



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

Aegis Senior Communities LLC
Aegis Living Bellevue Overlake
1845 116th Ave NE
Bellevue, WA 98004

RE: Aegis Living Bellevue Overlake License # 2567

Dear Administrator:

This letter addresses Compliance Determination(s) 48240 (Completion Date 10/04/2024) and 45144 (Completion Date 08/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/04/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-112A-0611-1-b, WAC 388-112A-0611-1-a, WAC 388-112A-0611-1-a-i, WAC 388-112A-0611-1-a-ii, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-1-a-iv, WAC 388-112A-0611-1-a-v, WAC 388-112A-0611-1-d, WAC 388-112A-0611-1-d-i, WAC 388-112A-0611-1-d-ii, WAC 388-112A-0611-2, WAC 388-112A-0720-2-a

The Department staff who did the on-site verification:

Michelle Yip, ALF Licenser
Kathy Young, Licenser

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

Sincerely,

Laurie Anderson

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

This document was prepared by Residential Care Services for the Locator website.



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

Statement of Deficiencies	License #: 2567	Compliance Determination # 45144
Plan of Correction	Aegis Living Bellevue Overlake	Completion Date
Page 1 of 4	Licensee: Aegis Senior Communities LLC	08/05/2024

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

The department completed data collection for an unannounced on-site follow-up on 08/05/2024, 08/05/2024, and 08/05/2024 of:

Aegis Living Bellevue Overlake
1845 116th Ave NE
Bellevue, WA 98004

This document references the following SOD dated: 08/05/2024

The following sample was selected for review during the unannounced on-site visit: 6 of 108 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensors
Michelle Yip, ALF Licensors

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

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

Laurie Anderson

Residential Care Services

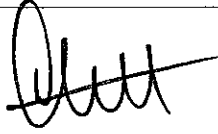
08/13/2024

Date

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

This document was prepared by Residential Care Services for the Locator website.

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Administrator (or Representative)

08-15-24

Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the seventy-hour long-term care worker basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in RCW 28A.300.010 ; and

(v) An assisted living facility or the administrator designee as provided under WAC 388-112A-0060 .

(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.

(d) If exempt from certification under RCW 18.88B.041 , a long-term care worker must complete and provide documentation of twelve hours of continuing education within forty-five calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; and

(i) Must complete twelve hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or

(ii) If the forty-five calendar day time period allows the long-term care worker to complete continuing education in January or February of the following year, the credit hours earned will be applied to the calendar year in which the long-term care worker was hired.

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

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:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 4 staff (Staff E and Staff F) met all their training requirements needed to provide resident care. This failure placed all 108 residents at risk of receiving inadequate care from untrained staff.

Findings included...

Review of Secure Tracking and Reporting System (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/06/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/21/2024.

STAFF E

Review of the facility's employee roster showed the facility hired Staff E, Associate Care Director, on 07/29/2017.

Review of the facility's Associate Care Director job description, revised 01/07/2021, showed the Associate Care Director assisted with resident care, services, and medications.

Review of the facility's care staff schedule from 07/21/2024 through 08/05/2024, showed Staff E worked five shifts per week.

Review of Staff E's employee file showed Staff E maintained an active Nursing Assistant Certificate. Review of Staff E's employee file showed no documentation that Staff E completed any of the required 12 hours of DSHS approved continuing education trainings from their April 2024 birthday to their April 2024 birthday.

STAFF F

Review of the facility's employee roster showed the facility hired Staff F, Lead Care Manager, on 11/29/2016.

Review of the facility's Lead Care Manager job description, revised 02/25/2016, showed

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the Lead Care Manager provided direct personal care and services to residents.

Review of the facility's care staff schedule from 07/21/2024 through 08/05/2024, showed Staff F worked five shifts per week.

Review of Staff F's employee file showed Staff F maintained an active Nursing Assistant Certificate. Review of Staff F's employee file showed documentation that Staff F completed 3.5 hours of the required 12 hours of DSHS approved continuing education trainings from their February 2023 birthday to their February 2024 birthday

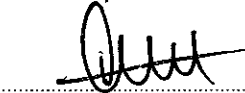
During an interview on 08/05/2024 at 9:43 AM, Staff A, General Manager, stated that they were aware Staff E and Staff F did not complete their continuing education requirements.

This is an uncorrected deficiency previously cited under WAC 388-78A-2472 subsection (2)(e) and WAC 388-112A-0611 subsection (1)(a)(iii) on 06/06/2024.

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, Aegis Living Bellevue Overlake is or will be in compliance with this law and / or regulation on (Date) 08-23-24.

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



Administrator (or Representative)

08-15-24

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

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

The department completed data collection for the unannounced on-site full inspection on 05/20/2024, 05/20/2024, 05/23/2024 and 05/23/2024 of:

Aegis Living Bellevue Overlake
1845 116th Ave NE
Bellevue, WA 98004

The following sample was selected for review during the unannounced on-site visit: 12 of 102 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensors
Michelle Yip, ALF Licensors
Thomas Forkgen, ALF Licensors

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

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

Laurie Anderson

06/17/2024

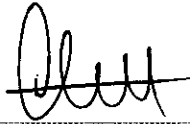
Residential Care Services

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.

This document was prepared by Residential Care Services for the Locator website.

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Administrator (or Representative)

06-20-24

Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the seventy-hour long-term care worker basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in RCW 28A.300.010 ; and

(v) An assisted living facility or the administrator designee as provided under WAC 388-112A-0060 .

(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.

(d) If exempt from certification under RCW 18.88B.041 , a long-term care worker must complete and provide documentation of twelve hours of continuing education within forty-five calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; and

(i) Must complete twelve hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or

(ii) If the forty-five calendar day time period allows the long-term care worker to complete continuing education in January or February of the following year, the credit hours earned will be applied to the calendar year in which the long-term care worker was hired.

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

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:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 4 of 7 staff (Staff A, Staff E, Staff F, and Staff J) met all their training requirements needed to provide resident care. This failure placed all residents at risk of receiving inadequate care from untrained staff.

Findings included...

Review of the facility's Director of Operations job description, revised 02/26/2016, showed the Director of Operations provided direct oversight of the Assisted Living department and the Life's Neighborhood (memory care unit). The job description showed the Director provided hands-on assistance to the staff. Review of the facility's Lead Care Manager job description, revised 02/25/2016, showed the Lead Care Manager provided direct personal care and services to residents. Review of the facility's Associate Care Director job description, revised 01/07/2021, showed the Associate Care Director assisted with resident care, services, and medications.

STAFF A

Observations between 05/20/2024 and 05/23/2024 showed Staff A interacted with residents in the facility.

Review of the facility's employee roster showed the facility hired Staff A, General Manager, on 01/15/2018.

Review of the Department of Social and Health Services (DSHS) Secure Tracking and reporting System (STARS) showed Staff A, Administrator, was the Administrator in the Assisted Living Facility since 01/02/2023.

Review of Staff A's employee file showed Staff A was certified as Home Care Aide in 2018. The file showed Staff A maintained an active Home Care Aide Certificate. The file showed no documentation that Staff A completed any Department of Social and Health Services approved Continuing Education (CE) training between their 2022 birthday and their 2023 birthday.

STAFF E

Observation on 05/22/2024 at 9:02 AM, showed Staff E provided care to a resident.

Review of the facility's employee roster showed the facility hired Staff E, Associate Care Director, on 07/29/2017.

Review of Staff E's employee file showed Staff E maintained an active Nursing Assistant Certificate. Review of Staff E's employee file showed no documentation that Staff E completed any of the required 12 hours of DSHS approved continuing education trainings from their April 2024 birthday to their April 2024 birthday. The file showed that on 09/13/2023, Staff E's First Aid/Cardiopulmonary Resuscitation (CPR) card expired.

Review of the facility's care staff schedule from 05/05/2024 through 05/25/2024, showed Staff E worked one to two shifts per week.

STAFF F

Observation on 05/23/2024 at 8:10 AM, showed Staff F passed medications to residents.

Review of the facility's employee roster showed the facility hired Staff F, Lead Care Manager, on 11/29/2016.

Review of Staff F's employee file showed Staff F maintained an active Nursing Assistant Certificate. Review of Staff F's employee file showed documentation that Staff F completed 3.5 hours of the required 12 hours of DSHS approved continuing education trainings from their February 2023 birthday to their February 2024 birthday.

Review of the facility's care staff schedule from 05/05/2024 through 05/25/2024, showed Staff F worked five to eight shifts per week.

STAFF J

Observations between 05/20/2024 and 05/23/2024 showed Staff J interacted with residents in the facility.

Review of the facility's employee roster showed the facility hired Staff J, Director of Operations, on 03/13/2019.

Review of the facility's untitled document, dated 02/06/2024, showed that Staff A designated Staff J as the Administrator to make decisions to direct operation of the facility when they were not in the facility or when they were unavailable by telephone or email.

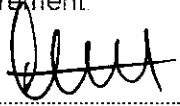
Review of Staff J's employee file showed Staff J maintained an active Nursing Assistant Certificate. The file showed Staff J completed 3.5 hours of the required 12 hours of the

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DSHS approved continuing education trainings between their 2022 birthday and their 2023 birthday.

During an interview on 05/21/2024 at 10:44 AM, Staff M, Business Office Manager, stated that prior to their start as the office manager, there was a backlog of staff records that needed to be entered into the computerized system. Staff M stated that they were unable to locate any of the staffs' 12 hours of continuing education credits. Staff M stated that they were aware that Staff E First Aid/CPR certification was expired.

During an interview on 05/23/2024 at 12:01 PM, Staff M stated that they were unaware staff were required to complete the CE courses approved by DSHS. Staff M stated that staff completed the online CE courses from their contracted vendor.

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, Aegis Living Bellevue Overlake is or will be in compliance with this law and / or regulation on (Date) <u>07-21-24</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>06-20-24</u> _____ Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

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

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 housekeeping staff (Staff K and Staff L) implemented safe infection control practices while performing housekeeping and laundry tasks. This failure placed all residents at risk of contracting infectious illnesses through cross-contamination from improperly handled laundry service.

Findings included...

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Review of Centers for Disease Control and Prevention website stated the best practice for linen (and laundry) handling included: use of reusable gloves before handling soiled linen; never carry the soiled linen against the body; and carefully roll up the soiled linen to prevent contamination of the air, surfaces, and the cleaning staff.

Review of the facility's document titled, "Residential Laundry Facilities Policy", revised 08/01/2017, showed Universal Precautions or handwashing was practiced when handling dirty laundry. Staff were required to wash their hands between handling dirty and clean laundry. Review of the facility's policy titled, "Standard (Universal) Precautions Overview", revised 08/24/2022, showed all body fluids were considered potentially infectious.

Observation on 05/22/2024 between 8:30 AM and 9:12 AM, showed Staff K, Housekeeper, and Staff L, Housekeeper, processed residents' laundry in the facility's commercial laundry room. Observation showed the staff looked through each resident's laundry, identified the soiled areas on bedding, pants, and underwear and pretreated the stains with a commercial-grade product before staff placed the soiled laundry in the washing machine. Observation showed that as Staff K and Staff L moved between dirty and clean laundry, the staff changed their gloves without washing or sanitizing their hands.

Observation on 05/22/2024 between 9:15 AM and 9:45 AM, showed Staff K and Staff L stripped the resident sheets and pillowcases from the beds, remade the residents' beds, and collected the residents' dirty laundry. Observation of this process showed both Staff K and Staff L moved between three resident apartments and four beds without changing gloves. Observation showed Staff K and Staff L pulled off the bedding and held the dirty and clean linens against their clothing.

During an interview on 05/22/2024 at 9:06 AM, Staff K stated that they handled a lot of soiled laundry. Staff K stated that their own clothing got so dirty processing resident laundry, they could not wear their clothing again without first being washed.

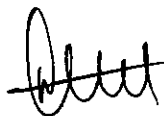
During an interview on 05/22/2024 at 10:45 AM, Staff A, Administrator, stated that staff were trained to change their gloves between apartments. Staff A stated that staff were trained to sanitize their hands between glove changes.

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, Aegis Living Bellevue Overlake is or will be in compliance with this law and / or regulation on (Date) 07-21-24.

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

Administrator (or Representative)



Date 06-20-24

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 pets (Pet 1, Pet 2, and Pet 3) received regular veterinary examinations and were current with their vaccinations. These failures placed all the residents at risk of contracting illnesses spread by pets.

Findings included...

Observations during the full inspection, from 05/20/2024 through 05/23/2024, showed pets in the common areas of the facility, daily.

PET 1

Observation on 05/23/2024 at 9:03 AM, showed Pet 1 in Resident 6's apartment.

Review of the facility's veterinary records showed Pet 1 was overdue for vaccinations and examination. The records showed Pet 1's Bordetella vaccination and examination expired on 11/04/2023.

PET 2

Review of the facility's veterinary records showed Pet 2 was overdue for an examination. The records showed Pet 2's examination and rabies vaccination expired on 12/14/2023.

PET 3

Review of the facility's veterinary records showed Pet 3 was overdue for an examination on 11/30/2022. The records showed Pet 3's Bordetella vaccination and examination expired on 03/29/2017.

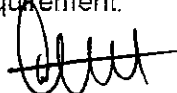
During an interview on 05/21/2024 at 12:37 PM, Staff M, Business Office Manager, stated that they supervised the Concierge Team that managed the pet binder of records for each pet within the facility. Staff M stated that they focused on ensuring the pets received an attestation of good health from a veterinarian upon admission to the facility. The Concierge Team ensured that pets were current with their rabies vaccine. Staff M stated that they were unaware pets needed to be current on other vaccinations appropriate for the species. Staff M was unaware that pets required regular veterinarian examinations. Staff M stated that they did not track when any of the pets' were due for an examination or vaccinations other than rabies.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis Living Bellevue Overlake is or will be in compliance with this law and / or regulation on (Date) 07-21-24.

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



Administrator (or Representative)

06-20-24

Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to submit the Washington state name and date of birth background inquiry (BGI) for 11 of 17 sampled contracted staff (Staff N, Staff R, Staff S, Staff T, Staff U, Staff V, Staff W, Staff X, Staff Y, Staff Z, and Staff AA) within one business day after their start date. This failure placed all residents at risk for abuse and neglect from caregivers and staff persons with unknown background.

Findings included...

Review of the facility's Employee Schedule showed that in May 2024, the facility hired contracted care staff to provide care and services to the residents.

STAFF N

Observation on 05/23/2024 between 8:00 AM and noon showed Staff N provided care to residents in the memory care unit.

Review of the facility's Employee Schedule showed that between 05/05/2024 and 05/23/2024, Staff N, Caregiver, worked 13 days in the facility. Review of Staff N's personnel record showed no documentation of when Staff N started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

STAFF R

Review of the facility's Employee Schedule showed that Staff R, Caregiver, worked in the facility on 05/18/2024, 05/19/2024, and 05/20/2024. Review of Staff R's personnel record showed no documentation of when Staff R started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

STAFF S

Review of the facility's Employee Schedule showed that Staff S, Caregiver, worked in the facility on 05/18/2024 and 05/19/2024. Review of Staff S's personnel record showed no documentation of when Staff S started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/22/2024, during the licensing inspection.

STAFF T

Review of the facility's Employee Schedule showed that between 05/06/2024 and 05/23/2024, Staff T, Caregiver, worked 12 days in the facility. Review of Staff T's personnel record showed no documentation of when Staff T started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

STAFF U

Review of the facility's Employee Schedule showed that Staff U, Caregiver, worked in the facility on 05/05/2024, 05/16/2024, and 05/20/2024. Review of Staff U's personnel record showed no documentation of when Staff U started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

STAFF V

Review of the facility's Employee Schedule showed that between 05/12/2024 and 05/19/2024, Staff V, Caregiver, worked four days in the facility. Review of Staff V's personnel record showed no documentation of when Staff V started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/22/2024, during the licensing inspection.

STAFF W

Observation on 05/23/2024 between 08:00 AM and noon showed Staff N provided care to residents in the memory care unit.

Review of the facility's Employee Schedule showed that between 05/05/2024 and 05/23/2024, Staff W, Caregiver, worked seven days in the facility. Review of Staff W's personnel record showed no documentation of when Staff W started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

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STAFF X

Review of the facility's Employee Schedule showed that between 05/06/2024 and 05/12/2024, Staff X, Caregiver, worked 13 days in the facility. Review of Staff X's personnel record showed no documentation of when Staff X started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

STAFF Y

Review of the facility's Employee Schedule showed that Staff Y, Caregiver, worked in the facility on 05/05/2024 and 05/11/2024. Review of Staff Y's personnel record showed no documentation of when Staff X started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/22/2024, during the licensing inspection.

STAFF Z

Review of the facility's Employee Schedule showed that between 05/07/2024 and 05/19/2024, Staff Z, Caregiver, worked five days in the facility. Review of Staff Z's personnel record showed no documentation of when Staff X started working in the facility. The records showed that the facility completed the Washington state name and date of birth BGI on 05/23/2024, during the licensing inspection.

STAFF AA

Review of the facility's Employee Schedule showed that Staff AA, Caregiver, worked in the facility on 05/10/2024 and 05/12/2024. Review of Staff AA's personnel record showed no documentation of when Staff AA started working in the facility. The records showed no documentation that the facility completed the Washington state name and date of birth BGI for Staff AA.

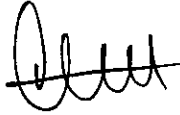
During an interview on 05/23/2024 at 12:10 PM, Staff M, Business Office Manager, confirmed that the facility hired caregivers from a contracted healthcare agency. Staff M stated that they did not keep track of when each contracted staff started work in the facility. Staff M stated they did not find any personnel records that showed the start date of work for each contracted staff. Staff M stated that they were unfamiliar with the background check requirements for contracted staff.

Plan/Attestation Statement

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

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

- (1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or
- (2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 1 of 1 sampled staff (Staff B) was tested for tuberculosis. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's policy titled, "Tuberculosis (TB) Requirements by State – Employees and Residents", dated 11/21/2023, showed the facility followed the Washington Administrative Code (WAC) on TB testing requirements. The policy showed the facility required all employees be tested for TB.

STAFF B

Review of the facility's Employee Roster showed the facility hired Staff B, Medication Care Manager, on 09/16/2022. Review of Staff B's personnel file showed that Staff B completed a two-step TB skin test. The first step was completed on 03/29/2022 and the second was completed on 04/16/2022. The two-step TB skin tests showed negative results. There was no documentation that showed Staff B completed a one-step TB skin test when rehired on 09/16/2022, as required.

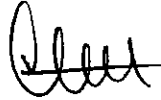
During an interview on 05/21/2024 at 9:30 AM, Staff M, Business Office Manager, stated that they were responsible for maintaining the TB documentation in the personnel files for all employees. Staff M stated that Staff B was rehired in September 2022. Staff M stated that they were unaware Staff B was required to complete one-step TB test when hired.

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WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

- (1) Ensure that the staff person has a chest X-ray within seven days;
- (2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and
- (3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 1 of 1 sampled staff (Staff C) followed up with the required procedures after the staff tested positive for TB. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's policy titled, "Tuberculosis (TB) Requirements by State – Employees and Residents", dated 11/21/2023, showed the facility followed the Washington Administrative Code (WAC) on TB testing requirements. The policy showed the facility required all employees be tested for TB.

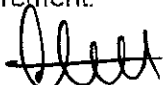
STAFF C

Review of the facility's Employee Roster showed the facility hired Staff C, Care Manager 2, on 07/12/2023. Review of Staff C's personnel file showed that on 07/14/2023, Staff C completed one TB test with a positive result. There was no documentation that showed Staff C completed a chest X-ray within seven days from the positive TB test. There was no documentation that showed Staff C was evaluated for signs and symptoms of TB. There was no documentation that showed Staff C followed up with the health care provider's recommendation.

During an interview on 05/21/2024 at 9:30 AM, Staff M, Business Office Manager, stated that they were responsible for maintaining the TB documentation in the personnel files for

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all employees. Staff M stated that they were aware that in July 2023, Staff C tested positive for TB. Staff M stated that they were unfamiliar with the required procedures to be followed when any staff tested positive for TB.

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WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

- (b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:
- (iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the assisted living facility failed to post the most recent Department of Social and Health Services full inspection report, dated November 2022, in a visible location within the facility premises. This failure placed all residents at risk of being uninformed of any facility deficiencies.

Finding included...

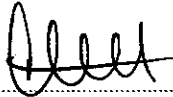
Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that the DSHS last conducted a full inspection at the assisted living facility in November 2022.

Observation on 05/20/2024 between 9:00 AM and 4:00 PM and on 05/21/2024 between 9:00 AM and 1:30 PM. showed that there was no copy of the November 2022 inspection report posted in the assisted living premises. Observation on 05/21/2024 at 1:30 PM showed the DSHS November 2022 full inspection report was kept inside a cabinet behind the front desk. Observation showed no sign posted outside the cabinet and at the front desk that informed others that the most recent full inspection report was kept there.

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During the resident group meeting on 05/21/2024 at 1:00 PM, several anonymous residents stated that they were unable to find the most recent DSHS full inspection anywhere in the facility. The residents stated that they wanted to know when the last full inspection was and what the inspection results were.

During an interview on 05/21/2024 at 1:30 PM, Staff Q, Lead Concierge, stated that the facility maintained the Department's letters in a binder. Staff Q stated that they were unaware that the facility was required to post the most recent inspection report in a conspicuous place. Staff Q stated that they "always" kept the binder inside the cabinet behind the front desk.

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WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to implement prescribed medical orders for 1 of 12 sampled residents (Resident 4). This failure placed Resident 4 at risk for increased medical complications and a decreased quality of life.

Findings included...

RESIDENT 4

Review of the facility's document titled, "Resident Dietary Policy", dated 02/28/2023, showed that nectar thick liquids were identified as "Level 2, mildly thick". The policy showed that in the daily stand-up meeting, the General Manager was responsible to ensure that all new and updated modified and special diets were reviewed with all staff. The policy showed that Medication Care Managers (unlicensed staff who dispense and administer medications) or nursing staff prepared thickened liquids for residents, as

needed.

Review of Resident 4's records showed that the facility admitted Resident 4 in [REDACTED] of 2021 with a diagnosis of "[REDACTED]".

Review of Resident 4's Individual Care Plan (ICP), dated 05/20/2024, showed Resident 4 received a "special diet/modified meal diet: thickened liquid: nectar thick". The ICP showed Resident 4 required "nectar thick liquids (level 2)". The ICP showed the facility provided "pre-thickened beverages". The ICP showed staff would ensure Resident 4 received "proper liquid consistency".

Observation on 05/22/2024 at 12:05 PM, showed Resident 4 seated at the dining room table of the secured Memory Care "Life's Neighborhood" unit. Observation showed Staff N, Agency Staff, served Resident 4 un-thickened water. Observation showed Resident 4 drank the water from the glass. Observation showed other residents were served chicken noodle soup. Observation showed staff did not serve soup to Resident 4.

During an interview on 05/22/2024 at 12:08 PM, Staff G, Care Medication Manager, stated that Resident 4 would be served chicken noodle soup once the broth was thickened to nectar thick consistency. Staff G stated that they were unaware Resident 4 was served un-thickened water and removed the water. Staff G stated that Staff N, Agency staff, served Resident 4 the un-thickened water.

During an interview on 05/22/2024 at 12:09 PM, Staff N stated that they served all the residents' water to drink that was not thickened, which included Resident 4.

Observation on 05/23/2024 at 8:45 AM, showed Resident 4 sat in a wheelchair at the dining room table for breakfast. Observation showed a glass of un-thickened water on the table in front of Resident 4.

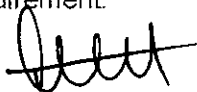
During an interview on 05/23/2024 at 8:46 AM, Staff O, Licensed Nurse, stated that Staff A, General Manager, served the unaltered water to all the residents who were in the dining room, which included Resident 4.

Observation in the Life's Neighborhood kitchen on 05/23/2024 at 8:48 AM, showed Staff P, Culinary Services Director, plated food for the residents. During an interview at this time, Staff P stated that there was pre-thickened water in the refrigerator ready to serve. Staff P stated that the staff were supposed to use the pre-thickened water to serve residents that required modified liquids. Staff P stated that Resident 4 was supposed to be served nectar thick liquids only.

During an interview on 05/23/2024 at 8:50 AM, Staff A, General Manager, stated that they served several residents plain, unmodified water. Staff A stated that they were not able to recall whether they served Resident 4 water that was not thickened to nectar thick

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consistency.

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WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences:

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to assess 1 of 1 resident (Resident 12) for the use of bed side rails. This failure placed Resident 12 at risk for injury from entrapment in the bed side rail.

Findings included...

Review of Resident 12's records showed that the facility admitted Resident 12 in [REDACTED] 2022.

Observation of Resident 12's apartment on 05/22/2024 at 2:10 PM, showed a hospital bed with two half-length siderails. The bed side rails were attached to either side of the head of the bed and were in the down position.

Review of Resident 12's records showed there was no assessment completed that documented Resident 12's need and use of the bed side rails.

Review of Resident 12's Individual Service Plan (ISP), dated 03/03/2024, did not show

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Resident 12 used any bed side rails, attached to each side of the bed.

During an interview on 05/22/2024 at 2:10 PM, Resident 12 stated that they did not realize the bed side rails were attached to the bed. Resident 12 stated they did not use the bed side rails.

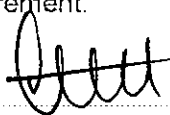
During an interview on 05/23/2024 at 9:30 AM, Staff I, Medication Care Manager, stated that they provided care for Resident 12. Staff I stated that Resident 12 did not use the half-length side rail on either side of the bed. Staff I stated that Hospice must have brought them in when Resident 12 was on Hospice services.

During an interview on 05/23/2024 at 11:30 AM, Staff H, Registered Nurse, Health Services Director, stated that they did not complete an assessment for bed side rails. Staff H stated that they were not aware Resident 12's bed had bed side rails attached.

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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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Individual Service Plan (ISP) for 6 of 12 sampled residents (Resident 1, Resident 2, Resident

4, Resident 5, Resident 10, and Resident 12). This failure placed the residents at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

RESIDENT 1

Review of Resident 1's records showed that the facility admitted Resident 1 in [REDACTED] 2023.

Observation of Resident 1's apartment on 05/22/2024 at 2:00 PM showed a Roho cushion (a pressure relieving cushion) on the seat of Resident 1's manual wheelchair. Observation showed the Roho cushion was partially inflated. Observation showed another foam cushion sat on top of the Roho cushion. Observation showed Resident 1 laid in a hospital bed. Observation showed Resident 1 used an indwelling urinary catheter (a tube that is inserted through the urinary track to drain urine from the bladder) with a urinary catheter bag (a drainage bag that collects urine). The bag hung on the right side, at the foot of the bed.

Review of Resident 1's undated assessment showed that Resident 1 required assistance with medication management. The assessment showed that Resident 1 used a manual wheelchair and required mechanical assistance with transfers. The assessment showed that Resident 1 was at risk of potential skin breakdown.

Review of Resident 1's ISP, dated 04/15/2024, showed Resident 1 received nurse delegation for medication administration and flushing the urinary catheter. The ISP showed Resident 1 used a manual wheelchair. There was no documentation that showed Resident 1 used a Roho cushion on the wheelchair. There was no documentation that instructed the Care Managers on how to check that the Roho cushion was properly inflated and what to do when the Roho cushion was inadequately inflated. The ISP showed Resident 1 received hospice care services.

Review of Resident 1's records showed there was no nurse delegation documents.

During an interview on 05/22/2024 at 2:00 PM, Staff E, Associated Care Director, stated that an air pump for the Roho cushion was kept in Resident 1's room. Staff E stated that the instructions and user guide for the Roho cushion were unavailable in Resident 1's room and in the memory care unit. Staff E stated that they were unsure of where the instructions and user guide was stored.

During an interview on 05/23/2024 at 11:00 AM, Staff H, Registered Nurse, Health Services Director, confirmed that Resident 1 did not receive any nurse delegation for medication management and flushing the urinary catheter. Staff H stated that the external hospice care provider managed the urinary catheter. Staff H stated that their wellness nurses performed routine flushing the urinary catheter. Staff H stated that their Medication Care Managers changed the urine bag and emptied the urine from the bag daily. Staff H stated

that they did not update in the service plan for Resident 1. Staff H stated that they were aware Resident 1 used a Roho cushion. Staff H stated the did not document in Resident 1's service plan the use of a Roho cushion or any staff guidelines for proper use of the cushion.

RESIDENT 2

Review of Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2023.

Review of Resident 2's February 2024, March 2024, April 2024, and May 2024 electronic Medication Administration Records (eMAR) showed that Resident 2 received 81 milligrams (mg) of Aspirin (a blood thinner medication) daily.

Review of Resident 2's assessment Resident 2 required assistance with medication management. The assessment showed no documentation that Resident 2 received daily blood thinner medication.

Review of Resident 2's ISP, dated 05/20/2024, showed no documentation that showed Resident 2 received Aspirin daily. There was no documentation that provided care staff with guidance about the possible side effects from aspirin, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed if Resident 2 showed any side effects associated with daily aspirin use.

RESIDENT 4

Review of Resident 4's records showed that the facility admitted Resident 4 in [REDACTED] 2021. The records showed Resident 4 was diagnosed with [REDACTED].

Review of Resident 4's February 2024, March 2024, April 2024, and May 2024 eMARs showed that Resident 4 was diagnosed as an [REDACTED]. Review of the eMARs showed no order for insulin. The eMARs showed an order for daily blood glucose checks (a test to determine the amount of sugar in the blood). The order showed staff were to notify the nurse if the blood glucose was below 80 or above 300.

Review of Resident 4's ISP, dated 05/20/2024, showed Resident 4 was insulin dependent. There was no documentation that identified the possible signs and symptoms related to uncontrolled diabetes, such as hyperglycemia (high blood sugar levels), increased thirst, or excess urination.

During an interview on 05/22/2024 at 8:15 AM, Staff G, Medication Care Manager, stated that Resident 4 was not insulin dependent and there were no orders for insulin to be administered. Staff G stated that Resident 4's blood glucose level was checked each morning.

During an interview on 05/23/2024 at 11:30 AM, Staff H stated that Resident 4's order for insulin was discontinued several months ago. Staff H stated that they were unaware the service plan was not updated to document that the insulin was discontinued.

RESIDENT 5

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2021.

Observation of Resident 5's apartment on 05/21/2024 at 2:15 PM and on 05/22/2024 at 7:52 AM, showed an alternating pressure relieving mattress on top of Resident 5's hospital bed. An air pump for the mattress was attached to the headboard the bed. Observation on 05/21/2024 at 2:17 PM, showed Resident 5 was seated in a Broda wheelchair (a wheelchair designed to tilt and recline and minimize risk of pressure injuries).

Review of Resident 5's ISP, dated 04/17/2024, showed Resident 5 had a history of skin breakdown and at risk for skin breakdown to both heels. The ISP showed that the staff were responsible to ensure Resident 5's heels were checked twice a day, every morning and evening. There was no documentation that showed Resident 5 used an alternating pressure relieving mattress. The ISP showed Resident 5 was unable to empty their bladder and required an indwelling foley catheter. Observation on 05/22/2024 at 7:52 AM showed no evidence that Resident 5 used a catheter of any type.

During an interview on 05/21/2024 at 2:17 PM, Collateral Contact 1 (CC1, Resident Representative) stated that Resident 5 no longer used an indwelling foley catheter. CC1 stated that the catheter was removed months ago.

During an interview on 05/23/2024 at 11:30 AM, Staff H stated that Resident 5's catheter was removed a long time ago. Staff H stated that they were unaware the language for the indwelling catheter was not removed from the ISP.

RESIDENT 10

Review of Resident 10's records showed that the facility admitted Resident 10 in [REDACTED] 2022.

During an interview on 05/22/2024 at 11:38 AM, Resident 10 stated that they had a fistula (an access port used to connect blood vessels in medical procedures) in their right arm. Resident 10 stated that the fistula was used twice a week for dialysis (a medical procedure that helps to remove extra fluid and waste products from the blood).

Review of Resident 10's February 2024, March 2024, April 2024, and May 2024 eMARs showed that Resident 10 received dialysis twice a week. The eMAR showed Resident 10's blood pressure and pulse rate were checked after each dialysis treatment. The eMAR did not document that Resident 10's blood pressure should not be taken on the right arm where the fistula was located due to the risk of blood clots, infection, and compromised

patency.

Review of Resident 10's ISP, dated 03/24/2024, did not show Resident 10 received dialysis treatment. The ISP did not provide instructions that Resident 10's blood pressure should not be taken on the right arm where the fistula was located due to the risk of blood clots, infection, and compromised patency.

RESIDENT 12

Review of Resident 12's records showed that the facility admitted Resident 12 in [REDACTED] 2022.

Observation of Resident 12's apartment on 05/22/2024 at 2:10 PM, showed that Resident 12 ambulated independently without an assistive device. Observation showed a walker folded up and leaned against a wall, next to the head of the bed. Observation showed there was no wheelchair in the apartment. Observation showed a hospital bed with two half-length side rails attached to each side of the bed, at the head.

Review of Resident 12's February 2024, March 2024, April 2024, and May 2024 eMAR showed that Resident 12 received Levetiracetam (a medication used to treat seizures) 500 mg twice a day.

Review of Resident 12's ISP, dated 03/03/2024, showed that Resident 12 used a walker for ambulation. The ISP showed Resident 12 used a manual wheelchair. The ISP did not show Resident 12 used any bed side rails. The ISP did not show Resident 12 received medication for seizure activity. There were no instructions for the Care Managers on what to do when Resident 12 experienced a seizure.

During an interview on 05/23/2024 at 9:30 AM, Staff I, Medication Care Manager, stated that they provided care for Resident 12. Staff I stated that Resident 12 did not use a walker and did not use a wheelchair. Staff I stated Resident 12 was independent with ambulation without any assistive devices. Staff I stated that Resident 12 used a half-length siderail on each side of the bed. Staff I stated that hospice must have brought them in when Resident 12 received the hospice service. Staff I stated that they dispensed Resident 12's morning medications when they worked on that floor. Staff I stated they did not recall anything about seizure activity and would need to review the eMAR. Staff I stated they never witnessed Resident 12 experience any seizure activity.

During an interview on 05/23/2024 at 10:00 AM, Staff G, stated that they were unaware Resident 12 received seizure medications. Staff G stated that on 05/23/2024, they dispensed Resident 12's medications in the morning. Staff G confirmed that Resident 12 received Levetiracetam in that morning and the eMAR showed Levetiracetam was prescribed to Resident 12 for seizures. Staff G stated they had not witnessed Resident 12 experience any seizures.

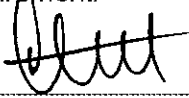
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During an interview on 05/23/2024 at 11:30 AM, Staff H stated that they were unaware Resident 12 received medication for seizures. Staff H stated that they were unaware of Resident 12's seizure history.

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