility did not have a Maintenance Director. Staff A stated that they were in the process of trying to hire a new Maintenance Director. Staff A stated they were unaware what training Staff I received for appropriate infection control measures to complete housekeeping tasks and laundry services.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 7/11/2024

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_____ _____

Administrator (or Representative) Date

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

07/03/2024

Kirkland Memory Care LLC
Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

RE: Jefferson House Memory Care Community # 2548

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 06/25/2024 and found that your facility does not meet the Assisted Living Facility requirements.

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

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

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

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

Kent, WA 98032

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

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

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

(vi) Emergency communication plan.

The locations of first aid kit supplies throughout the facility were not identified. The first aid kits were not readily available. During the inspection, the facility staff placed several first aid kits throughout the facility with identifier signs posted with each kit. The facility disaster plan did not contain the required information for on-duty staff persons’ responsibilities, the alternative resident accommodations, and a plan for emergency communications. During the full inspection, the facility staff reviewed and updated the disaster plan.

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

During a review of residents' records, the facility was unable to locate the Medicaid Statement of Understanding for two sampled residents. During the full inspection, the facility contacted the residents' representatives and obtained a signed Medicaid Statement of Understanding for both residents.

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

The facility failed to complete a character, competence, and suitability (CCS) review for 1 of 7 sampled staff (Staff G) when the name and date of birth background check showed results that required a CCS review. On 06/18/2024 during the full inspection, the facility completed a CCS review.

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 copy of the last full licensing report in a common area of the facility, accessible to anyone who wanted to review the report. There was no sign that showed anyone how to access the inspection report. During the licensing inspection, the facility staff displayed the binder with the licensing reports in an accessible place.

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

(1) The assisted living facility must:

(c) Ensure all menus:

(iii) Include all food and snacks served that contribute to nutritional requirements;

During a review of the facility's menus and dietary guide, the availability of an alternate entrée choice was not shown. During the full inspection, the facility administrator and dietary director started updating the resident menus to include the alternate entrée choice at each meal and the daily snack choices available.

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

Review of the residents' assessments showed no documentation of any care needs related to a diagnosis of [redacted]. There was no documentation that instructed staff of the residents' baseline condition and how to recognize changes in conditions and cognitive functioning that required additional assistance. During the full inspection, the facility staff started the updates of residents' assessments to provide required documentation of baseline functioning.

You Are Not:

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

You May:

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

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.

o Send your request to:

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

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

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

Enclosure