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

01/29/2024

HSRE-Stellar II TRS LLC
Overlake Terrace
2956 152nd Ave NE
Redmond, WA 98052

RE: Overlake Terrace # 2551

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 35945 (Completion Date 01/29/2024) and 32666 (Completion Date 11/28/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/29/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2320 Intermittent nursing services systems.

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

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

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

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

(d) Chapter 246-841 WAC, Nursing assistants; and

The Department staff who did the On Site verification:
Thomas Forkgen, ALF Licensor

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

Sincerely,

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site follow-up on 11/16/2023, 11/16/2023, and 11/16/2023 of:
Overlake Terrace
2956 152nd Ave NE
Redmond, WA 98052

This document references the following SOD dated: 11/28/2023

The following sample was selected for review during the unannounced on-site visit: 5 of 88 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

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

Residential Care Services _____ Date _____

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

Administrator (or Representative) Date

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

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

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

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

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

(d) Chapter 246-841 WAC, Nursing assistants; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 sampled staff (Staff U and Staff X) completed Nurse Delegation (ND) training and on-going oversight for 4 of 4 sampled residents (Resident 9, Resident 15, Resident 16, and Resident 18) who required medication administration and/or insulin administration. This failure placed Resident 9, Resident 15, Resident 16, and Resident 18 at risk of medication errors and potential decline in health when unqualified staff provided care.

Findings included...

Note: RCW 18.79 (3)(e) showed for delegation in community-based care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants under chapter 18.88A RCW or home care aides certified under chapter 18.88B RCW.

Note: WAC 246-840-930 (19) showed the registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks.

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed that on 06/01/2023, the Assisted Living Facility (ALF) received an initial citation for this regulation for Staff S, Staff T, Staff U, Staff V, and Staff W. The ALF signed an attestation statement that stated the facility would have a system in

place and the deficiency corrected by 08/24/2023. On 09/21/2023, the ALF received a second citation for this regulation for Staff U and Staff X. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/03/2023.

Review of the facility's Disclosure of Services showed the facility provided intermittent nursing services that included insulin injection administration by trained unlicensed staff through nurse delegation.

Review of the facility's undated policy titled, "Nurse Delegation Policy," showed that the facility required all nurse delegation to be done in accordance with the State requirements. The policy showed that the nurse delegation protocols included assessment of the residents' delegation needs, determination of capabilities of the delegated caregivers, and caregiver observations and training.

Review of the facility's Employee Roster showed that the facility hired Staff U (Resident Assistant/Medication Technician [unlicensed staff who assist and administer medications]) on 09/27/2022 and Staff X (Resident Assistant/Medication Technician) on 06/23/2023. Review of the personnel files showed that as of 11/16/2023, Staff U's NAR credential was in pending status. There was no documentation that showed Staff U was registered or certified as a nursing assistant or home care aide in Washington state without restriction, as required for a medication technician to be delegated.

Review of the facility's Nurse Delegation documentation showed that on 10/19/2023, Staff BB, Registered Nurse Delegator (RND), completed Staff U's medication administration delegation for Resident 9, Resident 15, Resident 16, and Resident 18 and the delegation for Resident 15's insulin administration. There was no documentation that showed Staff BB completed four weekly supervision and observation for Staff U's insulin administration delegation after 10/19/2023. The document showed that Staff X did not complete the RND's credential verification, supervision, and observation to be delegated.

During an interview on 11/16/2023 at 10:40 AM, Staff Y, Health and Wellness Director, confirmed that Resident 9, Resident 15, Resident 16, and Resident 18 received nurse delegation. Staff Y stated that on 10/19/2023, the facility hired Staff BB as the RND. Staff Y stated that Staff BB performed the nurse delegator duties and responsibilities which included training and delegation of medication administration and insulin injections to the medication technicians. Staff Y stated that Staff BB verified Staff U's Nursing Assistant Registration (NAR) credential and training completion. Staff Y stated that Staff BB delegated Staff U for medication assistance and insulin administration. Staff Y further stated that Staff BB did not delegate Staff X for medication management or insulin administration.

RESIDENT 9
Review of the facility's nurse delegation documentation showed that Resident 9 required nurse delegation for the administration of oral medications, topical medications, blood sugar check, insulin injections, and oxygen use. The documentation showed the RND obtained Resident 9's representative signature on 10/27/2023 to update Resident 9's

nurse delegation consent.

Review of Resident 9's November 2023 Medication Administration Records (MARs) showed that Staff U administered and signed off oxygen administration on 11/13/2023; Staff U administered and signed off administration of oral medications and topical medications on 11/14/2023 and 11/15/2023; and Staff U administered and signed off administration of blood sugar check on 11/15/2023. The MAR showed that on five days between 11/03/2023 and 11/16/2023, Staff X administered and signed off oxygen administration.

RESIDENT 15
Review of Resident 15's medical records showed that Resident 15 received Lantus Solos (a medication used to control high blood sugar) injections, 20 units subcutaneously (under the skin) at bedtime.

Review of the facility's nurse delegation documentation showed that Resident 15 required nurse delegation for the administration of oral medications, topical medications, ophthalmic (eye) medications, blood sugar checks, and insulin injections. The documentation showed the RND obtained Resident 15's representative signature on 10/30/2023 to update Resident 15's nurse delegation consent.

Review of Resident 15's November 2023 MAR showed that Staff U administered and signed off administration of oral medications, topical medications, and blood sugar check on 11/08/2023, 11/14/2023, and 11/15/2023 and administered and signed off insulin administration on 11/14/2023. The MAR showed that on five days between 11/03/2023 and 11/16/2023, Staff X administered and signed off administration of oral medications and topical medications.

RESIDENT 16
Review of the facility's nurse delegation documentation showed that Resident 16 required nurse delegation for administration of eye drops and crushed medications. The documentation showed that Resident 16's representative initially consented for nurse delegation on 06/05/2023. The document showed that the RND updated Resident 16's nurse delegation consent on 10/19/2023.

Review of Resident 16's November 2023 MAR showed that Staff U administered and signed off administration of eye drops and oral medications on 11/08/2023 and 11/14/2023. The MAR showed that on five days between 11/03/2023 and 11/16/2023, Staff X administered and signed off administration of eye drops and oral medications.

RESIDENT 18
Review of the facility's nurse delegation documentation showed that Resident 18 required nurse delegation for the administration of oral medications, topical medications, and blood sugar checks. The documentation showed that the RND obtained Resident 18's representative signature, with an unidentified date, to updated Resident 18's nurse delegation consent.

Review of Resident 18's November 2023 MAR showed that Staff U administered and signed off the administration of orals medications and topical medications on 11/14/2023 and 11/15/2023.

During an interview on 11/20/2023 at 1:00 PM, Staff BB stated that on 10/19/2023, they started the RND position at the ALF. Staff BB stated that as the RND, they followed the Washington State requirements for nurse delegation. Staff BB stated that when they initially delegated to medication technicians, they verified each medication technician's credential and provided an individual training to each delegated medication technician. Staff BB stated that they were unaware Staff U's NAR credential was in pending status when they delegated Staff U. Staff BB stated that they were unfamiliar with the nurse delegation criteria for insulin administration. Staff BB stated that they did not supervise and evaluate Staff U for the administration of insulin injections weekly, for the first four weeks, as required. Staff BB stated that Staff X did not complete the RND's individual training. Staff BB stated that they did not delegate Staff X.

This is a recurring deficiency previously cited on 06/01/2023 and an uncorrected deficiency previously cited on 09/21/2023.

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

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site follow-up on 09/05/2023, 09/05/2023, and 09/05/2023 of:

Overlake Terrace
2956 152nd Ave NE
Redmond, WA 98052

This document references the following SOD dated: 09/21/2023

The following sample was selected for review during the unannounced on-site visit: 6 of 82 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

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

Residential Care Services _____ Date _____

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

Administrator (or Representative) Date

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

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

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

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

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

(d) Chapter 246-841 WAC, Nursing assistants; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 sampled staff (Staff U, Resident Assistant/Medication Technician [unlicensed staff who assists and administers medications] and Staff X, Resident Assistant/Medication Technician) completed Nurse Delegation (ND) training and on-going oversight for 2 of 2 sampled residents (Resident 9 and Resident 15) who required assistance with diabetes management. This failure resulted in two residents receiving insulin injections from staff unqualified to provide injections and placed the residents at risk of medication errors and potential decline in their health when unqualified staff provided care.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/01/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/16/2023. The facility requested an extension, and it was approved for a new correction date of 08/24/2023.

Review of the facility's undated document titled "Disclosure of Services Required by RCW 18.20.300", showed the facility provided intermittent nursing services that included insulin injection administration by trained unlicensed staff through nurse delegation.

Review of the facility's undated document titled "Nurse Delegation Policy" showed that the facility required all nurse delegation to be done in accordance with the State requirements. The document showed that the nurse delegation protocols included assessment of the residents' delegation needs, determination of capabilities of the delegated caregivers, and caregiver observations and training.

During an interview on 09/05/2023 at 9:50 AM, Staff A, Executive Director, stated that after the former Registered Nurse Delegator (RND) resigned from the position on 07/03/2023, the facility appointed Staff AA, Corporate Health Services Director, to be the RND. Staff A stated that between 07/05/2023 and 09/05/2023, Staff AA was regularly stationed in Utah. Staff A stated that every two weeks, Staff AA flew into Washington state and reported to the facility. Staff A further stated that Staff AA performed the nurse delegator duties and responsibilities that included staff training and delegation of insulin administration to the medication technicians.

RESIDENT 9
Review of the facility's untitled document for Resident 9, updated 09/05/2023, showed that the facility admitted Resident 9 in [redacted] 2019 with a medical diagnosis of [redacted]. The document showed that Resident 9's medication orders included Insulin Glargine Solo (a medication used to control high blood sugar), inject 20 units subcutaneously (inject under the skin), twice daily.

Review of the facility's document titled "Nurse Delegation: Consent for Delegation Process" showed that on 04/05/2023, Resident 9's representative consented for nurse delegation on behalf of Resident 9. Review of Resident 9's "Nurse Delegation – Assumption of Delegation", updated 07/05/2023, showed that Resident 9 required assistance with blood sugar check and insulin administration.

Review of Resident 9's August 2023 and September 2023 "Medication Administration Records (MARs)" showed that on 08/02/2023, 08/17/2023, 08/31/2023 and 09/04/2023, Staff U administered and signed off the administration of the Insulin Glargine Solo injection. The MARs showed that on 08/05/2023 and 09/02/2023, Staff X administered and signed off the administration of the Insulin Glargine Solo injection.

RESIDENT 15
Review of the facility's untitled document for Resident 15, updated 09/05/2023, showed that the facility admitted Resident 15 in [redacted] 2022 with a medical diagnosis of [redacted]. The document showed that Resident 15's medication orders included Lantus Solos (a medication used to control high blood sugar) injection, inject 20 units subcutaneously nightly at bedtime.

Review of the facility's document titled "Nurse Delegation: Consent for Delegation Process" for Resident 15 showed that on 04/26/2023, Resident 15's representative consented for nurse delegation on behalf of Resident 15. Review of Resident 15's "Nurse Delegation-Assumption of Delegation", updated 07/05/2023, showed that Resident 15 required

assistance with insulin administration.

Review of Resident 15's August 2023 and September 2023 MARs showed that on 08/31/2023 and 09/04/2023, Staff U administered and signed off the administration of the Lantus Solos insulin injection.

Review of the facility's untitled ND documentation showed that on 07/05/2023, Staff AA delegated Staff U and Staff X for the administration of insulin injections to Resident 9 and Resident 15. The document showed Staff AA checked off Staff U's credential in active status. There was no documentation that showed the type of Staff U's credential Staff AA verified. Additionally, the document showed that Staff AA reviewed Staff U and Staff X's records to evaluate the training and competency for delegation. The document showed Staff AA did not observe or demonstrate insulin administration to Staff U and Staff X when Staff AA initially delegated to them.

Review of the facility's undated "Employee Roster" showed that the facility hired Staff U on 09/27/2022 and Staff X on 06/23/2023. Review of the facility's personnel files showed Staff U's Nursing Assistant Registration (NAR) was in pending status. The personnel files showed Staff U completed the Department's Home Care Aide Basic Training on 12/31/2022. The personnel files showed no documentation that showed Staff U was currently registered or certified as a nursing assistant or home care aide in Washington state without restriction, as required for the medication technician to be delegated.

Review of the facility's follow-up email titled "Requested Items from Revisit 09/05/2023", dated 09/06/2023, showed the facility did not have any documentation that showed the RND performed four weekly supervision and observations for Staff U and Staff X's delegation of insulin injections.

During an interview on 09/06/2023 at 4:30 PM, Staff A stated that the facility's business office manager maintained the personnel files for staff and kept track of their credential status and training completion. Staff A stated they were unaware of Staff U's pending NAR status. Staff A stated that they were unaware that Staff U was unqualified to perform nurse delegation tasks and to administer insulin to residents.

During an interview on 09/07/2023 at 10:21 AM, Staff AA stated that in July 2023, they started the RND position at the ALF. Staff AA stated that as the RND, they followed the Washington State requirements for nurse delegation. Staff AA stated that they trained and delegated insulin injection administration to Staff U and Staff X for Resident 9 and Resident 15. Staff AA stated that in July 2023 when they verified Staff U's credential, they were unaware Staff U's NAR was in pending status. Additionally, Staff AA stated that they were unfamiliar with the delegation criteria for insulin administration. Staff AA stated that in July 2023 when they initially delegated to Staff U and Staff X, they completed nursing visits to the facility every 2 weeks. Staff AA stated that they did not supervise and evaluate Staff U and Staff X weekly for the first 4 weeks, as required.

This is an uncorrected deficiency previously cited on 06/01/2023.

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

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

_____ _____

Administrator (or Representative) Date

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

Statement of Deficiencies	License #: 2551	Compliance Determination # 23359
Plan of Correction	Overlake Terrace	Completion Date
Page 1 of 20	Licensee: HSRE-Stellar II TRS LLC	06/01/2023

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 the unannounced on-site full inspection on 05/08/2023, 05/08/2023, 05/11/2023 and 05/11/2023 of:
Overlake Terrace
2958 152nd Ave NE
Redmond, WA 98052

The following sample was selected for review during the unannounced on-site visit: 9 of 83 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

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

Laurie Anderson — Residential Care Services

06/06/2023 — 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) 6/15/2023 Date

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

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a medical device was safely installed for use and secured to prevent any entrapment for 1 of 1 resident (Resident 6). This failure placed Resident 6 at risk for potential entrapment and injury.

Findings included...

BED ENABLER
Review of the Department of Health and Social Services (DSHS) document titled "Dear Assisted Living Facility Administrator", dated 05/16/2013, showed Assisted Living Facility Providers were issued this letter related to the safety risks associated with the use of all medical devices. The letter listed "some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted."

Review of the facility's policy titled "Bed Safety and Bed Rails Policy Statement", dated August 2022, showed that bed rails would be checked for compatibility and size prior to use. The policy showed that the bed rails assessment included the resident's cognitive status with additional safety measures taken for residents who were identified as high risk for injury, such as entrapment due to "altered mental status". The policy also showed the bed rail "will leave no gap wide enough to entrap a resident's head or body". The policy showed that maintenance staff routinely inspected all resident beds and related equipment to identify risks and problems which included potential entrapment risks.

Review of a facility undated document titled "Resident Characteristic Roster" showed the facility admitted Resident 6 in January of 2023. The Roster showed that Resident 6 resided in the secured Memory Care unit. The Roster did not identify that Resident 6 used a medical device.

Review of Resident 6's undated "Service Plan Task" showed Resident 6's cognition status was impaired due to a diagnosis of [redacted]

leads to a decline in thinking, reasoning, and independent function). The service plan showed Resident 6 was a high risk for falls. Further review showed that Resident 6 used a side bed rail to promote bed mobility when Resident 6 was in bed, such as turning and assistance with care tasks. The Service Plan further showed the side rails were "to be down" when Resident 6 was not receiving care. The service plan also showed that before Resident 6 attempted to use the bed rail, staff were to check the bed rail for safety and to ensure appropriate maintenance when used.

Review of a "Mobility Device Safety Assessment", dated 05/01/2023, showed Resident 6 used the bedrail for bed mobility and transfers, moving up and down in bed, and transferring more safety. The assessment showed that there was no gap between the mattress and the rail where a body part could become caught.

Observation of Resident 6's apartment on 05/09/2023 at 2:42 PM, showed an electric hospital bed with a full-length bed rail attached to the side of the bed. The bed was pushed up against the wall. The bed rail was designed with four rails that measured 34 inches in length. There were three 4-inch gaps in between each rail. Observation showed that with minimal effort, the top part of the bedrail pulled away from the bed by 6-inches.

Observation on 06/10/2023 at 7:50 AM, showed Resident 6 lying in a hospital bed with a bed rail attached on one side of the bed. Further observation showed Agency Staff O, Memory Care Resident Assistant, assisted Resident 6 with personal care tasks. Agency Staff O instructed Resident 6 to grasp hold of the bedrail to assist with bed mobility. Observation showed Resident 6 used the top rail of the bedrail to turn on their side to allow Staff O to provide incontinence (lack of voluntary control over urination and/or defecation) care. The bedrail moved away from the bed when Resident 6 grasped hold of the top rail. Staff K, Memory Care Resident Assistant, arrived to assist Agency Staff O with Resident 6's care. Observation showed Staff K directed Resident 6 to turn on their side a second time to allow the two staff to assist Resident 6 with the dressing task. Observation showed Resident 6 was able to stick their arm through and in-between the bedrail and grasp a lower rail to pull themselves on to their side. This movement showed how Resident 6's arm could potentially become trapped.

During an interview on 06/10/2023 at 1:15 PM, Staff B, Registered Nurse, Health and Wellness Director, stated a bed rail assessment was completed for Resident 6. Staff B stated the assessment determined the bed rail was safe for Resident 6 to use.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 10/15/2023

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

Administrator (or Representative) 6/15/2023 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 observation, record review, and interview the facility failed to administer an initial Tuberculosis (TB) Skin test within three days of hire for 5 of 9 staff (Staff A, Executive Director, Staff B, Health and Wellness Director, Staff C, Resident Assistant and Medication Technician (unlicensed staff who dispenses and administers medications), Staff D, Resident Assistant and Medication Technician, and Staff F, Housekeeper). This failure placed all 83 residents at risk of contracting Tuberculosis, a communicable respiratory disease from Staff with an unknow tuberculosis status.

Findings included...

Review of a Department of Social and Health Services (DSHS) "Dear Administrator/Provider" letter, dated 05/17/2022, showed that Washington state expenenced a significant increase in the number of TB cases. The letter stated that to reduce the risk of illness to the vulnerable people served, TB testing was reinstated on July 1, 2022. In addition, the letter stated that Residential Care Services encouraged facilities and providers to immediately begin staff TB testing. This would allow facilities time to meet the TB testing requirements on 07/01/2022.

Review of the facility's document titled "Employee Census", dated 05/08/2023, showed the facility hired Staff A on 02/15/2023, Staff B on 03/20/2023, Staff C on 08/09/2021, Staff D on 04/26/2021, and Staff F on 03/21/2023.

STAFF A
Observations between 05/08/2023 through 05/11/2023 during the Departments licensing visit showed Staff A interacted with the residents.

Review of Staff A's personnel records showed no documentation that Staff A was administered a one-step TB skin test injection. Further review showed documentation that a two-step TB skin test injection administration was unable to be administered since the initial one-step TB skin test injection was not administered.

During an interview on 05/09/2023 at 2:28 PM, Staff A confirmed they had not received an inital TB skin test injection within three days of hire. Staff A stated they received a skin test injection that morning, 05/09/2023. Staff A extended their arm to show an where the initial skin test injection was administered.

STAFF B
Observations between 5/08/2023 to 05/11/2023 during the Departments licensing visit showed that Staff B was present in the facility. Observation showed Staff B interacted and assessed with the residents.

Review of Staff B's personnel records showed that on 02/02/2017, Staff B had a negative TB blood test. This test result was more than 12 months before the facility hired Staff B. There was no documentation in the records that showed Staff B received an initial one-step skin test within three days of hire at this facility, as required. Further review of Staff B's personnel records showed that on 05/08/2023, Staff B signed their own TB screening assessment.

STAFF C
Review of Staff C's personnel records showed that on 07/04/2018, Staff C had a negative TB blood test. This test result was more than 12 months before the facility hired Staff C. There was no documentation in the records that showed Staff C received an initial one-step skin test within three days of hire at this facility, as required.

STAFF D
Review of Staff D's personnel records showed no documentation that Staff D was administered a one-step TB skin test injection within three days of hire, as required.

STAFF F
Review of Staff F's personnel records showed Staff F was not administered an initial one-step TB skin test injection. Further review showed a two-step TB skin test injection was unable to be administered since the initial one-step TB skin test injection was not administered.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 6/30/2023

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

Administrator (or Representative) 6/15/2023 Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

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

This requirement was not met as evidenced by:

Based on record review, and interview the facility failed to administer a one-step Tuberculosis (TB) Skin test within three days of hire for 1 of 1 staff (Staff G, Dining Room Server) This failure placed all 83 residents at risk of contracting Tuberculosis, a communicable respiratory disease from Staff with an unknown tuberculosis status.

STAFF G
Review of Staff G's personnel records showed that the facility hired Staff G on 04/21/2023 as a Dining Room Server. Staff G's personnel record showed they received a one-step TB skin test injection on 12/06/2023 four months prior to their hire date. The results of the one-step administered on 12/06/2022, and read on 12/09/2023, showed the results were negative for TB. Further review of Staff G's records showed no documentation that the facility administered a one-step TB skin test injection within three days of hire, as required.

During an interview on 02/03/2023 at 8:00 AM, Staff P, Business Office Manager, stated that they were aware the facility had not administered a one-step TB test injection for Staff G.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 6/30/2023

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

Administrator (or Representative) 6/15/2023 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to update the "Service Task Plans" and "Assessment and Care Plan" for 2 of 2 residents (Resident 3 and Resident 6). This failure placed both residents at risk for not having their needs met.

Findings included...

Review of the facility's undated document titled "Resident Characteristics Roster", showed that the facility admitted Resident 3 in [redacted] of 2020. The Roster showed that the facility admitted Resident 6 in [redacted] of 2023.

RESIDENT 3
Review of Resident 3's "Service Plan Task", with most recent date of 09/22/2023, showed Resident 3 required assistance with their medications. The plan provided instructions that showed Resident 3 "cannot perform any part of medication management. Nurse must delegate medication administration and staff may need to do hand over hand assistance or spoon feed medication to resident". Further review showed that Resident 3 required "significant total assist: Staff administer medications as delegated by licensed health care professional according to service plan".

Observation on 05/09/2023 at 11:22 AM, showed Resident 3 sat in a wheelchair, in their apartment. Resident 3 maneuvered their wheelchair about the apartment. Resident 3 presented as alert, oriented to self, and responded to their environment appropriately.

During an interview on 05/09/2023 at 11:22 AM, Resident 3 stated that they were independent with feeding themselves and taking their medications. Resident 3 stated the Medication Technicians (unlicensed staff who dispense and administer medications) placed their pills in a plastic medication cup and handed the medication cup to Resident 3. Resident 3 stated that they put the pills in their own mouth.

RESIDENT 6

OVERLAY AIR MATTRESS AND HOSPITAL BED

Observation of Resident 6's apartment on 05/09/2023 at 2:42 PM, showed a hospital bed with a bedrail. On top of the bed sat an alternating pressure relieving air mattress (A mattresses designed with rows of air cells, which can be inflated or deflated to alternate the pressure within the lying surface of the mattress. A pump automatically inflates or deflates the cells automatically).

Observation on 05/10/2023 at 7:50 AM showed Resident 6 laying in their hospital bed, on top of the alternating pressure relieving mattress. The mattress was observed to be deflated and the air pump attached to the foot of the bed was not operational. Further observation showed that when the switch on the pump was turned on and off, it would not operate. Observation showed both the air pump and the hospital bed did not have power and were plugged into outlets along the same wall. The Department Representative plugged the two medical devices into the outlets on the opposite wall. Both medical devices then functioned correctly.

Observation on 05/10/2023 at 7:50 AM showed Staff O, Agency Staff/Memory Care Resident Assistant, provided incontinence care for Resident 6. At 8:05 AM, Staff K entered the room to assist Staff O. During an interview on this same date and time, Staff K, Memory Care Resident Assistant, stated that the air pump would not turn on and the hospital bed was broken. Staff K stated that the bed and the air mattress had not worked for a long time. Staff K stated that the durable medical equipment company needed to fix them both. Staff K stated that the hospital bed was broken and in the low position. Staff K stated that their back hurt to bend over so far to provide Resident 6 care while the resident was in the bed. Staff K also stated that the hand crank on the bed did not work.

Observation on 05/10/2023 at 1:00 PM, showed that Resident 6's air mattress and hospital bed did not have power. There was no sign next to the power switch to show it should not be turned off or that it operated the two medical devices. During an interview on this same date and time, Staff N, Memory Care Resident Assistant/Medication Technician, stated that the two devices did not work. Staff N was observed flipping the wall switch on off and on. Staff N stated that the switch did not do anything. At the direction of the Department's Representative, Staff N flipped the wall switch to the on position which turned on the air pump and the air mattress started to inflate.

Observation on 05/11/2023 at 12:06 PM, showed Resident 6's bed and air mattress pump were not operational and did not have power. The wall switch that controlled the power to the medical devices was in the off position. During an interview on this same date and time, Staff K stated they did not know the switch on the wall supplied power to the outlets where the two medical devices were plugged into. Staff K stated they would put a sign over the switch to inform staff not to turn the switch off.

Review of Resident 6's "Assessment and Care Plan" dated 02/22/2023, showed Resident 6 had used a hospital bed for re-positioning and assistance with care. The Plan showed documentation of an "overlay or alternating air mattress pending decision from hospital". Further review of the Plan showed the facility used the Braden Scale (an assessment tool to measure the elements of risk that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure) to assess Resident 6's risks that contribute

to skin breakdown. The Plan showed the Braden Scale score indicated Resident 6 was considered a high risk for skin breakdown. Based on the score, Resident 6 needed to be repositioned frequently while in bed and wear heel protection boots. The Plan did not document that show Resident 6 used an alternating pressure relieving overlay air mattress, did not provide instructions for how it was to be used and did not show a power switch located on the wall needed to be turned on to supply power to the outlets that both the air mattress and hospital bed were plugged in to.

Review of Resident 6's "observation notes" showed that between 02/01/2023 and 05/05/2023, staff documented observations of Resident 6's skin condition. The notes showed that on 02/01/2023 staff continued with pressure relieving devices for bilateral heels and coccyx (medical term for tailbone). Additional documentation showed that Resident 6's coccyx was pink and red, at times and the heels were boggy (soft) with blisters, at times. Further review showed Resident 6 previously received Home Health nurse services for wound care treatment.

During an interview on 05/10/2023 at 11:45 AM, Staff H, Maintenance Director, confirmed that there was a switch that controlled the power to the outlets where the medical devices were plugged into. Staff H stated that when the switch was turned off, the medical devices would not operate.

SPECIAL DIET
Review of Resident 6's "Assessment and Care Plan" dated 02/22/2023," showed Resident 6 was on a special diet. Resident 6 received a general diet with a physician specified order of low salt to prevent symptoms of vertigo (dizziness) related to Resident 6's Meniere's disease (an inner ear problem that can cause dizziness).

Observation between 05/09/2023 at 12:45 PM and 05/11/2023 at 12:06 PM showed Resident 6 received a general diet for breakfast and lunch. Observation showed staff placed the food was onto a plate and the plates were placed on the kitchen counter for staff to distribute to the residents. Observation showed there was no identifying information on the plates that designated any resident's special diet requirements. Observation showed the staff randomly selected the plates and randomly served to the residents with no consideration for special dietary needs. Further observation showed breakfast served to all residents, including Resident 6, included sausage, eggs, bacon, and French toast. On 05/11/2023 at 12:06 PM, Resident 6 was received a ham sandwich with soup for lunch.

During an interview on 05/11/2023 at 12:10 PM, Staff R, Life Enrichment Coordinator for Memory Care, stated that Resident 6 was not on a special diet. Staff R stated Resident 6 received the same general diet as all other residents, ever since they admitted to the facility. Staff R then read Resident 6's diet in the service plan and stated that they were unaware it showed Resident 6 was on a special diet.

During an interview on 05/11/2023 at 12:15 PM, Resident 6 stated that they had not requested a special diet and they did not want a special diet. Resident 6 stated that they

like the food they were served..

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 6/15/2023

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

Johnson
Administrator (or Representative)

6/15/2023
Date

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

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

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

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

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

(d) Chapter 246-841 WAC, Nursing assistants; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 5 sampled staff (Staff S, Certified Nursing Assistant/Resident Assistant/Medication Technician [unlicensed staff who assists and administers medications], Staff T, Resident Assistant/Medication Technician, Staff U, Resident Assistant, and Staff V, Certified Nursing Assistant, Resident Assistant/Medication Technician, and Staff W, Resident Assistant/Medication Technician) completed nurse delegation training and on-going oversight for 2 of 2 sampled resident (Resident 8 and Resident 10) who required assistance with diabetes management. The facility failed to implement nurse delegation services for 1 of 1 resident (Resident 10). The facility also failed to ensure 1 of 1 staff (Staff V) maintained current credentials as a nursing assistant or home care aide. These failures placed Resident 8 and Resident 10 at risk of medication errors and potential decline in their health when unqualified staff provided care.

Findings included...

Review of the facility's undated document titled "Disclosure of Services Required by RCW 18.20.300", showed the facility provided intermittent nursing services that included insulin injection administration by trained unlicensed staff through nurse delegation.

Review of the facility's document titled "Nurse Delegation Policy", undated, showed that the facility required all nurse delegation to be done in accordance with the State requirements. The document showed that the nurse delegation protocols included assessment of the residents' delegation needs and determination of capabilities of the delegated caregivers.

During the entrance interview on 05/09/2023 at 9:55 AM, Staff B, Registered Nurse, Health and Wellness Director, stated that the facility hired them as the Registered Nurse Delegator in March 2023. Staff B stated that they established the nurse delegation program in the memory care unit. Staff B stated that they delegated the medication technicians who assisted the memory care residents with medications.

RESIDENT 9
Review of the facility's untitled document for Resident 9, dated 05/08/2023, showed that the facility admitted Resident 9 in [redacted] 2019 with a medical diagnosis of [redacted]. The document showed that Resident 9's medication orders included "Insulin Glargine Solo (a medication used to control high blood sugar), inject 20 units subcutaneously (inject under the skin), twice daily", and "Humalog Kwik (a medication used to control high blood sugar), inject subcutaneously, per sliding scale (insulin dose based on blood glucose levels)".

Review of Resident 9's nurse delegation documentation, dated 04/05/2023, showed that Resident 9 required assistance with blood sugar check and insulin administration. Review of the facility's document titled "Nurse Delegation: Consent for Delegation Process" showed that on 04/05/2023, Resident 9's representative consented for nurse delegation on behalf of Resident 9.

Review of Resident 9's April 2023 and May 2023 "Medication Administration Records (MARs)" showed that on 04/24/2023, 04/26/2023, 04/28/2023, 05/01/2023, and 05/10/2023, Staff S administered and signed off the administration of the Insulin Glargine Solo injection. On 04/28/2023, Staff S signed off the administration of Humalog Kwik injection. The MARs showed that on 04/09/2023, 04/10/2023, 04/16/2023, 04/17/2023, 04/23/2023, 04/30/2023, 05/01/2023, 05/07/2023, and 05/08/2023, Staff T administered and signed off the administration of the Insulin Glargine Solo injection, and on 04/09/2023 04/10/2023, Staff T signed off the administration of the Humalog Kwik injection. The MARs showed that on 04/24/2023, 04/25/2023, 04/26/2023, 04/27/2023, 04/28/2023, and 04/29/2023, Staff U signed off the administration of the Insulin Glargine Solo injection. The MARs also showed that on 04/10/2023, 04/11/2023, 04/13/2023, 04/20/2023, 04/21/2023, 04/25/2023, 05/04/2023, 05/05/2023, 05/08/2023, and 05/09/2023, Staff V signed off the administration of the Insulin Glargine Solo injection, and on 04/20/2023 and 04/21/2023, Staff V signed off the administration of the Humalog Kwik injection.

Review of the facility's document titled "Nurse Delegation: Nursing Visit" for Resident 9 showed that on 04/05/2023, Staff B delegated five medication technicians for the administration of insulin injections. The document showed that Staff B did not delegate Staff S, Staff T, Staff U, and Staff V. Review of the facility's document titled "Nurse Delegation: Credentials and Training Verification" showed that the facility had not completed the credentials and training verification for Staff S, Staff T, Staff U, and Staff V.

Review of the facility's "Employee Roster", undated, showed that the facility hired Staff S on 04/26/2022; Staff T on 09/27/2022; Staff U on 09/27/2022; and Staff V on 02/14/2022.

Review of the facility's personnel files showed no documentation that showed Staff S completed the required Nurse Delegation Core and Nurse Delegation Diabetes trainings. There was no documentation that showed Staff T completed the required Nurse Delegation Core and Nurse Delegation Diabetes trainings. Review of the personnel files showed that on 05/11/2023, during the licensing inspection, Staff U submitted the Nurse Delegation Core and Nurse Delegation Diabetes training certificates. Further review of the personnel files showed that on 05/10/2023, during the licensing inspection, Staff V submitted the Nurse Delegation Core and Nurse Delegation Diabetes training certificates. Staff V's Washington State Department of Health Nursing Assistant Certification showed the credential status expired on 06/06/2022.

Observation on 05/09/2023 at 8:29 AM showed Staff V administered an insulin injection to Resident 9. During an interview at this time, Staff V stated that Resident 9 was unable to self-administer insulin injections. Staff V stated that facility staff administered Resident 9's insulin injections.

During an interview on 05/10/2023 at 9:45 AM, Staff B stated that the facility followed the State requirements for nurse delegation. Staff B stated that they, as the Registered Nurse Delegator, trained and delegated insulin injection administration to medication technicians. Staff B stated that they did not delegate to Staff V since they had not completed verification of Staff V's nurse delegation credentials and training. Staff B stated that they were unaware the facility assigned Staff V to administer insulin injections to Resident 9 prior to Staff V's delegation training.

During an interview on 05/10/2023 at 9:58 AM, Staff J, Resident Care Coordinator, stated that they completed the work schedule for medication Technicians. Staff J stated that they were familiar with the nurse delegation process. Staff J further stated that they were unaware Staff V's incomplete credential and training status prior to assigning Staff V administered insulin injections to Resident 9.

During a follow-up interview on 05/11/2023 at 10:50 AM, Staff B stated that they had not completed the verification of nurse delegation credentials and training for that Staff S, Staff T, and Staff U. Staff B stated that without verification of the credentials, Staff B was unable to approve insulin injection delegation for Staff S, Staff T, and Staff U.

RESIDENT 10
During an entrance conference interview on 05/08/2023 at 9:55 AM, Staff B stated that only the residents in the secured Memory Care required nurse delegation services. Staff B stated that they were no residents in the Assisted Living side of the facility that required nurse delegation services.

Review of Resident 10's "Resident Information" dated 05/18/2023, showed that the facility admitted Resident 10 in [redacted] 2022, with a medical diagnosis of [redacted].

Review of the facility's Registered Nurse Delegation binder found no documentation that staff were delegated to check Resident 10's blood sugar and administer insulin.

Review of Resident 10's "Service Plan Task" 10/31/2022 showed Resident 10 required assistance with diabetic services, which included fingerstick blood sugar testing three times a day. The plan instructed staff to allow Resident 10 to participate in the task. Further review showed that staff reminded Resident 10 to administer insulin injections three times a day. The plan showed staff may read the order and to verify the dose with Resident 10. Further instructions showed staff were allowed to assist with dialing the Kwikpen to the correct dose based on the sliding scale order. Staff would also monitor Resident 10 while they injected themselves with the insulin.

Review of Resident 10's March 2023, April 2023, and May 2023 electronic Medication Administration Records (eMAR) showed a physician's order for sliding scale insulin (insulin dose administered according to blood glucose level results) for Lispro (Fast acting insulin- absorb quickly generally within 15 minutes after administration) to be administered three times a day, before meals. Review of the March 2023 and April 2023 eMARs showed a physician's order that from 03/01/2023 through 04/27/2023, Resident 10 required 34 units of Basaglar insulin (Long-acting insulin) once per day, at bedtime. Review of the April 2023 and May 2023 eMARs showed an updated physician's order that from 04/28/2023 through 05/08/2023, Resident 10 required 36 units of Basaglar insulin once per day, at bedtime.

Observation on 05/08/2023 at 11:46 AM, showed Staff W brought a lancet (small, sharp object used to prick the skin to draw droplets of blood which is then used test a person's blood sugar level) pen to Resident 10 to perform a blood sugar check. Staff W instructed Resident 10 to depress the button on the pen to prick their own finger. Resident 10 had difficulty with their coordination and unable to depress the lancet device. Further observation showed Staff W placed their thumb over Resident 10's thumb on top of the release button. Staff W then depressed the button, which caused the lancet to break Resident 10's skin, and allowed a blood sample to be collected. Observation showed Staff W checking the order to determine amount of insulin needed. Further observation showed Staff W dialed the insulin pen to the number of units to be administered. Staff W handed the insulin to Resident 10 to inject themselves. Resident struggled to use the insulin pen to inject themselves. Staff W cued Resident 10 multiple times without successful injection by Resident 10. Staff W then placed their hand over Resident 10's fingers and pushed the

plunger on the insulin pen to complete the injection of the insulin.

Observation on 05/11/2023 at 7:52 AM, showed Resident 10 sat in a wheelchair in the third-floor medication room. Further observation showed Staff W administered Resident 10's insulin. When Staff W stood up, they noticed the Department Representative had watched as Staff W administered the insulin. Staff W exclaimed "you caught me".

Review of Staff W's personnel records showed Staff W completed the State of Washington's Department of Health nine-hour core nurse delegation training. Further review showed there was no documentation that showed Staff W completed the three-hour diabetes specialty training required of all staff who administer insulin injections.

During an interview on 05/08/2023 at 11:46 AM, Staff W stated that Resident 10 was assessed to do their own fingerstick to check their blood sugar and inject their own inulin. Staff W stated that sometimes Resident 10 struggled with the fingerstick insulin injection and required staff assistance.

During an interview on 05/08/2023 at 1:15 PM, Resident 10 stated that sometimes the staff completed the fingerstick for blood sugar checks and administered the insulin. Resident 10 stated that sometimes the staff wanted Resident 10 to do it. Resident 10 stated it was easier when the staff completed both the fingerstick blood sugar check and injected the insulin.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 7/16/2023

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

Administrator (or Representative) — 6/15/2023 Date

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 9 staff (Staff C, Memory Care Resident Assistant and Medication Technician (unlicensed staff who dispenses and administers medications), Staff D, Assisted Living Care Resident Assistant and Medication Technician, and Staff E, Memory Care Medication Technician/Resident Assistant) completed a Washington State name and date of birth background check every two years. This failure placed the 83 residents at risk for potential abuse or neglect by staff with an unknown background check.

Findings included...

Review of the facility's document titled "Employee Census", dated 05/08/2023, showed the facility hired Staff C on 08/09/2021, Staff D on 04/26/2021, and Staff E on 09/11/2020.

STAFF C
Review of Staff C's facility personnel records showed that an initial Washington State Name and Date of Birth Background Inquiry (BGI) was completed on 08/03/2020. This background check expired on 08/03/2022. Staff C completed a new BGI on 05/10/2023, 279 days after expiration of the initial BGI.

STAFF D
Review of Staff D's facility personnel records showed that an initial Washington State Name and Date of Birth Background Inquiry (BGI) was completed on 04/26/2021. This background check expired on 04/26/2023. Staff D completed a new BGI on 05/10/2023, 17 days after expiration of the initial BGI.

STAFF E
Review of Staff E's facility personnel records showed that the facility last completed a Washington State Name and Date of Birth Background Inquiry (BGI) on 09/09/2020. This background check expired on 09/09/2022. There was no documentation to show the facility completed a new background check, as required.

During an interview on 06/11/2023 at 11:12 AM, Staff P confirmed they were responsible for conducting the background checks and fingerprints for all employees. Staff P stated that they used the hire dates in the previous payroll program as their system for tracking when staff were due for a every two-year BGI. Staff P stated that in 2022 the corporate office changed to a new payroll system which deleted the information used to show when staff were due for the two-year BGI. Staff P stated that several employees BGI renewals were missed.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2551	Compliance Determination # 23359
Plan of Correction	Overlake Terrace	Completion Date
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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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 6/15/2023

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

Administrator (or Representative) 6/15/2023 Date

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 observation, interview and record review, the Assisted Living facility (ALF) failed to follow a Respiratory Protection Program (RPP) that implemented respirator mask fit-testing for 62 of 63 staff. This failure placed 83 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for infection prevention and control practices for healthcare setting in response to respiratory hazards. 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 standards of infection control to prevent and control the spread of respiratory infections, such as COVID-19 in healthcare settings.

Review of the DOH website showed the updated Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Health Settings, dated April 2023, included specific guidance around respirator fit testing. The guideline stated that facilities were required to have a written Respiratory Protection Program (RPP). An RPP must include medical clearance, fit testing, training, written policies, and documentation for all staff identified for potential exposure to a respiratory hazard. The facilities were required to provide initial and annual fit tests and to provide fit tested respirators to their employees.

Review of the Department's Secure Tracking and Reporting System (STARS) showed that on 02/14/2023, the facility reported an infectious disease outbreak after one staff tested positive for COVID-19.

Observation of the facility's PPE (Personal Protective Equipment) storage room showed the facility maintained an adequate supply of gowns, gloves, face shields, and N95 respirators.

During an interview on 05/08/2023 at 2:15 PM, Staff B, Health and Wellness Director stated that the facility had not developed a respiratory protection program. Staff B stated that they were unsure if staff identified as at risk for exposure to a respiratory hazard were fit-tested for the model and size of respirators in stock.

During an interview on 05/09/2023 at 10:15 AM, Staff A, Executive Director confirmed that the facility had not developed a written respiratory program. Staff A stated the facility followed the Respiratory Protection Guidance and Respiratory Medical Evaluation Questionnaire provided by the Occupational Safety and Health Administration (OSHA). Staff A stated that the facility had not fit tested the staff for the proper respirator masks.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 7/16/2023

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

Administrator (or Representative) — Date: 6/15/2023

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the water temperature in 7 of 7 sampled Memory Care rooms (rooms 101, 124, 126, 130, 137, 141 and 238), 2 of 2 Memory care common bathrooms (first floor bathroom 1 and bathroom 2), and the Memory Care Activity sink, accessible to the residents, maintained water temperatures between 105 degrees Fahrenheit (F) and 120 degrees F. This failure placed all residents at risk for potential injury and health issues.

Findings included...

Observation on 05/08/2023 at 11:02 AM, the water temperature in room 238's bathroom sink measured 96 degrees F and shower measured 94 degrees F. On 05/10/2023 at 8:32 AM, the water temperature in room 141's bathroom sink measured 97.7 degrees F; at 8:39

Statement of Deficiencies	License #: 2551	Compliance Determination # 23359
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AM, the water temperature in the first common bathroom sink measured 96.3 degrees F; at 8:41 AM, the water in the second common bathroom sink measured 102.4 degrees F; at 8:43 AM, the water temperature in room 124's bathroom sink measured 98.9 degrees F; at 8:48 AM, the water temperature in room 128's bathroom sink measured 102 degrees F; at 9:49 AM, the water temperature in Memory Care main activity room sink measured 96 degrees F; at 10:00 AM in room at 137's shower temperature measured 97 degrees F; at 10:32 AM, the water temperature in room 130's bathroom sink measured 101 degrees F; at 12:51 PM, the water temperature in room 101's bathroom sink measured 99 degrees F.

During an interview on 05/08/2023 at 11:00 AM, Resident 12 complained that the water temperature fluctuated, which caused the water to become too cold in the middle of shower.

During an interview on 05/10/2023 at 10:00 AM, Resident 11 complained of cold showers. Resident 11 stated that they missed a few showers due to the lack of hot water.

During the tour on 05/08/2023 at 11:55 AM, Staff H, Maintenance Director, acknowledged that the water temperatures were below the minimum allowed temperature. Staff H stated that plumbing services were unable to identify what caused the water temperatures to drop so low.

Record review of a facility document titled, "Logbook Documentation Water Temps", dated January 2023, February 2023, April 2023, and May 2023 showed that the facility randomly tested the water temperature in resident's room on each floor.

During an interview on 5/11/2023 at 3:30 PM, Staff A, Executive Director confirmed that the facility previously had multiple visits from several local plumbers. Staff A offered to move Resident 12 to a different unit. Resident 12 refused to move. Staff A stated that the facility did not have any solution to correct the issue at this time. Staff A stated that their Regional Maintenance Director scheduled a professional plumber for a consultation in May.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 7/16/2023

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

Administrator (or Representative) 6/15/2023 Date

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

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own 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 failed to secure 1 of 2 medication rooms (third floor medication room). This failure placed the 54 Assisted Living Residents at risk for harm had they accessed and used any of the medications.

Observation on 05/08/2023 at 11:46 AM, showed the third-floor medication room was propped open. There were no staff present in the room. Further observation of the area showed a pool table located in the third-floor foyer, outside the unsecured medication room. Observation showed several Residents in the foyer shooting pool.

Observation on 05/10/2023 at 8:26 AM showed the third-floor medication room door was wedged open with a two-pound dumbbell weight. Further observation showed two small refrigerators, one stacked on top of the other. The top refrigerator was labeled specimens. An unlocked padlock was observed inserted in the latch to secure the refrigerator. The specimen refrigerator was empty. The second refrigerator also had an unlocked padlock which was inserted in the latch. Observation showed the second refrigerator contained liquid Lorazepam (antianxiety narcotic, controlled drug), and multiple boxes of insulin (medication used to lower blood sugar) pens. The medication room door remained unsecured for 15 minutes. Further observation showed multiple residents independently ambulate past the unsecured medication room.

Observation on 05/10/2023 at 8:49 AM showed Staff F, Housekeeper, worked around the corner from the third-floor medication room. During an interview on this same date and time, Staff F stated that they did not leave the third-floor medication room door propped open. Staff F stated they had a key to the medication room. Staff F showed a ring of keys that included a key to the third-floor medication room.

Observation on 05/11/2023 at 11:22 AM, showed that the door to the third-floor medication room was propped wide open. Further observation showed that both refrigerators' padlocks were unlocked. The same medications observed on 05/10/2023 were again observed in the bottom refrigerator. Observation showed several Residents independently waked into the activity room that was located outside the medication room.

During an interview on 05/10/2023 at 8:43 AM, Staff T, an unidentified agency licensed nurse, stated that the third-floor medication room door was propped open to allow the

housekeeper to clean room.

During an interview on 05/11/2023 at 11:23 AM, Staff B, Registered Nurse, Health and Wellness Director, stated that the medication room was located next to their office. Staff B stated that they observed Staff Q, Registered Nurse, Corporate Resource Nurse, prop the door open. Staff B further stated that they a staff member access the medication refrigerator. Staff B stated that this was why it was unlocked.

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, Overlake Terrace is or will be in compliance with this law and / or regulation on (Date) 6/15/2023

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

[signature] 6/15/2023

Administrator (or Representative) Date