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

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

RE: Overlake Terrace License # 2551

Dear Administrator:

This letter addresses Compliance Determination(s) 54447 (Completion Date 02/07/2025) and 51030 (Completion Date 12/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/07/2025 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-3010-8-e, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2600-1-b, WAC 388-78A-2100-2-a, WAC 388-78A-3090-1-c

The Department staff who did the on-site verification:
Jane Hermano, NCI
Kathy Young, Licensor

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

Sincerely,

Laurie Anderson

Laurie Anderson, Community 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 #: 2551	Compliance Determination #51030
Plan of Correction	Overlake Terrace	Completion Date
Page 1 of 10	Licensee: HSRE-Stellar II TRS LLC	12/11/2024

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 12/02/2024 and 12/05/2024 of:
Overlake Terrace
2956 152nd Ave NE
Redmond, WA 98052

The following sample was selected for review during the unannounced on-site visit: 13 of 63 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensor
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

12/20/2024
Date

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

Administrator (or Representative) — Date: 12/31/24

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide lockable storage for 3 of 8 assisted living residents (Resident 3, Resident 4, and Resident 10). This failure placed residents at risk of financial loss, property loss, and a diminished quality of life.

Findings included...

Record review of the facility's Resident Characteristic Roster showed Resident 3, Resident 4, and Resident 10 handled their medications independently.

Observation on 12/04/2024 at 12:37 PM, showed Resident 3 stored their prescription medications in their apartment. No lockable storage was observed.

Observation on 12/04/2024 at 1:38 PM, showed Resident 4 stored their prescription medications in their apartment. No lockable storage was observed.

During an interview on 12/04/2024 at 12:37 PM, Resident 3 stated that they had no lockable storage in their apartment.

During an interview on 12/04/2024 at 1:38 PM, Resident 4 stated that they had no lockable storage in their apartment.

During an interview on 12/05/2024 at 10:00 AM, Resident 10 stated that they had no lockable storage in their apartment.

During an interview on 12/05/2024 at 11:32 AM, Staff G, Maintenance Director, stated that they were aware all assisted living residents did not have lockable storage in their apartments.

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) 1/28/25 .

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

Administrator (or Representative) — Date: 12/31/24

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 housekeeping utility cart (third-floor cart) with hazardous chemicals was locked while unattended and in resident areas. The facility failed to ensure 1 of 2 memory care resident's (Resident 6) apartment was free of unlocked hazardous chemicals. These failures placed all 64 residents at risk of injury due to skin and eye contact with hazardous chemicals and ingesting hazardous chemicals.

Findings included...

Review of the facility's "Hazardous Material Policy", revised 02/06/2024, showed it was suggested that staff lock housekeeping carts when unattended. Staff were to ensure that each resident's safety needs were protected.

HOUSEKEEPING CART
Observation on 12/02/2024 at 11:40 AM, showed that the housekeeping cart in the third-floor resident hall was unlocked with the rolltop for the cleaning chemicals' compartment in the up position. The housekeeper was not present. The cleaning chemicals were in view. The chemicals inside contained hazardous warning labels that indicated they were harmful if swallowed, to keep out of reach of children, and could cause skin and eye irritation.

During an interview on 12/02/2024 at 11:40 AM, Staff G, Maintenance Director, stated that housekeeping staff were trained not to leave the housekeeping carts unlocked and unattended.

During an interview on 12/04/2024 at 1:03 PM, Staff G clarified the policy and stated that they tell their staff locking the cart is the best practice which does not mean staff must lock the housekeeping carts.

RESIDENT 6
Observation of Resident 6's apartment in the memory care unit on 12/04/2024 at 9:28 AM, showed an unlocked cabinet. The cabinet contained a liquid laundry detergent and two bottles of hand sanitizer. The products' label read, "Keep out of reach of children."

Review of Resident 6's assessment and care plan, dated 10/01/2024, showed Resident 6 ambulated with walker independently. The care plan showed Resident 6 wandered throughout the unit. The care plan showed Resident 6 had cognitive impairment.

During an interview on 12/04/2024 at 9:45 AM, Staff I, Memory Care Director, stated that the facility encouraged best practice and kept potentially harmful substances or sharp objects locked.

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) 1/25/25

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

Administrator (or Representative) — Date: 12/31/24

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:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility failed to ensure 4 of 4 staff (Staff A, C, D, and E) completed all required training to perform their job duties and responsibilities. This failure placed all residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of the facility's undated personnel records showed the facility hired Staff A, Executive Director, on 11/13/2023; Staff C, Memory Care Resident Assistant, on 06/26/2023; Staff D, Memory Care Resident Assistant and Medication Technician, on 09/05/2023; and Staff E, Assisted Living Resident Assistant and Medication Technician on 02/14/2022.

SPECIALTY TRAINING
Review of Staff A and Staff C's personnel records showed no documentation that Staff A and Staff C completed the required dementia and mental health specialty training.

CONTINUING EDUCATION (CE)
Review of Staff D's personnel records showed no documentation that Staff D completed 12 hours of Department approved CE training, between their August 2023 birthday to their August 2024 birthday as required.

CPR and FIRST AID
Review of Staff E's personnel records showed no documentation that Staff E completed the required cardio-pulmonary resuscitation (CPR) training with hands-on skill development and first aid training.

During an interview on 12/04/2024, Staff J, Business Office Manager, stated that they were responsible for completion of the staff trainings for all employees. Staff J stated that they were aware of the staff training and CE requirements. Staff J stated that they were unaware that Staff D's annual CE trainings dated September 2024, did not apply from Staff D's 2023 birthday to their 2024 birthday.

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) 1/25/25 .

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

Administrator (or Representative) — Date 12/31/24

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the Assisted Living Facility failed to assess 3 of 5 residents (Resident 5, Resident 12, and Resident 13) for safe and proper use of a medical device. This failure placed Resident 6, Resident 12, and Resident 13 at risk of potential entrapment and injury.

Findings included...

NOTE: Per 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: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

Review of the facility's policy titled "Mobility Enablers Policy HW 101", revised 05/01/2024, showed that the facility allowed the use of bedside rails or other such devices (medical device designed to assist resident with repositioning and movement). The policy stated that the facility's licensed nurse or physical therapist assessed residents and residents on hospice (a program that provide special care to individual near the end of their life and stopped treatment to cure their diseases) in need of an assistive device. The policy stated the residents were informed of the risks associated with mobility devices. The policy stated that the facility ensures the residents assessed with such devices were monitored appropriately for safety as required by state law.

Review of the Dear Provider Letter titled "Safety Risk of Medical Devices", dated 05/15/2013, showed the potential risks of using side bed rails included strangulation, suffocation, and bodily injury. The letter showed the importance of evaluating the safety of each resident and recognize the risks of using medical devices, such as side bedrails.

RESIDENT 5
Observation of Resident 5's apartment on 12/04/2024 at 10:53 AM, showed two half-length side rails attached at the head of the bed, along the right and left side. Each of the bedrails measured approximately 26 inches in length. Observation showed the two rails were fully raised with a 3.5-inch gap between the rail supports.

Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2019. Review of the Resident 5's assessment and care plan, dated 10/10/2024, showed Resident 5 had poor coordination with limited use of right arm and required one-person assistance with transfers. Review of the care plan showed no documentation Resident 5 used a bedrail. There was no documentation Resident 5 was assessed to safely use the bedrail.

During an interview on 12/04/2024 at 10:54 AM, Resident 5 stated that they used the bedside rails to sit up in bed. Resident 5 stated that they started using the bed rail a while ago. Resident 5 was unable to recall if the staff had explained the potential risks of using bed rails.

RESIDENT 12
Observation of Resident 12's apartment on 12/05/2024 at 9:42 AM, showed quarter-length side rails attached at the head of the bed, along the right side. The bedrail measured approximately 18.5 inches in length. Observation showed the bedrail was fully raised with a 4.5-inch gap between the rail supports.

Review of Resident 12's records showed that the facility admitted Resident 12 in [redacted] 2024. Review of Resident 12's assessment and care plan, dated 10/31/2024, showed Resident 12 diagnosed with [redacted]. The care plan showed Resident 12 did not require assistance for transfer or mobility and showed no documentation Resident 12 used a bedrail. There was no documentation Resident 12 was assessed to safely use the bedrail.

RESIDENT 13
Observation of Resident 13's apartment on 12/05/2024 at 9:42 AM, showed a U-shaped quarter-length side rail attached at the head of the bed, along the right side. The bedrail measured approximately 11.5 inches in length with a pocket storage. Observation showed the bedrail was fully raised with an 11.5-inch gap.

Review of Resident 13's records showed that the facility admitted Resident 13 in

[redacted] 2024. Review of Resident 13's assessment and care plan, dated 10/31/2024, showed Resident 13 diagnosed with [redacted]. Review of the care plan showed Resident 13 required stand-by assistance for transfers. Review of the care plan showed no documentation Resident 13 used a bedrail. There was no documentation Resident 13 was assessed to safely use the bedrail, as required in the facility's bedrail policy.

During an interview on 12/05/2024 at 9:43 AM, Resident 12 and Resident 13's representative stated that the facility never discussed the potential risks when bed rails were used.

During an interview on 12/05/2024 at 1:37 PM, Staff A, Executive Director was unaware there was no documentation to show that Resident 6, Resident 12, and Resident 13 were assessed to safely use the bedrail.

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) 1/25/25 .

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

M. M

Administrator (or Representative)

12/31/24

Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observations, interview, and record reviews, the Assisted Living Facility failed to ensure 2 of 5 residents' (Resident 1 and Resident 11) medical devices were securely and safely installed for use and were aware of the risk of using. This failure placed Resident 1 and Resident 11 at risk of potential entrapment and injury from use of unsafe medical equipment.

Findings included...

Review of the facility's policy titled "Mobility Enablers Policy HW 101", revised 05/01/2024, showed that the facility allowed the use of bedside rails or other such

devices (medical device designed to assist resident with repositioning and movement). The policy stated that the facility's licensed nurse or physical therapist assessed residents and residents on hospice (a program that provide special care to individual near the end of their life and stopped treatment to cure their diseases) in need of an assistive device. The policy stated the residents were informed of the risks associated with mobility devices. The policy stated that the facility ensures the residents assessed with such devices were monitored appropriately for safety as required by state law.

Review of the Dear Provider Letter titled "Safety Risk of Medical Devices", dated 05/15/2013, showed the potential risks of using side bed rails included strangulation, suffocation, and bodily injury. The letter showed the importance of evaluating the safety of each resident and recognize the risks of using medical devices, such as side bedrails.

RESIDENT 1
Observation of Resident 1's apartment on 12/04/2024 at 10:20 AM, showed a half-length side rail attached at the head of the bed, along the left side. The bedrail measured approximately 26 inches in length with a 3.5-inch gap between the rail supports. Observation showed the bed rail was fully raised. Observation showed the side rail was loose and tilted when moved with minimal effort which created a gap, greater than four inches, between the mattress and the side rail.

Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] 2023. Review of the Resident 1's assessment and care plan, dated 10/10/2024, showed Resident 1 had limited mobility and required two-person assist with transfers. Review of Resident 1's mobility device safety assessment showed that Resident 1 used a bedrail as part of the hospital bed to assist in repositioning. The records showed no documentation that Resident 1 or their family representative was informed on the risk of bedside rail use, as required in the facility's side rail policy. Review of the care plan showed the staff were to ensure the bedrail was tight and to shake each use for stability.

During an interview on 12/04/2024 at 10:26 AM, Resident 1 stated that the side rail was loose and should be tightened. Resident 1 stated that they were unable to lower the rail. Resident 1 stated they were unaware of the potential risk of entrapment from the space between the mattress and the side rail.

RESIDENT 11
Observation of Resident 11's memory care apartment on 12/05/2024 at 8:54 AM, showed two half-length side rails attached at the head of the bed, along the right and left side. Each of the bedrails measured approximately 26 inches in length with a 3.5-inch gap between the rail supports. Observation showed the two rails were fully raised. The left bedside rail was loose and not firmly attached to the bed frame.

Review of Resident 11's records showed that the facility admitted Resident 11 in [redacted] 2022. Review of the Resident 11's assessment and care plan, dated 11/13/2024, showed Resident 11 diagnosed with [redacted]

[redacted] and [redacted]. Review of Resident 11's assessment showed that Resident 11 used a bedrail to assist with turning and repositioning in bed. Review of the record showed no documentation that Resident 11 or their family representative was informed on the risk of bedside rail use, as required in the facility's side rail policy. Review of the care plan showed the staff were to ensure the bedrails were tight and had no gaps to decrease the risk of entrapment.

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) 1/25/25 .

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

Administrator (or Representative) — Date: 12/31/24

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

12/20/2024

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

RE: Overlake Terrace # 2551

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 12/11/2024 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-2300 Food and nutrition services.

(1) The assisted living facility must:

(h) Develop, make known to residents, and implement a process for residents to express their views and comment on the food services; and

(i) Maintain a dining area or areas approved by the department with a seating capacity for fifty percent or more of the residents per meal setting, or ten square feet times the licensed resident bed capacity, whichever is greater.

The facility failed to ensure menus were posted in the memory care unit where the residents could see them. During the full inspection, the facility posted menus where the residents could see.

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

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

(b) Maintain any vehicles used for transporting residents in a safe condition;

(c) Provide, and tell staff persons of a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms;

(d) Provide emergency lighting or flashlights in all areas accessible to residents of the assisted living facility.

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

(iii) Able to be moved to the location where needed; and

The facility failed to ensure first aid kits were clearly marked, readily available, and appropriate for the size of the facility. During the full inspection, the facility made clearly marked first aid kits readily available throughout the facility.

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:

(i) A current assisted living facility license, including any related conditions on the license;

(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 post a copy of the last full inspection report and the current assisted living license in a conspicuous location available to residents and guests. During the inspection, the facility corrected this issue per the regulation.

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

The facility failed to ensure the ventilation system in the common bathrooms and utility closets with mop sink were exchanging fresh air from the outside to the inside of the facility. During the full inspection, the facility demonstrated that it had a quarterly system in place for reviewing the ventilation system and corrected the issue.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

The facility failed to ensure the resident-accessible memory care exterior courtyard was free of a used paint tray that collected stagnant water. During the full inspection, the facility emptied the water and removed the tray.

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

The Assisted Living Facility failed to read the required tuberculosis (TB) testing results for 1 of 6 staff (Staff D) within 48 to 72 hours following the first step of the two-step TB

skin test administration. Staff D's two-step TB skin tests showed negative results. During the inspection, the staff initiated a better tracking process to ensure skin test reaction for all staff were read and the result communicated within the required timeframe.

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

The facility failed to ensure that 1 of 2 pets (Pet 2) in the assisted living received regular examination and immunizations. The facility obtained current pet records during the time of the full inspection.

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

Plan of Correction

Agency Name	Citation Date
Overlake Terrace	12/11/2024
Submitted by	**Date of POC Submission**
Mindy Mendoza-Perry	12/31/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: (list WAC):388-78A-3010	
What *initial or immediate actions* were taken to address concerns affecting clients?	Overlake Terrace did a room audit to identify what apartments were without a lockable drawer, cupboard, or other secure space. The Maintenance Director then purchased locks for those apartments identified not to have a lockable secure space.
How will you apply the correction to all clients you support?	The maintenance department/ director will install purchased locks and ensure the locks remain in place by completing random audits of apartments to ensure there is a locked space.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Maintenance Director or maintenance department will ensure oversight for residents to have lockable space.
Date by which lasting correction will be achieved	Overlake Terrace will be in compliance with WAC 388-78A-3010 no later than 1/25/2025
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

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

Send copy to DDA Resource Manager or Residential Program Specialist for your region.

Plan of Correction

Agency Name	Citation Date
Overlake Terrace	12/11/2024
Submitted by	**Date of POC Submission**
Mindy Mendoza-Perry	12/31/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: (list WAC): WAC 388-78A-3100	
What *initial or immediate actions* were taken to address concerns affecting clients?	Overlake Terrace ensures the safe storage of supplies and equipment by providing a secure area for potentially hazardous supplies and equipment. Overlake Terrace immediately ensured all housekeeping carts were locked and housekeeping staff were aware carts are to be locked anytime they are not visible. Overlake Terrace removed the laundry detergent and hand sanitizer from the memory care apartment it was found in to ensure resident safety.
How will you apply the correction to all clients you support?	To ensure WAC 388-78A-3100 is followed there have been random checks done by the Executive Director and Business Office Manager when housekeeping carts are unsupervised, all carts were found to be locked during the checks. Executive Director and Business Office Manager checked 4 random memory care apartments to ensure no products labeled "keep out of reach of children" were left unlocked, no apartments had such items unlocked.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	To ensure WAC 388-78A-3100 is followed and safe storage of supplies and equipment are secured in an area that avoids potentially hazardous supplies and equipment from being accessed by residents the memory care director and maintenance director will do random audits quarterly to ensure items are locked and secure in resident apartments and housekeeping carts.
Date by which lasting correction will be achieved	Overlake Terrace will be in compliance with WAC 388-78A-3100 by 1/25/25.
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400
Send copy to DDA Resource Manager or Residential Program Specialist for your region.

Plan of Correction

Agency Name	Citation Date
Overlake Terrace	12/11/2024
Submitted by	**Date of POC Submission**
Mindy Mendoza-Perry	12/31/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: (list WAC): WAC 388-78A-2474 and WAC 388-78A-2600	
What *initial or immediate actions* were taken to address concerns affecting clients?	Overlake Terrace shall ensure requirements for chapter 388-112A WAC are followed to ensure residents are not at risk of unmet care needs from staff because of incomplete training. Overlake Terrace aims to provide the necessary care and services for residents including those with special needs and supports services that are provided to residents within our care. Overlake Terrace has completed an audit to identify staff members who need specialized training, CPR, or continuing education. Those staff identified in the audit have either completed the required training or have been scheduled to complete the training no later than 1/25/25 with an outside trainer. The audit staff have been noted to have CPR and continuing education units as required by chapter 388-112A WAC.
How will you apply the correction to all clients you support?	The Business Office Manager has scheduled training for dementia and mental health specialty training with an outside provider on Jan 13, 2025. Staff lacking training have been informed the training is mandatory. The Business Office Manager will see proper training has been completed by the appropriate staff or staff will be removed from the schedule starting on 1/25/25 until the training is complete. Additionally, to ensure the systemic and operational change for compliance of WAC 388-78A-2474 and WAC 388-78-2600 the Business Office Manager has created a spreadsheet with dates to track completion of training requirements.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	The Business Office Manager will utilize the spreadsheet to track employee training requirements of chapter 388-112A WAC. The Executive Director will randomly audit employee files to ensure the training tracked is accurate and complete so resident are not placed at risk of unmet care needs from staff with incomplete training.
Date by which lasting correction will be achieved	Overlake Terrace will follow WAC 388-78A-2474 and WAC 388-78A-2600 by 1/25/25.
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Laurie Anderson, Field Manager
Residential Care Services

Region 2, Unit D
20425 72nd Avenue S, Suite 400

Send copy to DDA Resource Manager or Residential Program Specialist for your region.

Plan of Correction

Agency Name	Citation Date
Overlake Terrace	12/11/2024
Submitted by	**Date of POC Submission**
Mindy Mendoza-Perry	12/31/2025
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: (list WAC): WAC 388-78A-2100 (2090)	
What *initial or immediate actions* were taken to address concerns affecting clients?	Overlake Terrace obtains sufficient information to assess the capabilities, needs and preferences of our residents. Overlake Terrace completes a full assessment of our residents during admission (or within or within 14 days of the admission date) and at least annually. During the full assessment if a resident is found to use bed side rails the risks of using bed side rails will be discussed with the resident/ responsible party and an assessment will be completed to ensure the safety of each resident when using a medical device- such as bed side rails. Immediately staff identified what residents had bed side rails and educated families/ residents about the risks vs benefits of bed side rail usage. Staff ordered covers to protect residents from gaps between the rail support and the mattress- these will be put in place when received from vendor. Mobility Device Assessments began on residents with the use of mobility enhancers such as bed side rails.
How will you apply the correction to all clients you support?	To ensure WAAC 388-78A-2100 is followed Overlake Terrace has implemented the following systemic changes. When any full assessment is completed, and bed side rails are used immediate completion of the Mobility Device Safety Assessment will be done by the nurse completing the assessment. Additionally, the nurse will engage in a conversation with the resident/ responsible party to ensure the risks of using bed side rails is discussed. Only after the resident/ responsible party agree to the use of bed side rails will the bed side rails be used and not prior to the facility covering them with a protective cover to avoid strangulation, suffocation, or bodily injury.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	To ensure WAC 388-78A-2100 and WAC 388-78A-2090 are followed the community Licensed Nurse/ Health and Wellness Director shall complete an audit for use of bed side rails. During the audit the nurse or director shall ensure bed side rails have covers, risks have been discussed with the resident/ responsible party, and a Mobility Device Safety Assessment has been completed.
Date by which lasting correction will be achieved	Overlake Terrace will ensure compliance with WAC 388-78A-2100 and WAC 388-78A-2090 by 1/25/25.
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

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

Send copy to DDA Resource Manager or Residential Program Specialist for your region.

Plan of Correction

Agency Name	Citation Date
Overlake Terrace	12/11/2024
Submitted by	**Date of POC Submission**
Mindy Mendoza-Perry	12/31/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: (list WAC): WAC 388-78A-3090	
What *initial or immediate actions* were taken to address concerns affecting clients?	Overlake Terrace adheres to WAC 388-78A-3090 to keep equipment and furnishings clean and in good repair. Additionally Overlake Terrace's goal is to keep residents safe and free from the risk of potential entrapment and injury from use of unsafe medical equipment. On 12/6/24 Overlake Terrace checked all residents bed side rails to ensure they were not loose to avoid injury to a resident from unsafe medical equipment. Overlake Terrace adjusted equipment, as needed, to ensure bed rails were tight and did not shake for stability.
How will you apply the correction to all clients you support?	The following systemic and operational changes will be implemented to ensure WAC 388-78A-3090 is met. A new system has been implemented to ensure bed side rails are tight and firmly attached to the bed to avoid risks associated with unsafe medical equipment; Maintenance department will check the equipment regularly to ensure it is in good repair. Overlake Terrace nurse will complete a Mobility Device Safety Assessment on residents who utilize bed side rails. A discussion with resident/ responsible party will be prompted to ensure risks of use of bed side rails are disclosed. Overlake Terrace will ensure covers for siderails are used to avoid suffocation, strangulation, or bodily injury.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Maintenance Director/ Licensed Nurse/ Health and Wellness Director, Memory Care Director will each be part of the auditing process to ensure bedrails are in good repair, assessed properly, risk of siderails are explained to resident/ responsible party, and covers are placed on side rails. Random audits by Executive Director/ designee will be completed to ensure all parties responsible are following WAC 388-78A-3090.
Date by which lasting correction will be achieved	Overlake Terrace will be in compliance with WAC 399-78A-3090 by 1/25/25.
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Laurie Anderson, Field Manager

Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Send copy to DDA Resource Manager or Residential Program Specialist for your region.