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

Mirror Lake Village LLC
Mirror Lake Village
31000 9th Pl SW
Federal Way, WA 98023

RE: Mirror Lake Village License # 2564

Dear Administrator:

This letter addresses Compliance Determination(s) 52443 (Completion Date 01/02/2025) and 49841 (Completion Date 11/06/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/02/2025 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-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-e, WAC 388-78A-2170-1

The Department staff who did the on-site verification:
Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

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

Sincerely,

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site follow-up on 11/06/2024 and 11/06/2024 of:

Mirror Lake Village
31000 9th Pl SW
Federal Way, WA 98023

This document references the following SOD dated: 11/06/2024

The following sample was selected for review during the unannounced on-site visit: 15 of 65 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

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

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

Residential Care Services

Date

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

Administrator (or Representative) Date

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in 5 of 15 residents' (Resident 4, Resident 5, Resident 7, Resident 10, and Resident 14) Negotiated Service Agreements (NSA), the care needs and interventions for diagnoses and physician ordered medical treatments. This failure placed Resident 4, Resident 5, Resident 7, Resident 10, and Resident 14 at risk for unmet care needs and worsening of [redacted] diagnosed conditions.

Findings included…

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 05/07/2024, a second citation on 08/07/2024, and a third citation on 09/17/2024 for Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 06/21/2024, 08/17/2024, and again on 10/21/2024.

RESIDENT 4

Review of Resident 4's November 2024 Medication Administration Record (MAR) showed that Resident 4 received 50 milligrams (mg) of Sertraline (medication used to treat depression) daily, by mouth, for depression.

Review of Resident 4's assessment and service plan (also known as an NSA), dated 10/05/2024, showed no guidance for the staff about the signs and symptoms of depression. There was no guidance for the staff about the type of interventions used when Resident 4 showed signs and symptoms of depression.

RESIDENT 5
Review of Resident 5's record showed documentation of a completed feeding and swallowing evaluation, dated 06/17/2021. The feeding and swallowing evaluation results included a section titled, "CAREGIVER GUIDELINES FOR SAFE FEEDING".

Review of Resident 5's assessment and service plan, dated 06/18/2024, showed that Resident 5 received a mechanical soft diet (easily chewed and swallowed foods) and nectar thickened liquids (liquids with a thickener added). The plans showed no guidance for the staff about the type of actions to be taken when Resident 5 experienced swallowing or choking difficulties. The plans showed no instructions for staff about the documentation needed for incidences of swallowing difficulty and the monitoring of Resident 5's dietary intake. There were no instructions about what signs of increased swallowing difficulties to report to the nurse.

RESIDENT 7
Review of the facility characteristic roster showed that Resident 7 resided in the memory care unit. The roster showed that Resident 7 exhibited exit-seeking behaviors.

Review of Resident 7's assessment and service plan, dated 06/18/2024, showed no instructions for staff about how to manage Resident 7's exit-seeking behaviors when observed. The plans showed no instructions for staff about what documentation was needed for incidences of exit-seeking.

RESIDENT 10
Review of Resident 10's pre-admission assessment, dated 01/02/2024, showed that Resident 10 required one staff person assistance with transfers. The assessment showed that Resident 10 was verbally and physically resistive to care assistance and required cuing and encouragement.

Review of Resident 10's admission assessment and service plan, dated 06/18/2024, showed no instructions for staff about how to manage behaviors when Resident 10 demonstrated resistance to care and exhibited verbal and physical aggressive behaviors. The plans showed no instructions for staff about what documentation was needed for incidences of resistance to care and aggressive behaviors.

Resident 14
Review of Resident 14's November 2024 MAR showed Resident 14 received 2.5 mg of Eliquis (blood thinning medication) twice daily, by mouth, for the prevention of blood clots. The MAR showed Resident 14 received 25 mg of Sertraline (medication used to treat depression) daily, by mouth, for a diagnosis of [redacted].

Review of Resident 14's pre-admission assessment, dated 10/22/2024, showed no documentation that Resident 14 had a [redacted] diagnosis. The assessment showed no indication that Resident 14 received blood thinning medications.

Review of Resident 14's NSA, dated 11/06/2024, showed no diagnosis of [redacted]. The NSA showed that Resident 14 had a diagnosis of [redacted] The NSA showed no guidance for the staff about the possible side effects from the use of Eliquis, such as an increased risk for bleeding or bruising. The NSA showed no instructions for staff about what actions were needed for any side effects or the reporting of any signs and symptoms of side effects to the nurse. The NSA showed no guidance for the staff about managing the signs and symptoms of depression. The NSA showed no instructions for staff about what actions were needed for any worsening of depression symptoms or reporting of worsening symptoms to the nurse. There were no instructions about what side effects to monitor for the Sertraline medication and when to report any side effects to the nurse.

During an interview on 11/06/2024 at 1:40 PM, Staff X, Director of Wellness, stated that they were aware that Resident 14 received services for medication assistance, which included their Eliquis and Sertraline medications. Staff X stated that they were aware that Resident 14's NSA lacked documented instructions and guidance for caregivers regarding the [redacted] diagnosis and Eliquis and Sertraline medications.

This is an uncorrected deficiency cited on 09/17/2024 a recurring deficiency previously cited on 07/19/2024 and 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 4 residents (Resident 4 and Resident 15) side bed rails, attached to the residents' beds, were free from safety risks. This failure placed Resident 4 and Resident 15 at risk of harm or death from unsafe medical equipment.

Findings included…

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 05/07/2024; a second citation on 07/19/2024; and a third citation on 09/17/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 06/21/2024, 08/17/2024, and 10/21/2024.

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 strangling, suffocating, 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 bed rails.

During an interview on 11/06/2024, Staff W, Executive Director, and Staff X, Director of Wellness, stated that Resident 4 and Resident 15 resided in the facility and utilized bed side rail medical devices.

RESIDENT 4
Review of Resident 4's Service Plan, dated 10/05/2024 showed Resident 4 was assessed as requiring total hands-on caregiver assistance for all mobility needs and transfers to and from their bed as well as changes in position while in bed. The plan showed Resident 4 was assessed to use bed side rails on both the right and left sides of their bed. The plan showed Resident 4 required a wheelchair for mobility.

Observation of Resident 4's room on 11/06/2024 at 11:40 AM showed Resident 4 in their wheelchair with a family member present in the room. Observation showed half side rails attached at the top of Resident 4's bed, along both the right and left side. Observation showed the left-side rail in the raised position, and the right-side rail in the lowered position. The bed side rails measured approximately 36 inches wide with a four-inch gap between vertical rail bars. The left side rail was not securely attached to the bed frame. There was a three-inch thick cushion along the length of the right-side rail,

placed between the right-side rail and the mattress. During an interview at the time, Resident 4 stated that they felt unsafe with the cushions between the side rails and the mattress as it prevented them from using the side rails to assist in positioning in bed. Resident 4 stated that they are unable to independently raise or lower the bed side rails.

RESIDENT 15
Review of Resident 15's assessment and service plan, dated 10/21/2024, showed that Resident 15 required a wheelchair for mobility, required the assistance of two staff persons for transfers, and used a Hoyer lift for transfers. The plan showed that Resident 15 used side bed rails for positioning while in bed.

Observation of Resident 15's room on 11/06/2024 at 12:14 PM showed half side rails attached at the top along both the right and left side of Resident 15's bed. Observation showed the bed rails were in the raised position. The bed rails measured approximately 36 inches wide with a four-inch gap between vertical rail bars. Observation showed a rectangular, solid cushion, three inches thick, approximately 14 inches wide, and 36 inches long was placed between the side rail and the mattress on the left and right side of Resident 15's bed. The solid cushion placed between the side rails and the mattress placed Resident 15 at potential risk for suffocation if Resident 15 rolled over onto the cushion and blocked airflow to their mouth and nose. The cushions created a barrier that prevented Resident 15 from correctly using the side rails for positioning while in bed.

During an interview on 11/06/2024 at 2:36 PM, Staff X stated that Resident 15 was unable to independently put the side rails down. Staff X stated that Resident 15 was unable to call for staff assistance.

During an interview on 11/06/2024 at 2:45 PM, Staff W stated that they were aware that the side bed rails with cushion barriers created a potential suffocation and entrapment risk.

This is an uncorrected deficiency cited on 09/17/2024 a recurring deficiency previously cited on 07/19/2024 and 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

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

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

The department completed data collection for an unannounced on-site follow-up on 09/17/2024 and 09/17/2024 of:

Mirror Lake Village
31000 9th Pl SW
Federal Way, WA 98023

This document references the following SOD dated: 09/17/2024

The following sample was selected for review during the unannounced on-site visit: 0 of 60 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

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

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

Residential Care Services

Date

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

Administrator (or Representative) Date

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in 5 of 10 residents' (Resident 2, Resident 4, Resident 5, Resident 7 and Resident 10) Negotiated Service Agreements (NSA), the care needs and interventions for diagnoses and physician ordered medical treatments. This failure placed Resident 2, Resident 4, Resident 5, Resident 7 and Resident 10 at risk for unmet care needs and worsening of [redacted] diagnosed conditions.

Findings included…

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 05/07/2024 and a second citation on 08/07/2024 for Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 06/21/2024 and again on 08/17/2024.

RESIDENT 2

Review of Resident 2's August 2024 and September 2024 Medication Administration Records (MAR) showed that Resident 2 received 81 milligrams (mg) of Enteric Coated Aspirin (a coating on the tablet to allow for passage through the stomach to the small intestine before dissolving) daily, by mouth, for a diagnosis of [redacted].

Review of Resident 2's assessment and service plan (also known as an NSA), dated 06/18/2024, showed no guidance for the staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 4
Review of Resident 4's August 2024 and September 2024 MARs showed that Resident 4 received 50 mg of Sertraline daily, by mouth, for depression.

Review of Resident 4's assessment and service plan, dated 06/18/2024, showed no guidance for the staff about managing the signs and symptoms of depression. The plans showed no guidance for the staff for interventions when signs and symptoms were observed in Resident 4's behaviors. The plans showed no instructions for staff about what actions were needed for any worsening of depression symptoms. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 5
Review of Resident 5's record showed the facility admitted Resident 5 on [redacted]/2021.

Review of Resident 5's record showed documentation of a completed feeding and swallowing evaluation, dated 06/17/2021. The feeding and swallowing evaluation results included a section titled "CAREGIVER GUIDELINES FOR SAFE FEEDING".

Review of Resident 5's assessment and service plan, dated 06/18/2024, showed that Resident 5 received a mechanical soft diet (easily chewed and swallowed foods) and nectar thickened liquids (liquids with a thickener added). The plans showed no guidance for the staff about the safe feeding guidelines for Resident 5. The plans showed no guidance for the staff for actions to be taken for Resident 5 when swallowing difficulties and choking occurred. The plans showed no instructions for staff about documenting incidences of swallowing difficulty and monitoring Resident 5's dietary intake. There were no instructions about what signs of increased swallowing difficulties to report to the nurse.

RESIDENT 7
Review of Resident 7's record showed the facility admitted Resident 7 on [redacted]/2023. The facility characteristic roster showed that Resident 7 resided in the memory care unit. The roster showed that Resident 7 exhibited exit-seeking behaviors.

Review of Resident 7's assessment and service plan, dated 06/18/2024, showed no instructions for staff to manage Resident 7's exit-seeking behaviors were observed. The plans showed no instructions for staff about documenting incidences of exit-seeking.

Review of Resident 7's August 2024 and September 2024 Medication Administration Records (MAR) showed Resident 7 received 81 mg of Enteric Coated Aspirin daily, by mouth, for a diagnosis of [redacted].

Review of Resident 7's admission and service plans, dated 06/18/2024, showed no guidance for the staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 10
Review of Resident 10's record showed the facility admitted Resident 10 on [redacted]/2024.

Review of Resident 10's pre-admission assessment, dated 01/02/2024, showed that Resident 10 required one staff person assistance with transfers. The assessment showed that Resident 10 was resistant to care assistance and required cuing and encouragement.

Review of Resident 10's admission assessment and service plan, dated 06/18/2024, showed no instructions for staff to manage behaviors when Resident 10 demonstrated resistance to care and exhibited verbal and physical aggressive behaviors. The plans showed no instructions for staff for about documenting incidences of resistance to care and aggressive behaviors.

During an interview on 09/17/2024 at 1:45 PM, Staff X, Director of Nursing Services, and Staff W, Executive Director, stated that they were unaware that the assessments and service plans for Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10 lacked documented instructions and guidance for caregivers about the care needs and interventions for diagnoses and physician ordered medical treatments.

This is a repeated deficiency cited on 07/19/2024 and an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed ensure 3 of 3 residents (Resident 2, Resident 4, and Resident 5) side bed rails, attached to the residents' beds, were free of entrapment hazards. This failure placed Resident 2, Resident 4, and Resident 5 at risk of harm or death from unsafe medical equipment.

Findings included…

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 05/07/2024 and a second citation on 08/07/2024 for Resident 2 and Resident 4. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 06/21/2024 and again on 08/17/2024.

RESIDENT 2
Review of Resident 2's Face Sheet showed the facility admitted Resident 2 on [redacted]/2023. Resident 2 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 2's assessment and service plan n(also known as an Negotiated Service Assessments), dated 06/18/2024, showed that Resident 2 required two-person hand-on assistance with transfers. The plans showed no documentation that Resident 2 used a side bed rail for positioning while in bed. The plans showed no documentation that Resident 2 required a mechanical lift device (Hoyer lift) to assist with transfer.

On 9/17/2024 at 11:13 AM, observation of Resident 2's room showed a half siderail attached at the top of Resident 2's bed, along the right side. Observation showed the bed was in the raised position. The bed rail measured approximately 30 inches wide with a four-inch gap between vertical rail bars. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 09/17/2024 at 1:37 PM, Staff X, Director of Wellness, stated that Resident 2 was unable to independently put the side rails down.

RESIDENT 4
Review of Resident 4's Face Sheet showed the facility admitted Resident 4 on [redacted]/2024. Resident 4 admitted with diagnoses of [redacted] and [redacted].

Review of Resident 4's pre-admission assessment, dated 02/13/2024, showed that Resident 4 was bed bound most of the time, not independently mobile and used a hospital bed. Review showed no indication that Resident 4 used a side bed rail for assistance with positioning while in bed.

On 09/17/2024 at 11:16 AM, observation of Resident 4's room showed half siderails attached at the top of Resident 4's bed, along both the right and left side. Observation showed the bed rails were in the raised position. The bed rails measured approximately 36 inches wide with a four-inch gap between vertical rail bars. The right-side bed rail was attached to the bed frame with a four-inch gap between the side rail and the mattress. The right and left side rails were not securely attached to the bed frame. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 09/17/2024 at 1:36 PM, Staff W, Executive Director, stated that Resident 4 was unable to independently put the side rail down.

RESIDENT 5
Review of Resident 5's Face Sheet showed the facility admitted Resident 5 on [redacted]/2021. Resident 5 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 5's assessment and service plan, dated 06/18/2024, showed that Resident 5 was dependent on a wheelchair for mobility and required two staff person assistance with a Hoyer lift (a mechanical device used to assist with transfers) for all transfers. There were no instructions that explained how staff assisted Resident 5 to use side bed rails for positioning while in bed.

On 09/17/2024 at 1:15 PM, observation of Resident 5's room showed bilateral siderails attached along the right and left side of Resident 5's bed. Observation showed the left

side bed rail was in the raised position. The bed rails measured approximately 54 inches in length with a five-inch gap between horizontal rail bars. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 09/17/2024 at 1:36 PM, Staff X stated that Resident 5 was unable to independently put the side rails down. Staff X stated that Resident 5 was unable to call for staff assistance.

During an interview on 09/17/2024 at 1:45 PM, Staff W stated that they were aware that the uncovered side bed rails created a potential entrapment risk. Staff W and Staff X stated that they were aware that side bed rail covers were available for residents that used side bed rails.

This is a repeated deficiency cited on 07/19/2024 and an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(a) That the electronic monitoring does not violate chapter 9.73 RCW;

(b) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(12) If the assisted living facility determines that a resident, resident's family, or other third party is electronically monitoring a resident's room or apartment without complying with the requirements of this section, the assisted living facility must disconnect or remove such equipment until the appropriate consent is obtained and notice given as required by this section.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in writing an initial agreement to use electronic monitoring, the duration of use, and quarterly reevaluations of electronic surveillance for 1 of 3 sampled residents (Resident 12). This failure placed Resident 12 at risk for potential violation of their rights.

Findings included…

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 05/07/2024 and a second citation on 08/07/2024 for Resident 12. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 06/21/2024 and again on 08/17/2024.

During the entrance interview on 09/17/2024 at 10:45 AM, Staff W, Executive Director, stated that Resident 11, Resident 12, and Resident 13 used electronic monitoring devices in their rooms. Staff W stated that Resident 12 did not sign any consent form to use electronic monitoring devices. Staff W stated that Resident 12’s representatives installed the electronic monitoring equipment in Resident 12’s room, without facility staff knowledge.

Observation on 09/17/2024 at 11:13 AM, showed a paper sign taped to Resident 12’s apartment door. The sign read “Electronic Monitoring in Use”.

Review of Resident 12’s records showed no documentation of any consent, no documentation of the duration of usage, and no documentation of a quarterly review for continued use.

During an interview on 09/17/2024 at 1:44 PM, Staff W stated that the facility did not have the required documentation in Resident 12’s records for the request to use electronic monitoring. Staff W stated that when the facility gained knowledge of the device in Resident 12’s room, the facility did not disconnect the electronic monitoring device, as required. Staff W stated that they were aware of the Washington Administrative Code requirements and facility expectations for resident requested electronic monitoring devices.

This is a repeated deficiency cited on 07/19/2024 and an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site follow-up on 07/19/2024 and 07/19/2024 of:

Mirror Lake Village
31000 9th Pl SW
Federal Way, WA 98023

This document references the following SOD dated: 07/19/2024

The following sample was selected for review during the unannounced on-site visit: 10 of 63 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, Community Complaint Investigator
Steven Garrett, LTC Licensor

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

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

Residential Care Services

Date

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

Administrator (or Representative) Date

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in 5 of 10 residents (Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10) Negotiated Service Agreements (NSA), the care needs and interventions for diagnoses and physician ordered medical treatments. This failure placed Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10 at risk for unmet care needs and worsening of [redacted] diagnosed conditions.

Findings included…

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/07/2024 for Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/12/2024.

RESIDENT 2

Review of Resident 2's June 2024 and July 2024 Medication Administration Records (MAR) showed that Resident 2 received 81 milligrams (mg) of Enteric Coated Aspirin (a coating on the tablet to allow for passage through the stomach to the small intestine before dissolving) daily, by mouth, for a diagnosis of [redacted].

Review of Resident 2's combined assessment/service plan (NSA), dated 04/17/2024, showed no guidance for the staff about possible side effects from the daily use of Aspirin, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 4
Review of Resident 4's June 2024 and July 2024 MARs showed Resident 4 received 50 mg of Sertraline daily, by mouth, for depression.

Review of Resident 4's NSA, dated 02/13/2024, showed no guidance for the staff about the signs and symptoms of depression and any interventions, if needed. There was no documentation of the possible side effects of the medication. The service plan showed no instructions for staff about what actions were needed for any worsening of depression symptoms. There were no instructions about when to report any signs and symptoms of depression or medication side effects to the nurse.

RESIDENT 5
Review of Resident 5's records showed documentation of a completed feeding and swallowing evaluation, dated 06/17/2021. The feeding/swallowing evaluation results included a section titled, "CAREGIVER GUIDELINES FOR SAFE FEEDING". These guidelines included: giving liquids one step at a time, giving small bites (one teaspoon at a time), feeding slowly with extra time between bites, watching to ensure the client has swallowed before giving another bite or sip, if any coughing occurs waiting two minutes before giving another bite or sip, alternate between liquids and solids, discontinue after one hour, and starting with protein and vegetables then carbohydrates afterwards.

Review of Resident 5's NSA, dated 04/14/2024, showed that Resident 5 received a mechanical soft (easily chewed and swallowed foods) and nectar thickened liquids (liquids with a thickener added). The NSA showed no guidance for the staff about the safe feeding guidelines for Resident 5. The NSA showed no guidance about actions staff needed to take when Resident 5 experienced swallowing difficulties or when choking occurred. The service plan showed no instructions for staff to document any incidences of swallowing difficulty and to monitor Resident 5's dietary intake. There were no instructions about the signs of increased swallowing difficulties and when to report the incidents to the nurse.

RESIDENT 7

Review of the facility's undated characteristic roster showed that Resident 7 resided in the facility memory care unit. Review of the facility characteristic roster showed that Resident 7 was an active exit-seeker (a person who continually searches for a way out of the building).

Review of Resident 7's June 2024 and July 2024 MARs showed Resident 7 received 81 mg of Enteric Coated Aspirin daily, by mouth, for a diagnosis of [redacted].

Review of Resident 7's annual NSA, dated 04/16/2024, showed no instructions for staff for re-directing Resident 7 when exit-seeking behaviors were observed. The NSA showed no instructions for staff about documenting incidences of exit-seeking. The NSA showed no guidance for the staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 10
Review of Resident 10's pre-admission assessment, dated 01/02/2024, showed that Resident 10 required the assistance of one staff person when transferring. The assessment showed that Resident 10 required cueing, encouragement, and was resistant to care.

Review of Resident 10's combined assessment/service plan (NSA), dated 04/24/2024, showed no instructions for staff for re-directing Resident 10 when Resident 10 demonstrated resistance to care. There were no staff instructions about how to manage Resident 10's verbal and physical aggressive behaviors. The NSA showed no instructions for staff about when to document any incidences of resistance to care and aggressive behaviors.

During an interview on 07/19/2024 at 2:40 PM, Staff B, Director of Wellness, and Staff W, Executive Director, stated that they were unaware that Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10's combined assessments/service plans lacked any documented instructions and guidance for caregivers about the care needs and interventions related to the diagnoses and physician ordered medical treatments.

This is an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 residents (Resident 2, Resident 4, and Resident 10) medical devices were safe and free of entrapment hazards. This failure placed Resident 2, Resident 4, and Resident 10 at risk of potential harm or death from use of unsafe medical equipment.

Findings included…

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/07/2024 for Resident 2, Resident 4, and Resident 10. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/12/2024.

RESIDENT 2
Review of Resident 2's Face Sheet showed the facility admitted Resident 2 on [redacted]/2023. Resident 2 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 2's combined assessment/service plan (NSA), dated 04/17/2024, showed that Resident 2 required two-person hands-on assistance with transfers. The NSA showed no documentation that Resident 2 used a side bed rail for assistance with positioning while in bed.

On 07/19/2024 at 12:16 PM, observation of Resident 2's room showed a half siderail was attached at the head of the bed, on the left side. Observation showed the bed was in the raised position. The bed rail measured approximately 30 inches wide with a four-inch gap between vertical rail bars. The side rail was not covered to protect the resident's limbs from possible entrapment.

During an interview on 07/19/2024 at 2:36 PM, Staff B, Director of Wellness, stated that Resident 2 was unable to independently raise or lower the side rails.

RESIDENT 4
Review of Resident 4's Face Sheet showed the facility admitted Resident 4 on [redacted]/2024. Resident 4 admitted with diagnoses of [redacted] and [redacted].

Review of Resident 4's pre-admission assessment, dated 02/13/2024, showed that Resident 4 was bed bound most of the time, not independently mobile, and used a hospital bed. The assessment showed no documentation that Resident 4 used a side bed rail for assistance with positioning while in bed.

On 07/19/2024 at 12:10 PM, observation of Resident 4's room showed half siderails were attached at the head of the bed, along both the right and left side. Observation showed the bed rails were in the raised position. The bed rails measured approximately 30 inches wide with a four-inch gap between the vertical rail bars. The left side rail was not firmly attached to the bed frame. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 07/19/2024 at 2:36 PM, Staff B stated that Resident 4 was unable to independently raise or lower the side rails.

RESIDENT 10
Review of Resident 10's Face Sheet, showed that the facility admitted Resident 10 on [redacted]/2024. Resident 10 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 10's pre-admission assessment, dated 01/02/2024, showed that Resident 10 was dependent on a wheelchair for mobility, required the assistance of one staff person when transferring, and used a bed in a lowered position, closer to the floor. Review showed no documentation that Resident 10 used a side bed rail for assistance with positioning while in bed.

On 07/19/2024 at 12:15 PM, observation of Resident 10's room showed a half siderail attached at the head of the bed, along the left side. Observation showed the bed rail was in the raised position. The bed rail measured approximately 26 inches wide with a five-inch gap between the horizontal rail bars. The left side rail was not firmly attached

to the bed frame. The side rail was not covered to protect the resident's limbs from possible entrapment.

During an interview on 07/19/2024 at 2:34 PM, Staff B stated that Resident 10 was unable to independently raise or lower the side rail. Staff B stated that Resident 10 was unable to call for staff assistance.

During an interview on 07/19/2024 at 2:35 PM, Staff B stated that they were aware that the uncovered side bed rails created a potential entrapment risk. Staff W, Executive Director, and Staff B stated that they were unaware that side bed rail covers were not being used to cover the side rails for residents that used side bed rails.

This is an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(a) That the electronic monitoring does not violate chapter 9.73 RCW;

(b) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(12) If the assisted living facility determines that a resident, resident's family, or other third party is electronically monitoring a resident's room or apartment without complying with the requirements of this section, the assisted living facility must disconnect or remove such equipment until the appropriate consent is obtained and notice given as required by this section.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in writing an initial agreement to use electronic monitoring, the duration of use, and quarterly reevaluations of electronic surveillance for 1 of 2 sampled residents (Resident 12). This failure placed Resident 12 at risk for potential violation of their rights.

Findings included…

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/07/2024 for Resident 12. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/12/2024.

During the entrance interview on 07/19/2024 at 10:15 AM, Staff W, Executive Director, and Staff B, Director of Wellness, stated that the facility had two residents, Resident 11 and Resident 12, who used electronic monitoring devices in their rooms. Staff B stated that Resident 12 did not sign any consent form to use electronic. Staff B stated that Resident 12 did not have a roommate. Staff B stated that Resident 12’s representatives installed the electronic monitoring equipment in Resident 12’s room without facility staff knowledge.

Observation on 07/19/2024 between 12:05 PM and 12:15 PM, showed a paper sign taped to the door of Resident 12’s room. The sign read “Electronic Monitoring in Use”.
Review of Resident 12’s records showed no documentation of any consent, no documentation of the duration of usage, and no documentation of a quarterly review for continued use.

During an interview on 07/19/2024 at 2:44 PM, Staff W stated that the facility did not have the required documentation in Resident 12’s records for the request to use electronic monitoring. Staff B stated that the facility did not disconnect the electronic monitoring devices, as required, when the facility gained knowledge of the device in Resident 12’s room. Staff B stated that they were unaware of the Washington Administrative Code requirements and facility expectations for resident requested electronic monitoring devices.

This is an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 2 staff (Staff 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 Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/07/2024 for Staff E. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/12/2024.

Review of facility's personnel records showed the facility hired Staff E, Resident Caregiver, on 03/02/2021. Review showed Staff E's date of birth as February 05.

Review of the facility's personnel records showed no documentation that Staff E completed 12 hours of department approved CE training between 02/05/2023 and 02/05/2024, as required.

During an interview on 07/19/2024 at 2:40 PM, Staff W, Executive Director, stated that they were aware of the training and certification requirements. Staff W stated they were

unaware that Staff E did not complete the required CE trainings.

This is an uncorrected deficiency previously cited on 05/07/2024.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for the unannounced on-site full inspection on 04/16/2024 and 04/23/2024 of:

Mirror Lake Village
31000 9th Pl SW
Federal Way, WA 98023

The following sample was selected for review during the unannounced on-site visit: 10 of 58 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, Community Complaint Investigator
Steven Garrett, LTC Licensor

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

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

Residential Care Services

Date

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

Administrator (or Representative) Date

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in 5 of 10 residents (Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10) Negotiated Service Agreements (NSA), the care needs and interventions for diagnoses and physician ordered medical treatments. This failure placed the residents at risk for unmet care needs and worsening of [redacted] diagnosed conditions.

Findings included…

RESIDENT 2
Review of Resident 2's February 2024, March 2024, and April 2024 Medication Administration Records (MAR) showed that Resident 2 received 81 milligrams (mg) of Enteric Coated Aspirin (a coating on the tablet to allow for passage through the stomach to the small intestine before dissolving) daily, by mouth, for a diagnosis of [redacted].

Review of Resident 2's combined assessment/service plan (NSA), dated 12/14/2023, showed no guidance for the staff about possible side effects from the use of Aspirin, such

as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 4
Review of Resident 4's March 2024 and April 2024 MARs showed Resident 4 received 50 mg of Sertraline daily, by mouth, for depression.

Review of Resident 4's NSA, dated 02/13/2024, showed no guidance for the staff about the signs and symptoms of depression and any interventions, if needed. There was no documentation of the possible side effects of the medication. The service plan showed no instructions for staff about what actions were needed for any worsening of depression symptoms. There were no instructions about when to report any signs and symptoms of depression or medication side effects to the nurse.

RESIDENT 5
Review of Resident 5's records showed documentation of a completed feeding and swallowing evaluation dated 06/17/2021. The feeding/swallowing evaluation results included a section titled, "CAREGIVER GUIDELINES FOR SAFE FEEDING". These guidelines included: giving liquids one step at a time, giving small bites (1 teaspoon at a time), feeding slowly with extra time between bites, watching to ensure the client has swallowed before giving another bite or sip, if any coughing occurs waiting 2 minutes before giving another bite or sip, alternate between liquids and solids, discontinue after one hour, and starting with protein and vegetables then carbohydrates afterwards.

Review of Resident 5's NSA, dated 08/30/2022, showed that Resident 5 received a mechanical soft (easily chewed and swallowed foods) and nectar thickened liquids (liquids with a thickener added). The NSA showed no guidance for the staff about the safe feeding guidelines for Resident 5. The NSA showed no guidance about actions staff needed to take when Resident 5 experienced swallowing difficulties or when choking occurred. The service plan showed no instructions for staff to document any incidences of swallowing difficulty and to monitor Resident 5's dietary intake. There were no instructions about the signs of increased swallowing difficulties and when to report the incidents to the nurse.

RESIDENT 7
Review of the facility's undated characteristic roster showed that Resident 7 resided in the facility memory care unit. Review of the facility characteristic roster showed that Resident 7 was an active exit-seeker (a person who continually searches for a way out of the building).

Review of Resident 7's February 2024, March 2024, and April 2024 MARs showed Resident 7 received 81mg of Enteric Coated Aspirin daily, by mouth, for a diagnosis of [redacted].

Review of Resident 7's pre-admission NSA, dated 08/18/2023, showed no instructions for staff for re-directing Resident 7 when exit-seeking behaviors were observed. The NSA

showed no instructions for staff about documenting incidences of exit-seeking. The NSA showed no guidance for the staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

RESIDENT 10
Review of Resident 10's pre-admission assessment, dated 01/02/2024, showed that Resident 10 required the assistance of one staff person when transferring. The assessment showed that Resident 10 required cueing, encouragement, and was resistant to care.

Review of Resident 10's pre-admission combined assessment/service plan (NSA), dated 01/02/2024, showed no instructions for staff for re-directing Resident 10 when Resident 10 demonstrated resistance to care. There were no staff instructions about how to manage Resident 10's verbal and physical aggressive behaviors. The NSA showed no instructions for staff about when to document any incidences of resistance to care and aggressive behaviors.

During an interview on 04/23/2024 at 2:45 PM, Staff B, Director of Wellness, and Staff A, Executive Director, stated that they were unaware that Resident 2, Resident 4, Resident 5, Resident 7, and Resident 10's combined assessments/service plans lacked any documented instructions and guidance for caregivers about the care needs and interventions related to the diagnoses and physician ordered medical treatments.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

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

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

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 6 of 10 sampled residents (Resident 1, Resident 4, Resident 5, Resident 6, Resident 9, and Resident 10) or their representatives signed their Main Assessment (NEW) Results and Service Plan (Service Plan is equivalent to the negotiated service agreement). This failure placed Resident 1, Resident 4, Resident 5, Resident 6, Resident 9, and Resident 10 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included…

RESIDENT 1
Review of Resident 1's resident information document showed that the facility admitted Resident 1 on [redacted]/2022. Review of Resident 1's Service Plan, dated 01/24/2023, showed the plan was signed and dated by facility staff and resident/resident's representative on this date. There was no documentation that an annual Service Plan was reviewed and signed by anyone in January 2024.

RESIDENT 4
Review of Resident 4's resident information document showed that the facility admitted Resident 4 on [redacted]/2024. Review of Resident 4's Service Plan, dated 02/13/2024, showed no signatures by facility staff, resident, or the resident's representative.

RESIDENT 5
Review of Resident 5's resident information document showed that the facility admitted Resident 5 on [redacted]/2021. Review of Resident 5's Service Plan, dated 08/30/2022, showed the plan was signed and dated by facility staff and resident's representative on this date. There was no documentation that an annual Service Plan was reviewed and signed by anyone in August 2023.

RESIDENT 6
Review of Resident 6's resident information document showed that the facility admitted Resident 6 on [redacted]/2021. Review of Resident 6's Service Plan, dated 03/17/2021, showed the plan was signed and dated by facility staff and resident's representative on this date. There was no documentation that an annual Service Plan was reviewed and signed by anyone in March 2022 or March 2023.

RESIDENT 9
Review of Resident 9's resident information document showed that the facility admitted Resident 9 on [redacted]/2024. Review of Resident 9's Service Plan, dated 03/27/2024, showed the plan was not signed and dated by the resident or the resident's representative.

RESIDENT 10
Review of Resident 10's resident information document showed that the facility admitted Resident 10 on [redacted]/2024. Review of Resident 10's record showed a pre-admission

assessment/service plan, dated 01/02/2024, was not signed and dated by the resident or the resident's representative.

During an interview on 04/18/2024 at 2:30 PM, Staff A, Executive Director, and Staff B, Director of Wellness, stated that they were aware the Main Assessment (NEW) Results and Service Plans required signatures from facility staff, residents, or the resident's representatives at least annually. Staff B stated that they were aware that some of the Main Assessment (NEW) Results and Service Plans were not signed and dated by facility staff, residents, or their representatives, as required.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 residents (Resident 2, Resident 4, and Resident 10) medical devices were safe and free of entrapment hazards. This failure placed Resident 2, Resident 4, and Resident 10 at risk of potential harm or death from use of unsafe medical equipment.

Findings included…

RESIDENT 2
Review of Resident 2's Face Sheet, showed the facility admitted Resident 2 on [redacted]/2023. Resident 2 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 2's combined assessment/service plan (NSA), dated 12/14/2023, showed that Resident 2 required two-person hands-on assistance with transfers. The NSA showed no documentation that Resident 2 used a side bed rail for assistance with positioning while in bed.

On 4/23/2024 at 12:50 PM, observation of Resident 2's room showed half siderails were attached at the head of the bed, along both the right and left side. Observation showed the bed was in the lowered position. The bed rails measured approximately 30 inches wide with a four-inch gap between vertical rail bars. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 04/23/2024 at 2:36 PM, Staff B, Director of Wellness, stated that Resident 2 was unable to independently raise or lower the side rails.

RESIDENT 4
Review of Resident 4's Face Sheet, showed the facility admitted Resident 4 on [redacted]/2024. Resident 4 admitted with diagnoses of [redacted] and [redacted].

Review of Resident 4's pre-admission assessment, dated 02/13/2024, showed that Resident 4 was bed bound most of the time, not independently mobile, and used a hospital bed. The assessment showed no indication that Resident 4 used a side bed rail for assistance with positioning while in bed.

On 04/23/2024 at 12:40 PM, observation of Resident 4's room showed half siderails were attached at the head of the bed, along both the right and left side. Observation showed the bed rails were in the raised position. The bed rails measured approximately 30 inches wide with a four-inch gap between the vertical rail bars. The left side rail was not firmly attached to the bed frame. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 04/23/2024 at 2:36 PM, Staff B stated that Resident 4 was unable to independently raise or lower the side rails.

RESIDENT 10
Review of Resident 10's Face Sheet, showed that the facility admitted Resident 10 on [redacted]/2024. Resident 10 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 10's pre-admission assessment, dated 01/02/2024, showed that Resident 10 was dependent on a wheelchair for mobility, required the assistance of one staff person when transferring, and used a bed in a lowered position, closer to the floor. Review showed no documentation that Resident 10 used a side bed rail for assistance with

positioning while in bed.

On 04/23/2024 at 12:50 PM, observation of Resident 10's room showed a half siderail attached at the head of the bed, along the left side. Observation showed the bed rail was in the raised position. The bed rail measured approximately 26 inches wide with a five-inch gap between the horizontal rail bars. The left side rail was not firmly attached to the bed frame. The side rail was not covered to protect the resident's limbs from possible entrapment.

During an interview on 04/23/2024 at 2:36 PM, Staff B stated that Resident 10 was unable to independently raise or lower the side rail. Staff B stated that Resident 10 was unable to call for staff assistance.

During an interview on 04/23/2024 at 2:45 PM, Staff B stated that they were unaware that the uncovered side bed rails created a potential entrapment risk. Staff A, Executive Director, and Staff B stated that they were unaware that side bed rail covers were available for residents that used side bed rails.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

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

(a) Chapter 18.79 RCW, Nursing care;

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure for 2 of 3 residents (Resident 4 and Resident 8) received medication assistance from caregivers with proper nurse delegation training. This failure placed Resident 4 and Resident 8 at risk of medication errors and a diminished quality of life.

Findings included…

Nurse Delegation:
Note: The Nurse Delegation Program, under Washington State law, allows nursing assistants and Home Care Aides working in community-based care settings to perform certain tasks such as administration of prescription medications or assistance with insulin and blood glucose testing, which are normally performed by licensed nurses. A registered nurse must teach and supervise the nursing assistant as well as provide nursing assessments of the resident's condition. Nurse Delegation is specific to each resident, each caregiver, and each task and is not transferrable. Documentation must be specific and include all required information as listed in Washington Administrative Code (WAC) 246-840.

WAC 246-840-930 defined the criteria for delegation. Delegation must Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes supervision at least every ninety days. With delegation of medications, the supervision occurs when there are changes in medications (frequency, dosage, as needed which may require nursing judgement). With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent. The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated tasks. Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator (RND).

Review of the facility's Disclosure of Services showed the facility provided intermittent nursing services. The disclosure stated the community allowed for assistance with sliding scale insulin upon approval of the Registered Nurse Delegator. The disclosure stated routine insulin and blood glucose testing may be provided through nurse delegation. Insulin must be in an insulin pen.

Review of the Resident 4's records showed the facility admitted Resident 4 on [redacted]/2024 with a diagnosis of [redacted]. The records showed that Resident 4 required assistance with blood glucose testing and insulin injections.

Review of Resident 8's records showed the facility admitted Resident 8 on [redacted]/2024 with a diagnosis of [redacted]. The records showed that Resident 4 required assistance with blood glucose testing and insulin injections.

Review of the Facility Characteristic Roster showed that Resident 4 and Resident 8 required nurse delegation services for assistance with medication administration.

Review of nurse delegation records showed Staff G, RND, assessed Resident 4 on 03/27/2024. The records showed that on 03/27/2024, Staff G delegated 14 facility staff to provide Resident 4 with medication administration. The records showed Staff G assessed Resident 8 on 04/08/2024. The records showed that on 04/08/2024, Staff G delegated 14 facility staff to provide Resident 8 with medication administration.

Review of the nurse delegation training and competency documents for 14 staff (Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, Staff U, and Staff V) showed that Staff G marked each staff's delegation form as complete for nurse delegation training and competency through "record review". The documents showed that Staff I completed training on 11/27/2023; Staff J completed training on 01/11/2023; Staff K completed training on 12/13/2023; Staff L completed training on 01/11/2023; Staff M completed training on 01/11/2023; Staff N completed training on 01/11/2023; Staff O completed training on 01/11/2023; Staff P completed training on 01/11/2023; Staff Q completed training on 02/13/2023; Staff R completed training on 09/26/2023; Staff S completed training on 05/09/2023; Staff T completed training on 06/14/2023; Staff U completed training on 08/29/2023 and Staff V completed training on 09/05/2023. The documents showed all 14 staff training and competency trainings were completed before the facility admitted Resident 4 and Resident 8. There was no documentation that showed Staff G provided weekly supervision of the 14 staff for four weeks. There was no documentation that showed Staff G required the staff perform a return demonstration for the administration of medication.

During an interview on 04/23/2024 at 2:20 PM, Staff A, Executive Director and Staff B, Director of Wellness, stated that they were unaware of the Washington Administrative Code that regulated nurse delegation. Staff A stated that they were unaware that the facility was accountable for the delivery of nurse delegated services.

During a phone interview on 04/25/2024 at 2:30 PM, Staff G stated that they did not observe the 14 staff administer insulin injections. Staff G stated that they did not complete the required four weeks of supervision for the 14 staff. Staff G stated that they only observed staff who worked when Staff G was at the facility for their regularly scheduled visits. Staff G stated that all staff to be delegated signed the nurse delegation paperwork as confirmation the staff read and understood the nurse delegator's instructions. Staff G stated that the facility obtained consent for nurse delegation in the admission paperwork. Staff G stated that they were not present when consent was obtained. Staff G stated that they were not always informed of new admissions and were unsure of how the facility provided medication or insulin administration to residents before Staff G was able to delegate staff. Staff G stated that they used a classroom style training and YouTube videos for staff that needed to be delegated. Staff G stated that it was impossible to individually delegate each staff person for each new admission or newly diagnosed [redacted].

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(a) That the electronic monitoring does not violate chapter 9.73 RCW;

(b) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(12) If the assisted living facility determines that a resident, resident's family, or other third party is electronically monitoring a resident's room or apartment without complying with the requirements of this section, the assisted living facility must disconnect or remove such equipment until the appropriate consent is obtained and notice given as required by this section.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in writing an initial agreement to use electronic monitoring, the duration of use, and quarterly reevaluations of electronic surveillance for 2 of 2 sampled residents (Resident 11 and Resident 12). This failure placed Resident 11 and Resident 12 at risk for potential violation of their rights.

Findings included…

During the entrance interview on 04/16/2024 at 10:15 AM, Staff A, Executive Director, and Staff B, Director of Wellness, stated that the facility had two residents, Resident 11 and Resident 12, who used electronic monitoring devices in their rooms. Staff B stated that the facility did not have a policy for the use of electronic monitoring devices. Staff A stated that Resident 11 signed a consent form to use electronic monitoring. Staff A stated that Resident 11 did not have a roommate. Staff A stated that Resident 12 did not sign any consent form to use electronic. Staff A stated that Resident 12 did not have a roommate. Staff A stated that Resident 12's representatives installed the electronic monitoring equipment in Resident 12's room without facility staff knowledge.

Observation on 04/16/2024 between 11:45 AM and 12:03 PM, showed a paper sign taped to the door of Resident 11's and Resident 12's rooms. The sign read "Electronic Monitoring in Use".

Review of Resident 11's records showed a signed consent form, dated 01/25/2024. There was no documentation of an initial agreement for use of electronic monitoring. There was no documentation that explained the duration of usage. There was no documentation of any quarterly review for the continued use of electronic monitoring.

Review of Resident 12's records showed no documentation of any consent, no documentation of the duration of usage, and no documentation of a quarterly review for continued use.

During an interview on 04/23/2024 at 2:14 PM, Staff A, Executive Director, stated that the facility did not have the required documentation in Resident 11 and Resident 12's records for the request to use electronic monitoring. Staff A stated that the facility did not disconnect the electronic monitoring devices, as required, when the facility gained knowledge of the devices in each resident's room. Staff A stated that they were unaware of the Washington Administrative Code requirements and facility expectations for resident requested electronic monitoring devices.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 6 staff (Staff A, Staff C, and Staff D) were screened for Tuberculosis (TB) as required. This failure placed all residents at risk of exposure to TB, an infectious disease.

Findings included…

Review of the facility's personnel records showed that the facility hired Staff A, Executive Director, on 08/15/2023; Staff C, Resident Caregiver, on 03/25/2024; and Staff D, Resident Caregiver, on 11/09/2023.

Review of Staff A's personnel records showed that on 09/05/2023, Staff A completed step one of the two-step TB skin test. The first step was initiated 21 days after Staff A's date of employment.

Review of Staff C's personnel records showed that on 04/28/2023, Staff C completed a radiology examination (chest x-ray). The records showed that there was no documentation of a previous positive skin test that supported the need for a chest x-ray. There was no documentation that Staff C completed any other TB testing when hired.

Review of Staff D's personnel records showed no documentation that Staff D completed any testing to be screened for TB within 3 days of employment.

During an interview on 04/17/2024, Staff A, Executive Director, stated that they were unaware of the TB screening requirements within three days of employment. Staff A stated that they were unaware Staff C and Staff D were not screened for TB within three days of employment.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 6 staff (Staff E and Staff F) 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 facility's personnel records showed the facility hired Staff E, Resident Caregiver, on 03/02/2021 and Staff F, Resident Caregiver, on 03/17/2021.

CONTINUING EDUCATION (CE)
Review of facility's personnel records showed Staff E's date of birth as 02/05 and Staff F's date of birth as 04/11.

Review of the facility's personnel records showed no documentation that Staff E completed any department approved CE training between 02/05/2023 and 02/05/2024, as required.

Review of the facility's personnel records showed no documentation that Staff F completed any department approved CE training between 04/11/2023 and 04/11/2024, as required.

During an interview on 04/17/2024 at 3:45 PM, Staff A stated that they were unaware of the training and certification requirements. Staff A stated they were unaware that Staff E and Staff F did not complete the required CE trainings.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement infection control policies and requirements to protect 58 of 58 residents (Resident 1 through Resident 58) from infectious illnesses. This failure placed all 58 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included…

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

Review of the CDC website "Transmission-Based Precautions" at (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html), showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission including a fit-tested National Institute for Occupational Safety and Health (NIOSH)-approved N95 or higher level respirator for healthcare personnel.

Review of the DOH publication, "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings", dated October 31, 2022, showed specific guidelines for a Respiratory Protection Program (RPP) that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and annual fit tests for any employee identified as potentially being exposed to respiratory hazard. The publication showed that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

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

Review of the Department's Secure Tracking and Reporting System (STARS) showed that on 01/05/2024, the facility experienced an infectious disease outbreak when a resident tested positive for COVID-19. The system showed that the facility implemented isolation precautions for the resident who tested positive for COVID-19.

Review of the facility's policy titled, "Respiratory Protection Program for use by Healthcare Facilities during the COVID-19 Pandemic", dated March 2021, showed that facility staff used respirators to protect against transmission of the SARS-COV-2 virus and other airborne diseases. The policy showed that the categories of employees who are included in this program include: Certified Nurse Assistants, Registered Nurses, Health care assistants/caregivers, Maintenance staff, housekeeping staff, and Administrative staff. The policy showed that all employees designated to use N95 respirators would be fit-tested before using their respirator.

Review of the facility's undated policy titled, "Employee Medical Evaluation N95 Fit Testing", showed no documentation of any staff fit testing for any of the facility provided N95 respirators.

During an interview on 04/17/2024 at 3:50 PM, Staff A, Executive Director, and Staff B, Director of Wellness, stated that they were unaware of the RPP policy and N95 fit testing requirements. Staff A and Staff B stated they were aware staff who might be required to be fit tested had not completed the fit testing requirements.

This is an uncorrected deficiency previously cited on 11/04/2022.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

05/09/2024

Mirror Lake Village LLC
Mirror Lake Village
31000 9th Pl SW
Federal Way, WA 98023

RE: Mirror Lake Village # 2564

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/07/2024 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-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

Several resident-labeled care and service information chart binders were in the assisted living and memory care nursing station offices. The binders were publicly visible through the office windows. During the inspection, facility staff removed the resident information that was publicly visible through the windows.

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;

The second-floor laundry room in the memory care building was unlocked. The laundry room contained soiled laundry, chemicals for use in the washing machines, and equipment used to clean residents' laundry. Observation showed several independently ambulatory residents with [redacted] related diagnosis [redacted] resided on the second floor. During the inspection, facility staff repaired the door latch and the lock mechanism that allowed the door to remain locked.

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, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure