STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Sapphire at Woodway, LLC
Woodway Senior Living
1712 E Maplewood Ave
Bellingham, WA 98225

RE: Woodway Senior Living License # 2563

Dear Administrator:

This letter addresses Compliance Determination(s) 46428 (Completion Date 09/04/2024) and 39933 (Completion Date 07/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/04/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2305-1, WAC 246-215-03526-4-c, WAC 246-215-03526-4-a, WAC 388-78A-2650-3, WAC 388-78A-2305-1, WAC 246-215-02120-1, WAC 388-78A-2210-1-b, WAC 388-78A-2130-3-b, WAC 388-78A-2310-2-c, WAC 388-78A-2310-2-f, WAC 388-78A-2630-1-a

The Department staff who did the on-site verification:
Judith Mellon, RN, Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely, Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 125373
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s):

Allegation(s):

1) Kitchen Staff are not handwashing or changing gloves after touching dirty dishes and are serving residents.
2) There is moldy fruit and food items.
3) There are undated and outdated dry-storage food items, undated items in the refrigerator and freezers.
4) Care staff enter the dry storage despite signs on the door that state Kitchen Staff Only.
5) The resident snack refrigerator in the staff lounge is outdated, moldy, dirty and not cleaned.
6) The facility fired Named Staff in retaliation for claiming a work injury.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Kitchen, handwashing, meals and food preparation, dining, residents in dining room, resident rooms, identified resident, sample resident, medication cart, elevator signage
Interviews:	Executive Director, Regional Registered Nurse, Director of Food Services, Dietary Staff, identified resident, sample residents, Nursing Staff
Record Reviews:	meal temperature logs from January 2024 to April 2024, medical records, facility medication policy and procedure, staff training records, state reporting log

Investigation Summary:

1) Kitchen Staff were observed handwashing and changing gloves between tasks. Kitchen Staff stated that they wash their hands and apply clean gloves after washing dishes and serving the residents in the dining room. Review of Dietary Staff Food Handler credentials showed that one of six dietary staff did not have the required Washington State Food Handler's card. Failed practice was identified. Citation was issued for Food Sanitation WAC 388-78A-2305 (1) and refer to Food Service WAC 246-215-02120 (1).

2, 3) The dry storage area of the Assisted Living Facility was observed and had moldy oranges and brown, rotten apples. A refrigerator had brown colored lettuce with brown liquid in the bag of lettuce. A package of meat was open to air and had ice crystals and a dried meat texture. A box of crepes were left open to air in a freezer. Multiple food items in freezers, refrigerators and the resident snack refrigerator were not dated or labeled and packages were loosely rolled closed with a paper clamp type clip. Failed practice was identified. Citations were issued for Food Sanitation WAC 388-78A-2305 (1), refer to Food Service WAC 246-215-03526 (4)(a)(c).
4) A sign on the kitchen dry storage door showed "employees only." No employees other than dietary staff were observed entering the ALFs dry-storage areas. No failed practice was identified.
5) A resident snack refrigerator located in the ALF staff lounge was observed to have freezer burned crepes opened to air in the freezer, unlabeled and undated take-out containers of food. Staff stated that the items should be labeled and not open to air. Failed practice was identified. Citations were issued for Food Sanitation WAC 388-78A-2305 (1) and refer to Food Service WAC 246-215-03526 (4)(a)(c).
6) Not able to substantiate. Facility Staff reported no Staff were terminated for retaliation. Named Staff did not respond to call attempts. No failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 125677
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s): 05/22/2024

Allegation(s):

1) There is a large turnover of staff and care is being done by Agency Staff who are not given orientation.
2) The Named Resident (NR) insulin was two hours late, not being given before meals or is being skipped.
3) An Unnamed Staff or Agency person had a short acting instead of a long-acting insulin for a NR and the NR stopped them from providing the wrong insulin.
4) The NR was given another residents medication.
5) The facility suggested the NR self-administer medications when the NR had not been allowed to self-administer a Tylenol.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Kitchen, handwashing, meals and food preparation, dining, residents in dining room, resident rooms, identified resident, NR and sample resident, resident rooms, medication cart, elevator signage, resident common areas
Interviews:	Executive Director, Regional Registered Nurse, Director of Food Services, Dietary Staff, identified resident, sample residents, Nursing Staff
Record Reviews:	Identified Resident and sample resident medical records including medication administration records from February 2024 through April 2024, facility medication policy and procedure, meal temperature logs from January 2024 to April 2024, medical records, staff training records, state reporting log

Investigation Summary:

1) Agency staff stated that they had received orientation and training to the medication cart and ALF prior to passing medication. Facility records dated 05/28/2024 showed orientation training was provided. The ALF recently hired a Registered Nurse. No failed practice identified.

2) Records reviewed showed the NR and a sample resident had insulin medications that were documented with time-ranges of being late from 2.5 hours to 6 hours late. Both residents stated that they did not receive their insulin as prescribed. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A-2210 (1)(b) Medication Services.
3) Not able to substantiate. Unable to identify staff or agency staff or verify allegation. No failed practice identified.
4) Electronic medication administration records were reviewed for the Named Resident and a second Resident. Medications audit reports were reviewed for medication administration. ALF staff stated that they were not aware of any residents being provided with someone else's medication. Unable to substantiate with staff. No failed practice was identified.
5) Record review showed the NR had a completed medication assessment and was assessed by a Registered Nurse to be capable to complete a partial self-administration of diabetic medication. The NR stated that they could self-inject their own insulin. Failed practice identified. Citations were issued for non-compliance to WAC 388-78A-2310 (2)(c)(f) Intermittent Nursing Services and WAC 388-78A-2130 (3)(b) Service Agreement Planning relating to medications.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 128410
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s):

Allegation(s):
The facility elevator had not been working eight days from 04/17/2024 until 04/25/2024.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	front door entrance and elevator signage, resident dining room, stairwells, resident living quarters,
Interviews:	Executive Director
Record Reviews:	No facility documentation available

Investigation Summary:
When entering the Assisted Living Facility, the entrance door was observed to have a sign informing visitors that the elevator was out of service until further notice. The ALF Staff stated the elevator stopped working the previous day on 04/17/2024. Dietary staff were observed serving some residents in the dining room and were preparing take-out containers to deliver to residents who were unable to attend the dining room for meals. Dietary Staff stated that some residents were unable to walk down the stairs to go to the dining room. A resident stated that they couldn't go downstairs when they wanted to because they were unable to use the steps because they needed to use their walker for balance and were afraid that they would fall. The elevator was reported by the ALF's management that the elevator had not been working from 04/17/2024 until 04/25/2024. Review of the Department's Secure Tracking and Reporting System on 04/18/2024 showed a report was not made to the State Hotline related to the elevator outage. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A-2650 (3) Reporting fires and incidents.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 128635
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s):

Allegation(s):
A Named Resident (NR) was not receiving medication on time.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Named Resident and sampled Residents and their living quarters, medication cart,
Interviews:	Executive Director, Regional Registered Nurse, Named Resident, sample residents, Medication Technician, Resident Care Coordinators
Record Reviews:	NR's medical records including negotiated service agreement, medication administration records and administration report from March 2024 through May 2024, facility medication policy and procedure, treatment records from March 2024 through May 2024

Investigation Summary:
Record review showed the NR's medicated treatments were provided late multiple times. The NR's scheduled administration time reports showed treatments were provided in a timeframe ranging from one hour 45 minutes up to four hours and one minute late. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A- 2210 (1)(b) Medications Services.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 131401
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s):

Allegation(s):

1) The Named Resident was missing a Fentanyl patch that was reported to the Named Staff.
2) Medication Technicians were unaware of how to apply Fentanyl patches and use liquid oxycodone medication.
3) There was no Registered Nurse working on the weekends to administer as needed medications.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Named Resident and sampled Residents and their living quarters, medication carts, narcotics, staff response to resident care needs
Interviews:	Executive Director, Regional Registered Nurse, Named Resident, sample residents, Medication Technician, Resident Care Coordinators
Record Reviews:	Named Resident and sample residents medical records including negotiated service agreement, medication administration records and administration report from March 2024 through May 2024, facility medication policy and procedure, treatment records from March 2024 through May 2024

Investigation Summary:

1) Records reviewed showed the NR's Fentanyl medication was signed as given. The ALF Administration and Staff stated they were unaware of any reported missing medications. Family stated the Named Resident received all medications and was only aware of medications provided late. Records showed multiple medications were provided late with timeframes that ranged from one hour 31 minutes to five hours and 57 minutes late. A citation was issued for non-compliance with WAC 388-78A-2210 (1)(b) Medication Services.
2) Records reviewed showed medication was provided to the Named Resident. Facility

Staff stated they were unaware of any difficulties in providing Fentanyl patches and liquid oxycodone medication. No failed practice was identified.
3) A Registered Nurse was hired, worked on the weekends, and provided assistance on the medication cart. Medication Technicians stated the Nurse would come in on the weekends to work and be available for staff. No failed practice was identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 131007
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s): 06/06/2024

Allegation(s):

1) The Named Resident (NR) was not receiving their thyroid medication on multiple occasions.
2) The bathroom floor in the NR's room had mold growing on the floor.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Named Resident and sampled Residents and their living quarters, medication cart, NR's bathroom flooring
Interviews:	Executive Director, Regional Registered Nurse, Named Resident, sample residents, Medication Technician, Resident Care Coordinators, Family
Record Reviews:	NR and sample Resident's medical records including negotiated service agreements, medication administration records and administration time reports from March 2024 through May 2024, facility medication policy and procedure, treatment records from March 2024 through May 2024

Investigation Summary:

1) Record review showed the NR's medications were provided late multiple times. The NR's medication administration time reports showed medications were provided in a timeframe ranging from one hour 50 minutes up to four hours and 52 minutes late. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A- 2210 (1)(b) Medications Services.
2) The NR's bathroom floor showed a dark colored stain on the linoleum floor near the shower stall. The linoleum floor area was smooth, had no type of growth or odor and appeared like a dye or liquid type stain. No black mold was observed. No failed practice was identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 131539
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s): 06/06/2024

Allegation(s):

1) The Named Staff (NS) was neglecting care of a Named Resident (NR). When the NR was not feeling well the NS refused to call 911 and told the NR to call 911 themself.
2) The NS had yelled at a NR.
3) The NR had a fall with injury prior to move in, complained of pain and the nurse never followed up on the NR.
4) The NR was left in their room for five days without a way to leave their room because of not having any portable oxygen tanks and the room was warm.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Named Residents and Named Resident's living quarters, staff response to resident care needs
Interviews:	Executive Director, Regional Registered Nurse, Named Resident, sample residents, Medication Technician, Resident Care Coordinators
Record Reviews:	NR's medical records including negotiated service agreement, medication administration records and administration report from March 2024 through May 2024, facility medication policy and procedure, treatment records from March 2024 through May 2024, negotiated service agreements and assessments, progress notes, facility grievance report, outside agency email

Investigation Summary:

1) The NR denied any knowledge of not feeling well or not having 911 notified. The NR denied any neglect of care or abuse by staff. The NR stated that all the staff are good, and the NR receives whatever they need. No failed was practice identified.
2) Record review showed the NR was to use a wheelchair for mobility for long distances. The NR notified ALF Staff that a NS had yelled at them because the NR had used a wheelchair provided by nursing staff. Record review showed facility staff documented that the NR had reported that a NS yelled at them, and that the NS had apologized. The facility staff denied notifying the State Hotline to report the incident.

Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A2630 (1)(a) Reporting Abuse and Neglect.
3) Record review showed the NR had a fall prior to moving into the facility. The NR stated that they had self-notified 911, had some pain while they were at their prior residence and then had returned to the Assisted Living Facility (ALF). The NR stated that they continued to have ongoing pain, was unsure of who to talk to in the ALF and notified an outside agency on what they should do. The outside agency provided information to the NR and notified the ALF Staff. The NR then self-notified 911 and self-transferred to the emergency room for further evaluation. Record review showed a diagnosis of a [redacted]. The facility updated a plan of care. No failed practice was identified.
4) The NR denied any concerns related to not having portable oxygen tanks, not being able to leave their room or that the room was hot. The NR was observed wearing oxygen with an oxygen concentrator (machine to help breathe oxygen) in their apartment and had several portable oxygen tanks available. No Failed practice was identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 39933
Intake ID: 131749
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/18/2024 through 07/09/2024
Complainant Contact Date(s): 06/06/2024

Allegation(s):

1) The Named Resident (NR) had medications missed or given late.
2) The Named Resident's (NR) Tylenol medication was late and the NR requested the medication and never received it.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 7 Closed records sample size: 1
Observations:	Named Resident and sampled Residents and their living quarters, medication cart
Interviews:	Executive Director, Regional Registered Nurse, Named Resident, sample residents, Medication Technician, Resident Care Coordinators, outside agency
Record Reviews:	NR and sample Resident's medical records including negotiated service agreements, medication administration records and medication administration time reports from March 2024 through May 2024, facility medication policy and procedure, treatment records from March 2024 through May 2024

Investigation Summary:

1 & 2) Records showed the NR's medications were provided late multiple times. The NR's scheduled administration time reports showed medication timeframes ranged from one hour 54 minutes up to four hours and 52 minutes late. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A- 2210 (1)(b) Medications Services.

Conclusion / Action:

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

☐ N/A

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 2563	Compliance Determination # 39933
Plan of Correction	Woodway Senior Living	Completion Date
Page 1 of 18	Licensee: Sapphire at Woodway, LLC	07/09/2024

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 an unannounced on-site complaint investigation on 04/18/2024 and 07/09/2024 of:

Woodway Senior Living
1712 E Maplewood Ave
Bellingham, WA 98225

This document references the following complaint number(s): 125373, 125677, 128410, 128635, 131401, 131007, 131539, 131749

The following sample was selected for review during the unannounced on-site visit: 7 of 68 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Judith Mellon, RN, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

07/19/2024
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: 7-22-24

WAC 246-215-03526 Temperature and time control Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).

(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:

(a) Using a method approved by the regulatory authority for refrigerated, ready-to-eat, time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;

(c) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or

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

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

This requirement was not met as evidenced by:

Based on observations, interviews, and record review the Assisted Living Facility (ALF) failed to ensure multiple food items held in 4 of 4 kitchen storage units, a Resident snack refrigerator, kitchen refrigerator, kitchen freezer and dry storage were labeled with a date to be used or removed by. This failure placed all residents at risk for food borne illnesses.

Findings included...

On 04/18/2024 at 11:22 AM, the ALF's kitchen dry food storage area was observed to have a shelving unit with a box of 4 oranges and a box with 5 apples sitting on the bottom shelf. The four oranges had fuzzy greenish-white mold covering the oranges. Three of the five apples were rotten, with brown coloring and two of the apples were soft and starting to discolor and turn brown.

On 04/18/2024 at 11:24 AM, Staff D, Dietary Manager, stated that he would get those out of there. Staff D did not respond if he was aware the fruit was rotten.

On 04/18/2024 at 11:27 AM, the kitchen freezer was observed to have an open bag with eight pieces of garlic open to freezer air and two bowls of uncovered ice cream. Both were not labeled or dated and had freezer burn. A bag with several pancakes was open to air,

had freezer burn with ice crystals and unreadable date on the package. Loosely rolled bags that were unlabeled and not dated had five freezer burned chicken patties, a large bag of meatballs, and freezer burned pork chops in them.

On 04/18/2024 at 11:28 AM Staff G, Dietary Aide, stated that the date on the pancakes looked like the pancake packages were opened on 01/09/2024.

On 04/18/2024 at 11:29 AM Staff D, Dietary Manager, stated that they were not aware that the pancakes were freezer burned.

Record review of the ALF's dietary menu showed Buttermilk pancakes were last served on 04/17/2024.

On 04/18/2024 at 11:45 AM the kitchen refrigerator was observed to have four packages of cheese loosely wrapped in plastic, open to air, not dated or labeled. Two cups of salad type dressing were unlabeled, not dated and a large bag of lettuce with brown leaves and brown liquid running through the bag.

On 04/18/2024 at 12:20 PM Staff A, Executive Director, was notified immediately and stated that Staff D should have thrown that away.

On 04/18/2024 at 1:29 PM a resident snack refrigerator located in the staff lounge was observed to have four white take-out containers, unlabeled & undated with roast beef sandwiches, discolored salad dressing and two containers with soggy toast with salad that was wilted. Four pieces of bread were loosely wrapped, undated and unlabeled. A quarter loaf of bread undated and loosely wrapped was on the shelf in the refrigerator. The resident snack freezer had an opened box that felt damp to touch, with crepes in an opened plastic bag with freezer burn and ice crystals. The crepes were not dated.

On 04/18/2024 at 1:46 PM, Staff A, Executive Director, stated that all the items in the refrigerator needed to be labeled and dated. Staff A stated that he was not aware of the freezer burned items, would throw out any items with freezer burn, and follow-up with the dietary staff.

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, Woodway Senior Living is or will be in compliance with this law and / or regulation on (Date) August 16, 2024 .

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

James K Ham — Administrator (or Representative)

July 22, 2024 — Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on observations and interviews the Assisted Living Facility (ALF) failed to notify the Aging and Disability Services Administration Complaint Resolution Unit Hotline when 1 of 1 elevator was not working. This failure resulted in residents' inability to leave their rooms and placed residents at risk for unmet care needs.

Findings included...

Observation on 04/18/2024 at 11:10 AM signage posted on the ALF's front entrance door showed "the elevator is down until further notice."

On 04/18/2024 at 11:10 AM, Staff A, Executive Director, stated that the elevator had not been working since 04/17/2024. A company was notified and was working on fixing the elevator. Staff A stated the elevator should be able to get fixed today.

Observation on 04/18/2024 at 11:12 AM showed an outside vendor in the ALF with a dolly wheeling a large blue barrel to the elevators.

Review of the Department's Secure Tracking and Reporting System on 04/18/2024 showed no report was made to the hotline related to the elevator not working.

04/18/2024 at 2:35 PM, signs posted on the elevator doors showed "Out of order. Pull call light for assistance."

On 04/18/2024 at 11:19 AM Staff D, Dietary Manager, stated that they were setting up for lunch. Staff D stated that the elevator was not working so they had some residents eating in the dining room and some residents eating in their rooms.

Observation on 04/18/2024 at 11:19 AM showed white take-out containers set up to be delivered to resident rooms after the main dining room was served.

On 04/18/2024 at 3:00 PM Resident 2 stated that they were eating in their room because they were not able to go up and down the stairs. Resident 2 stated that they were stuck in their rooms because of the elevator not working.

On 04/18/2024 at 3:00 PM Staff A stated that he did not report the elevator not working to the hotline.

On 04/25/2024 at 2:35 PM, the ALF's elevator was observed to have signs posted on the elevator doors out of order. Pull call light for assistance.

On 04/25/2024 at 7:00 AM, Staff I, Medication Technician, stated "No the elevator isn't fixed yet, it's still not working."

On 04/26/2024 at 9:20 AM, Staff A stated that the outside vendors were unable to finish the work, the ALF changed companies for repairs, the parts were replaced, and everything was now working.

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, Woodway Senior Living is or will be in compliance with this law and / or regulation on (Date) August 1, 2024 .

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

Jamie Lee — July 22, 2024

Administrator (or Representative) — Date

WAC 246-215-02120 Food worker cards.

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

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

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

This requirement was not met as evidenced by:

Based on interviews, and record review the Assisted Living Facility (ALF) did not ensure 1 of 6 kitchen staff (Staff G) working in the kitchen had a current Washington State food Handler's card. This failure placed Residents at risk for food borne illnesses.

Findings included...

Review of the Washington State Department of Health website; Washington State requires that all food workers have food safety training before handling food served to the public. Food workers who take a food safety training class and pass the State of Washington exam on food safety basics are issued a Food Worker Card (also called a food handler permit).

On 04/18/2024 at 11:19 AM Staff G, Dietary Aide, stated that they were a dietary aide and a caregiver. Staff G stated that they were helping in the kitchen and were getting ready for lunch.

Review of Staff G's employee file showed Staff G had an online certificate from Food Handler Solutions, ANSI (American National Standards Institute) accredited. ANSI is not an approved program for a food handler's card in Washington state.

On 04/18/2024 at 3:30 PM Staff A, Executive Director, stated that he was not aware Staff G did not have a Washington state approved food handler's permit. Staff A stated that he would have Staff G complete the correct food handler program.

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, Woodway Senior Living is or will be in compliance with this law and / or regulation on (Date) August 1, 2024 .

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

Administrator (or Representative) — July 1, 2024 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly,

must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 8 of 8 residents (Resident 1, 2, 3, 4, 5, 6, 7 and 8) received their medications as prescribed when medication administration records (MARs) were not updated, blood glucose readings were signed simultaneously with two different readings and medications were provided late. This failure resulted in Residents 1, 2, 3, 4, 5, 6, 7, and 8 not receiving their medications as prescribed, Resident 5 having pain and placed them at risk for medical complications.

Findings included...

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2020 with multiple medical diagnoses including [redacted] ([redacted]).

The negotiated service agreement (NSA) dated 01/02/2024 showed Resident 1 was diabetic, had blood sugar checks with a freestyle libre (the libre is a continuous glucose monitoring system to check blood sugar levels without a blood sample), and was on insulin.

The MAR dated February through April 2024 showed Resident 1 received Humalog 100U/ML (units per milliliter is a metric form of measurement) on a sliding scale (a sliding scale has blood sugar readings showing different dosages of insulin to provided) three times daily before meals at 7:30 AM, 11:00 AM and 4:30 PM, and received Lantus insulin at 8:00 PM. This task was signed off every day as being completed by a Medication Technician. Additional insulin directions showed "delegated staff may also inject."

Resident 1's care plan dated 04/05/2024 showed under a section titled "safety" that "some staff are delegated to give Resident 1 insulin" but Resident 1 should be encouraged to self-administer.

On 04/18/2024 at 12:34 PM, Staff C, Regional Registered Nurse, stated that all residents were able to self-administer their medications, and that there was no nurse delegation in the ALF. Staff C stated that Residents 1 and 2 were both diabetic, can self-administer their insulins and can change their libres.

On 04/18/2024 at 1:00 PM Staff C stated that she was not sure why it says delegation on the MARs, there was no nurse delegation. Staff C stated she thought that the MARs were not updated from when the ALF previously provided nurse delegation.

Review of an ALF report titled "Location of Administration Report" showed the scheduled and administered medication times that Medication Technicians provided medication for Resident 1. The report showed entries of late medication administration times of greater than two or three hours from February through April 2024 for Humalog 100U/ML insulin and Lantus insulin one time greater than two hours in March 2024.

On 04/18/2024 at 2:04 PM, Resident 1 stated that they were receiving their medications late and had almost received the wrong insulin.

On 04/25/2024 at 7:12 AM Staff E, Medication Technician, stated that she did not have time to sign the MAR that she gave the residents their medications. Staff E stated that she gets the medications ready, provides them to Residents and gets the next residents medication ready. Staff E stated that she goes back later and signs the MARs.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted].

Resident 2's most recent NSA dated 01/02/2024 showed Resident 2 was diabetic, had blood sugar checks with a freestyle libre and had insulin.

The MAR dated February through April 2024 showed Resident 2 was to receive Toujeo 300-U/ML (type of long-acting insulin used to control high blood sugar), to inject 44 units every morning, to check blood sugar three times a day at 8:00 AM, 12:00 PM, 4:00 PM and as needed. Resident 2's libre was to be changed every 14 days, to remove the prior libre and place a new libre per RN Delegation. On 02/27/2024 two 8:00 AM blood sugar entries were recorded as 279 and 240 on the same day at the same time. On 03/03/2024 two 8:00 AM blood sugar entries were also recorded as 173 and 309 the same day and time.

On 04/18/2024 at 1:00 PM Staff C, Regional Registered Nurse, stated that she did not know why the Medication Technicians had two 8:00 AM blood sugar entries and would have to take a look at that.

On 04/25/2024 at 7:12 AM Staff E, Medication Technician, stated that she did not know why she wrote 173 and 309 at the same time. Resident 2 gets her blood sugar checked three times a day at 8:00 AM, 12:00 PM and 4:00 PM. Staff E stated that she was unsure why she put two different entries in the same time frame.

Review of an ALF report titled "Location of Administration Report" showed the scheduled and administered medication times that Medication Technicians provided medication for Resident 2. The report showed entries of late medication administration times of greater than three to six hours late for Resident 2's Toujeo 300-U/ML insulin from February through April 2024 for Resident 2.

On 04/18/2024 at 3:00 PM Resident 2 stated that sometimes they don't get medications and sometimes they are late.

On 04/25/2024 at 7:12 AM Staff E, Medication Technician, stated that she did not have time to sign the MAR that she gave the residents their medications. Staff E stated that she gets the medications ready, provides them to Residents and gets the next residents medication ready. Staff E stated that she goes back later and signs the MARs.

Resident 3

Resident 3 was admitted to the ALF on [redacted]/2021 with multiple medical diagnoses including [redacted] ([redacted]) and [redacted].

The NSA dated 12/12/2023 showed Resident 3 was to receive medication assistance and the ALF's nursing staff were to order, store and administer all medications.

Review of Resident 3's MAR from March through May 2024 showed Resident 3 had physician orders for: Cooling pain relief 4% gel (used for temporary relief of minor aches and pains) to be applied topically twice a day at 6:00 AM and 9:00 AM. Another medication, Diclofenac Sodium 1% gel (used to treat pain and other symptoms of arthritis of joints) was to be applied topically, twice daily, at 6:00 AM and 6:00 PM.

Review of Resident 3's MAR "administration time" report showed Resident 3 received late treatments from March through April 2024 with timeframes ranging from one hour 45 up to four hours and one minute late.

On 05/23/2024 at 11:30 AM, Resident 3 stated the nursing staff bring my medications for me. I was getting my medications late and that's not right. I have a lot of pain and need to get them on time.

Resident 4

Resident 4 was admitted to the ALF on [redacted]/2021 with multiple medical diagnoses

including [redacted] ([redacted]).

The NSA dated 02/05/2024 showed Resident 4 was to receive medication assistance and that the ALF's nursing staff were to receive and store all medication.

Review of Resident 4's MAR from March through May 2024 showed Resident 4 had physician orders for Levothyroxine (used to treat hypothyroidism) 100 MCG (microgram: a unit of measurement) daily at 7:00 AM.

Review of Resident 4's MAR "administration time" report showed Resident 4 received late medications from March through April 2024 which included the medication levothyroxine with timeframes ranging from one hour and 50 minutes up to four hours and 52 minutes.

On 05/23/2024 at 11:23 AM, Resident 4 stated that they bring my medicine to me in the morning and sometimes they might not bring the medicine until later in the day.

Resident 5

Resident 5 was admitted to the ALF on [redacted]/2022 with multiple medical diagnoses including [redacted], [redacted] ([redacted]) and [redacted] ([redacted]).

The NSA dated 06/19/2023 showed Resident 5 was to receive medication assistance and that the ALF would store and secure all medications.

Review of Resident 5's MARs from March through May 2024 showed Resident 5 had physician orders for Bupropion (an antidepressant) twice daily at 7:30 AM and 7:30 PM, gabapentin (anticonvulsant and nerve pain medication) twice daily at 7:00 AM and 7:00 PM, potassium chloride ER (used to prevent and treat low levels of potassium) daily at 7:30 AM, furosemide (used to treat fluid retention) every morning at 7:30 AM, calcium carb/D (used to prevent low blood calcium) twice daily at 7:30 AM and 7:00 PM, Rosuvastatin (lowers cholesterol levels) every evening at 7:30 PM, Tylenol (treats mild pain) nightly at 8:00 PM and Alendronate (used to prevent bone breakdown and increase bone density) daily at 7:30 AM.

Review of the MAR administration time report dated March through April 2024 showed Resident 5 received medications late. Medication timeframes ranged from one hour and 54 minutes up to four hours and 52 minutes late.

On 05/23/2024 at 11:56 AM, Resident 5 stated that they were getting their medicine late.

Resident 5 stated that they had asked for their Tylenol in the evening and had asked again later for it. Resident 5 stated "They told me I had to ask for my medicine for pain. I'm afraid to ask for it so I just deal with the pain."

Resident 6

Resident 6 was admitted to the ALF on [redacted]/2024 with multiple medical diagnoses including [redacted] with pain and [redacted].

The NSA dated 05/09/2024 and showed Resident 6 was to have assistance with medications and that the medications were to be received and stored by the nursing staff.

MARs from May through June 5, 2024, showed Resident 6 had physician orders for Aspirin EC (enteric coated) daily at 8:00 AM, Atenolol (used to treat high blood pressure) daily at 8:00 PM, Furosemide every other day at 8:00 PM then was changed in May 2024 to once weekly at 7:00 AM, Lidocaine 5% patch (used to manage pain) put on for 12 hours at 8:00 AM then remove for 12 hours at 8:00 PM, Lisinopril (used to treat high blood pressure and heart conditions) daily at 8:00 PM , simvastatin (used to lower cholesterol), bedtime at 8:00 PM and trazodone (is an antidepressant and sedative), bedtime at 8:00 PM.

Review of the MAR administration report dated May through June 5, 2024 showed Resident 6 received late medications. Medication timeframes ranged from one hour and 54 minutes up to five hours and 15 minutes late.

On 05/23/2024 at 1:00 PM, Resident 6 stated that they were bringing in their pills late. Resident 6 stated that they liked to go to sleep early but had to wait up until the nursing staff brought the medication.

Resident 7

Resident 7 was admitted to the ALF on [redacted]/2020 with multiple medical diagnoses including [redacted].

The NSA had an initiated date of 04/27/2024 and showed Resident 7 was independent with medications.

MARs from March through May 2024, showed Resident 7 had physician orders for Atorvastatin daily, (a medication related to a diagnosis of [redacted]). From May 1st through May 22, 2024 the MAR showed two entries for Atorvastatin 80 mg by mouth "every day" for hypercholesterolemia. The two medication entries were overlapping, with

different start dates and no discontinue dates. One entry was scheduled for 7:30 AM and the second entry was scheduled for 7:30 AM and 8:00 AM.

Review of treatment records from March through May 2024 showed Resident 7 was to have a blood pressure check daily at 10:00 AM.

On 06/06/2024 at 10:43 AM, Resident 7 stated that they take their own medications and that the staff check my blood pressure for them. Resident 7 stated that the Staff don't come in to take their blood pressure at any set time just whenever they can.

On 06/06/2024 at 12:10 PM Staff H, Resident Care Coordinator, stated that Resident 7 did their own medication, and the nursing staff completed the blood pressures.

Review of Resident 7's MAR "administration time" report showed Resident 7 received late treatments for blood pressures from March through May 2024 with timeframes ranging from one hour 34 minutes up to six hours and 55 minutes late.

Resident 8

Resident 8 was admitted to the ALF on [redacted]/2024 with multiple medical diagnoses including [redacted] ([redacted]) [redacted], [redacted] ([redacted]) and [redacted] ([redacted]).

The NSA dated 02/07/2024 showed Resident 8 needed assistance with medications, and that the ALF would receive and store the medications. The NSA showed hospice care was initiated on 02/13/2024.

The MAR from March through May 2024 showed Resident 8 was prescribed multiple medications including pantoprazole (used to treat acid reflux and a damaged esophagus) daily at 7:00 AM, 4:00 PM then changed April 2024 to 7:00 AM and 7:00 PM for ulcer of the esophagus, lactulose for liver transplant failure daily at 7:30 AM and ondansetron a medication used for nausea daily at 7:00 AM and 7:00 PM.

Resident 8 received late medications from March through May 2024. Medication timeframes ranged from one hour 31 minutes to five hours and 57 minutes late.

On 04/25/2024 at 7:12 AM Staff E, Medication Technician, stated that she did not have time to sign the MAR that she gave the residents their medications. Staff E stated that she gets the medications ready, provides them to Residents and gets the next residents medication ready. Staff E stated that she goes back later and signs the MARs.

On 05/23/2024 at 1:17 PM, Collateral Contact 2 (CC2) stated that sometimes Resident 8 did not get medications at the right time and it was brought late. There were many times they had to ask for Resident 8's medication.

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, Woodway Senior Living is or will be in compliance with this law and / or regulation on (Date) August 16, 2024.

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

Administrator (or Representative) — Date: July 22, 2024

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 :

(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 interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled Residents (Resident 1) negotiated service agreements (NSA) addressed current medication needs related to Resident 1's self-administration of Diabetic medication management. This failure placed Resident 1 at risk for not receiving medications as prescribed.

Findings included...

Resident 1 was admitted to the ALF on [redacted]/2020 with multiple medical diagnoses including [redacted] ([redacted]).

The self-medication assessment dated 03/26/2024 showed Resident 1 was assessed by Staff C, Regional Registered Nurse, for diabetic management and self-administration of medications.

The negotiated service agreement (NSA) dated 01/02/2024 showed Resident 1 had blood sugar checks with a freestyle libre (the libre is a continuous glucose monitoring system to check blood sugar levels without a blood sample), was able to self-check blood sugars and

assistance with changing the libre sensor was done through delegation. The NSA showed under Resident 1's medication was received and stored by the ALF and that some staff were delegated to give Resident 1's insulin but Resident 1 should be encouraged to self-give.

A care plan dated 04/05/2024 showed Resident 1 needed assistance with self-administration of medications and to see the medication administration record (MAR) for further information. The care plan showed some staff were delegated to provide Resident 1's insulin but should encourage the resident to do it on their own.

On 04/18/2024 at 1:00 PM, Staff C, Regional Registered Nurse, stated that Resident 1's NSA just needed to be updated. There was no nurse delegation in the ALF. Resident 1 had a self-med assessment completed and was able to self-administer insulin.

Plan/Attestation Statement

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Administrator (or Representative) — Date: July 22, 2024

WAC 388-78A-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law:

(c) Diabetic management;

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure intermittent nursing services were provided for 2 of 2 diabetic residents (Resident 1 and 2) who received medication administration services for blood glucose testing and insulin injections. This failed practice placed Resident 1 and 2 at risk for medical complications related to diabetes management.

Findings included...

RCW 18.79.260 (3)(e)(v) Registered Nurse-Activities Allowed-Delegation of tasks shows the Nurse Delegation Program, under Washington State law, allows nursing assistants working in certain settings to perform certain tasks - such as administration of prescription medications including insulin injections - normally performed only by licensed nurses. A RN must instruct the nursing assistant regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate performance.

Review of WAC 246-840-930 (1)(3)(12)(i)(m)(14)(17)(18)(19) Criteria for delegation shows the RN must also ensure safe and effective services are provided including nursing assessments of the resident's condition to determine the condition remains stable and predictable. Nurse Delegation is specific to each resident, each caregiver, and each task. Documentation must be specific.

Review of the ALF's Disclosure of Services showed the ALF used nursing assistants under the delegation of a Registered Nurse to provide some authorized nursing services. Additional comments showed Diabetic management was limited to medication administration, glucose monitoring, and insulin administration.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2020 with multiple medical diagnoses including [redacted] ([redacted]).

The negotiated service agreement (NSA) dated 01/02/2024 showed Resident 1 had blood sugar checks with a freestyle libre (the libre is a continuous glucose monitoring system to check blood sugar levels without a blood sample), was able to self-check blood sugars and report the results before meals. The NSA showed changing the libre sensor was done through nurse delegation. The NSA showed under Resident 1's medication that some staff were delegated to give Resident 1's insulin but Resident 1 should be encouraged to self-administer, to maintain independence and involvement in their own care. Resident 1 has been assessed as able to self-administer with set up.

On 04/18/2024 at 12:34 PM, Staff C, Regional Registered Nurse, stated that all residents were able to self-administer their medications, and that there was no nurse delegation in the ALF. Staff C stated Residents 1 and 2 are both diabetic, can self-administer their insulins and can change their libre. Staff C stated that she was not the delegating nurse at the ALF and that the ALF was trying to get away from delegation.

Resident 1's Medication Administration Records (MARs) from February through April 2024 showed the following:

Resident 1 received Humalog 100U/ML (units per milliliter is a metric form of measurement) on a sliding scale (a sliding scale has blood sugar readings showing different dosages of insulin to be provided) three times daily before meals. This task was signed off every day as being completed by a Medication Technician. Additional insulin directions showed "delegated staff may also inject."

Resident 1's care plan showed under a "safety" title that "some staff were delegated to give Resident 1 insulin" but Resident 1 should be encouraged to self-administer.

On 04/18/2024 at 2:04 PM, Resident 1 stated that they had almost received the wrong insulin and that the Medication Technicians for example would give them insulin at 10:30 AM when they didn't eat until 1:00 PM.

On 04/18/2024 at 1:00 PM Staff C stated I'm not sure why it says delegation on the MARs, there is no nurse delegation. Staff C stated she thought that the MARs were not updated.

On 04/18/2024 at 2:15 PM, Staff E, Medication Technician, stated that she had nurse delegation training at another facility but did not have delegation training at the ALF.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted].

The NSA dated 01/02/2024 showed Resident 2 was to have a libre sensor change every two weeks, staff were to cue and encourage Resident 2 to do the change independently and Resident 2 was able to self-administer insulin with an insulin pen.

The MAR dated from February through April 2024 showed Resident 2's Libre was to be changed every 14 days, place a new Libre per nurse delegation.

On 04/18/2024 at 2:15 PM, Staff E, Medication Technician, stated that Resident 2 was not able to push the button on their insulin all the time and that all the insulin went into their brief. It's hit or miss with Resident 2's insulin, most of the time the Medication Technicians were doing the insulin for Resident 2. Staff E stated that she did not have delegation training at the ALF, but had received the nurse delegation training certificates prior to working at the ALF. Staff E stated that both Resident 1 and 2 had a Libre. Staff E stated that the ALF used Staff E to help them change the Libre to different areas on their arms because the ALF knew she had her certificates for nurse delegation training from another facility.

On 04/18/2024 at 3:15 PM, Staff C stated that she was not aware Resident 2 had insulin

running into the brief and if Resident 2 wasn't given a full dose the staff would have had to notify someone and dial up another dose if it all ran out.

On 04/18/2024 at 3:00 PM, Resident 2 stated that Staff E was the only one who was delegated.

On 04/18/2024 at 1:00 PM Staff C stated the ALF did not have any delegated residents.

Plan/Attestation Statement

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Administrator (or Representative) — Date: July 22, 2024

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to notify the Complaint Resolution Unit (CRU) as required when 1 of 1 resident (Resident 6) reported allegations of verbal inappropriateness. This failure resulted in preventing the Department from reviewing the ALF's response to abuse and neglect and placed all residents at risk for abuse.

Findings included...

Resident 6 was admitted to the ALF on [redacted]/2024 with multiple medical diagnoses including [redacted] ([redacted]) with pain and [redacted].

The NSA dated of 05/09/2024 showed Resident 6 needed assistance with transfers related to a lung disease, use of a wheelchair for mobility for long distances and used oxygen.

On 05/23/2024 at 1:00 PM, Resident 6 stated that they had a fall while they were off the ALF property after having just moved into the ALF. Resident 6 stated that they had pain while at their prior residence and had called 911. Resident 6 stated that they were then transferred back to the ALF. Resident 6 stated they continued to have pain and staff gave them a wheelchair to use to go to the dining room. Resident 6 stated they were in the lobby across from the Executive Director's office and that Staff B, Health and Wellness Director, came walking down the hallway with an angry look on her face. Staff B came over, was yelling, almost shouting at them and told them, you're independent you're not supposed to be in the wheelchair. Resident 6 stated that they had asked her why she was shouting and hostile to them. Staff B didn't answer and had just walked away from them.

On 06/05/2024 at 11:15 AM, Staff C, Regional Registered Nurse, stated that she was not aware of any verbal inappropriateness and that Staff B was very direct . Staff C stated that she had just heard on 06/05/2024 from a family member that they thought Staff B had an attitude.

On 06/05/2024 at 1:54 PM Staff A, Executive Director, stated that he was notified that Staff B had yelled at Resident 6 and had not reported it to the State hotline.

Review of an email dated 05/17/2024 at 11:15 AM showed Staff A was notified by Collateral Contact 1 (CC1), that Resident 6 was having ongoing pain and that Staff B yelled about using a wheelchair instead of a walker.

Review of a grievance form dated 05/03/2024 that was signed by Staff A showed a grievance/complaint Staff B had "yelled at Resident 6 and that Staff B thought Resident 6 was independent with a walker and not using a wheelchair full-time." The grievance form was signed 05/24/2024 in black ink.

Plan/Attestation Statement

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

Jamie Rae — July 22, 2024

Administrator (or Representative) — Date