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

Bellevue Associates LLC
Silverado - Bellevue
14428 NE 8th St
Bellevue, WA 98007

RE: Silverado - Bellevue License # 2573

Dear Administrator:

This letter addresses Compliance Determination(s) 43936 (Completion Date 07/10/2024) and 40715 (Completion Date 05/16/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/10/2024 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-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2660-3, WAC 388-78A-2660-4, RCW 70.129.120, WAC 388-78A-2700-1-g-v, WAC 388-78A-2466-1-b, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1, WAC 388-78A-2468-1, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2610-2-d, WAC 388-78A-2600-2-f, WAC 388-78A-2600-2-g, WAC 388-78A-2880-1-a, WAC 388-78A-2880-1-b, WAC 388-78A-2880-1-c, WAC 388-78A-2880-1-d, WAC 388-78A-2880-1, WAC 388-78A-2880-2, WAC 388-78A-2880-3, WAC 388-78A-2880

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

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

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 #: 2573	Compliance Determination # 40715
Plan of Correction	Silverado - Bellevue	Completion Date
Page 1 of 12	Licensee: Bellevue Associates LLC	05/16/2024

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

The department completed data collection for the unannounced on-site full inspection on 05/06/2024 and 05/09/2024 of:
Silverado - Bellevue
14428 NE 8th St
Bellevue, WA 98007

The following sample was selected for review during the unannounced on-site visit: 5 of 24 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, 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.

Laurie Anderson — Residential Care Services

05/29/2024 — Date

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

Administrator (or Representative) — Date: 6/6/2024

RCW 70.129.120 Restraints -- Physical or chemical. The resident has the right to be free from physical restraint or chemical restraint. This section does not require or prohibit facility staff from reviewing the judgment of the resident's physician in prescribing psychopharmacologic medications.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 sampled resident (Resident 6) was free of restraints. This failure placed Resident 6 at risk for physical and psychological harm and a diminished quality of life.

Findings included...

Review of the facility's policy titled, "Resident Rights", dated 01/08/2022, showed that all "communities will follow their specific State Resident Rights per licensing regulations".

Review of the facility's undated policy titled, "Elder and Dependent Abuse in Person's with Dementia", showed that "signs or indicators of possible abuse included: Signs of being restrained".

Observation on 05/08/2024 at 8:20 AM, showed Resident 6 seated in a tilt-n-space wheelchair, positioned at a second-floor dining room table for breakfast. Observation showed a buckled black strap across Resident 6's chest and arms. The strap was connected to a bolster (a thick pillow designed to provide support), positioned on each side of Resident 6. Observation showed the two bolsters were fasted to the wheelchair. Observation showed Resident 6's arms were underneath the strap which prevented them from freely moving their arms.

During an interview on 05/08/2024 at 8:30 AM, Staff K, Caregiver, stated that the strap

was a restraint which restricted Resident 6's freedom of movement. Staff K stated that Resident 6's family member wanted the strap in place. Staff K stated that the family member fastened the strap to Resident 6 when they were in the facility. Staff K stated that once the family member left, the staff unbuckled the strap. Staff K stated that Resident 6's family member was not in the facility that morning. Staff K stated that the care staff who assisted Resident 6 up must have fastened the strap.

During an interview on 05/08/2024 at 8:37 AM, Staff D, Caregiver, stated that with the help of Staff H, caregiver, they dressed and placed Resident 6 in the tilt-n-space wheelchair that morning. Staff D stated that they positioned the two bolsters, one on each side of Resident 6, and fastened the strap over Resident 6's chest and arms. Staff D stated that Resident 6's family member wanted the strap fastened to prevent Resident 6 from leaning over to grab the wheelchair and to prevent the possibility of Resident 6 falling out of the wheelchair.

During an interview on 05/08/2024 at 8:40 AM, Staff I, Licensed Practical Nurse (LPN), stated that Resident 6's family member brought the bolster with the strap into the facility. Staff I stated that the family member secured the bolster to Resident 6's wheelchair. Staff I stated that the family member fastened the strap buckle when they visited. Staff I stated that once the family member left, the staff unbuckled the strap. Staff I stated that the strap did not prevent Resident 6 from leaning over in the wheelchair. Staff I stated that the strap should not be used.

During an interview on 05/09/2024 at 11:24 AM, Staff G, LPN, Director of Health Services, stated that they were not aware of the strap until just recently. Staff G stated that all the licensed nurses denied any knowledge of the strap. Staff G stated that they were surprised to learn from the staff that the strap had been in place for two weeks. Staff G stated that Resident 6's family member designed and installed the bolsters with the strap to keep Resident 6 upright. Staff G stated that the strap was supposed to go under Resident 6's arms and over their chest. Staff G stated that restraints were not allowed in the facility and that Resident 6 should not have been restrained in that manner.

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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative)

6/6/2024

Date

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

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have a system in place to ensure that 3 of 3 hot water tanks (tank 1, tank 2, and tank 3), identified in the disaster manual as part of the three-day emergency water supply, was readily accessible for residents in an emergency. This failure placed the 24 residents at risk for dehydration or other health and hygiene issues secondary to a lack of safe, emergency drinking water.

Findings included...

Review of the facility's emergency operation plan showed that emergency water consisted of one gallon of water per person, per day, for three days. The plan identified the facility's three hot water tanks as part of the emergency water supply.

During the facility environmental tour on 05/07/2024 at 9:57 AM, observation showed three 100-gallon hot water tanks located on the second floor of the facility. Observation showed each hot water tank had a valve with no handle located at the bottom of each tank. There was no device available to turn the valve on to provide access to the emergency water. Observation showed there was no hose available to attach to the valve. There were no buckets available to collect the water. Observation showed there were no instructions on how to access the water in the tanks during an emergency.

During an interview on 05/07/2024 at 10:00 AM, Staff M, Director of plant operations, stated that the hot water tanks were designated as part of the emergency water supply. Staff M stated that the staff would access the hot water by attaching a hose to the valve of the hot water tank, place one end of the hose in a bucket, and use a tool to turn the valve on to drain the hot water tank. Staff M stated that the staff would allow the water to sit in the bucket until it cooled down. Staff M stated that there was not a hose available, there was no device to turn the hot water tank valve, and no bucket to collect the water. Staff M stated that there were no instructions for the staff to follow. Staff M stated that the staff would need to call them for instructions and then acknowledged that if the phone service was out, the staff would not have access to the water.

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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative) — Date: 6/6/2024

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a Washington state name and date of birth background inquiry (BGI) was conducted every two years for 1 of 6 sampled staff (Staff F). This failure placed all residents at risk of abuse or neglect from staff with an unknown background.

Findings included...

Review of the facility's personnel records showed that the facility hired Staff F, Caregiver, on 10/05/2021. Review showed that the last BGI was completed on 09/28/2021. Review showed that a new background check authorization form was submitted on 05/09/2024, 224 calendar days after the last BGI expired.

During an interview on 05/09/2024 at 9:45 AM, Staff A, Administrator, stated that they were aware of the background inquiry requirements. Staff A stated that they were unaware that Staff F did not complete the required BGI.

This is an uncorrected deficiency previously cited on 11/14/2022.

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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative) — Date: 6/6/2024

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 interview and record review, the facility failed to submit a Washington state name and date of birth background inquiry (BGI) within one business day after the start of work for 1 of 6 sampled staff (Staff B). This failure placed all residents at risk of abuse or neglect from staff with an unknown background.

Findings included...

Review of the facility's personnel records showed that the facility hired Staff B, Charge Nurse, on 02/14/2024. Review showed no documentation that Staff B completed an initial BGI on the day Staff B started work in the facility. Further review of the personnel records showed that Staff B completed a BGI on 05/07/2024, 82 days after Staff B's date of hire.

During an interview on 05/09/2024 at 9:45 AM, Staff A, Administrator, stated that they were aware of the background inquiry requirements. Staff A stated that they were unaware that Staff B did not complete the required BGI.

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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative) — Date: 6/6/2024

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 3 of 6 staff (Staff B, Staff C, 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 B, Charge Nurse, on 02/14/2024; Staff C, Caregiver, on 02/28/2024; and Staff F, Caregiver, on 10/05/2021.

CARDIOPULMONARY RESUSCITATION (CPR) AND FIRST AID
Review of the facility's personnel records showed no documentation that Staff B completed any CPR and First Aid training, as required.

Review of the facility's personnel records showed no documentation that Staff C completed any CPR and First Aid training, as required.

CONTINUING EDUCATION (CE)
Review of the facility's personnel records showed no documentation that Staff F completed any department approved CE training from their February 2023 birthday to their February 2024 birthday, as required.

During an interview on 05/09/2024 at 9:45 AM, Staff A, Administrator, stated that they were aware of the training and certification requirements. Staff A stated they were unaware that Staff B and Staff C did not complete the required CPR and First Aid trainings. Staff A stated that they were unaware that 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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative) — Date: 6/6/2024

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility staff failed to provide a standard of care to prevent infection for 1 of 1 resident (Resident 2). This failure placed Resident 2 at risk for infection.

Findings included...

Review of Resident 2's "Service Plan Detail", dated 03/08/2024, showed that the facility care staff provided hands on care, which included bed baths, peri care (the cleaning of a person's private areas), and hygiene care.

Observation on 05/09/2024 at 8:17 AM, showed Resident 2 laid in a hi-low hospital bed (a bed that can be raised or lowered in height) on their left side. Observation showed an alternating pressure relieving mattress (mattress to prevent skin break down by off-loading pressure on the body) under the resident. Observation showed that the pressure relieving mattress was deflated and the air pump was not working. Observation showed Staff K, Caregiver, and Staff J, Caregiver, provided bedside care for Resident 2. Observation showed Staff K and Staff J removed Resident 2's soiled briefs. Staff K used a disposable

moist wipe to clean Resident 2' buttocks area, wiping from the back to the front. Staff K folded the soiled wipe and reused the wipe to clean Resident 2's peri area. Staff K used the soiled wipe to further wipe from back to front, instead of from front to back to prevent the possibility of introducing bacteria into the body. Improper wiping from back to front could result in Resident 2 developing a urinary tract, bladder, or kidney infection.

During an interview on 05/09/2024 at 11:24 AM, Staff G, Licensed Practical Nurse, Director of Health Services, stated that when a caregiver provided bedside care, they were trained to wash their hands or use sanitizer, put on gloves, and make sure all the supplies were set-up. Staff G stated that the caregiver would raise the hi-low bed to the up position. Staff G stated that if the resident had a bowel movement, the caregiver would shower the resident or provide a sponge bath. Staff G stated that the caregiver removed the soiled briefs and used disposable wipes to clean the resident. Staff G stated that the caregiver would wipe from the front of a resident's private area to the back. Staff G stated that the caregivers should never use the same wipe to clean both areas. Staff G stated that the caregivers should never wipe from the back to front as this may cause different infections to develop.

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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative) — Date: 6/6/2024

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

(g) When there are urgent situations in the assisted living facility requiring additional staff support;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow their emergency response policies for 1 of 1 resident (Resident 3). This failure placed Resident 3 at risk for injury and compromised health when emergency medical evaluation was delayed.

Findings included...

Review of the facility's policy titled, "Activating 911", dated 01/22/2022, showed that "...there will be times when 911 will be activated. The 911 EMS (Emergency Medical Services) is activated, under the direction of or by a licensed nurse." The policy showed that "the Licensed Nurse will notify the physician, responsible party and the Director of Health Services of the resident's sever change in condition, promptly."

Review of the facility's policy titled, "Fall Management", dated 04/28/2022, showed "when a resident sustains a fall and hit his/her head or is on blood thinning medication, 911 will be called to transport the resident for further evaluation" in the emergency room.

Observation on 05/08/2024 at 8:40 AM, showed Resident 3 sat at a dining room table on the second floor. Resident 3 attempted to drink from an empty glass. Observation showed a yellowish, fading bruise on Resident 3's left side of face and neck.

Review of Resident 3's incident report and progress notes, dated [redacted]/2024, showed that during a routine check at 3:30 AM, Resident 3 was found on the floor. Staff L, Registered Nurse, conducted an assessment and determined that Resident 3 sustained a hematoma (an abnormal pooling of blood in the body under the skin that results from a broken or ruptured blood vessel) to the left side of the forehead. The assessment showed that Resident 3 was drowsy, legs were weak, vital signs stable, no seizure activity, no emesis (vomiting), and Resident 3 responded to questions. The documents showed that staff notified the primary physician of the fall via fax. The document showed that staff notified Staff G, Licensed Practical Nurse (LPN), Director of Health Services. The progress notes showed that at 2:45 PM, Resident 3 had a change of condition. The notes showed that Resident 3 was sluggish and slurred their words that morning. The notes showed Resident 3 had weakness "in all four extremities", was unable to ambulate to the dining room, and required a wheelchair. The notes showed that Staff B, LPN, activated emergency medical services. Resident 3 was transported to the hospital for further evaluation.

Review of Resident 3's hospital discharge documents, dated [redacted]/2024, showed an admitting diagnosis of [redacted] and [redacted]. The documents showed Resident 3 was hospitalized overnight for observation.

During an interview on 05/08/2024 at 8:45 AM, Staff I, LPN, stated that the yellowish bruise to Resident 3's left side of their head and neck was post residual from a fall on [redacted]/2024. Staff I stated that if there was obvious trauma to a resident, staff were to call 911 and the resident would be sent out to the hospital for further evaluation. Staff I stated that the nurse on duty may have been from an agency and did not know the facility's policy to send a resident out when they fell and hit their head. Staff I reviewed the Resident 3's progress notes and stated that the nurse on duty was a facility staff nurse. Staff I stated that the facility policy did not apply to the facility since the facility staffed with 24-hour licensed nurses who were able to assess the resident for injury.

During an interview on 05/08/2024 at 12:40 PM, Staff G stated that they were informed of Resident 3's fall and head trauma at around 6:00 AM on [redacted]/2024 via a text. Staff G stated that the facility policy was not followed and 911 should have been activated immediately. Staff G stated that Resident 3 should have been sent out to the hospital for further evaluation in accordance with the facility policy, instead of waiting almost 12 hours later.

During an interview on 05/15/2024 at 2:29 PM, Collateral Contact, (CC1) stated that they were notified of Resident 3's fall and head injury between 8:00 AM and 11:00 AM on [redacted]/2024. CC1 stated that they were not called at 3:30 AM. CC1 stated that they had asked the facility not to call them for issues regarding Resident 3's behavior. CC1 stated that they expected the facility to notify them of any medical issues, injuries, or emergencies. CC1 stated that they asked the nurse who called them if Resident 3 was sent to the hospital to be evaluated. CC1 stated the nurse responded with "do you want us too"? CC1 stated that they instructed the nurse to send Resident 3 out to the hospital to be evaluated.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 6/6/2024

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

(d) Provide all additional documentation as requested by construction review services;

(2) Obtain the written approval of construction review services for the new use of the room; and

(3) Ensure the facility functional program and room list are updated to reflect the change.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to notify the Department of Social and Health Services Construction Review Services (CRS) of the change in use for 1 of 1 room (Room 108) being used for contracted therapy services. This failure placed all the residents at risk of mistakenly residing in an apartment not properly designed for living.

This allowed for the room use to be misidentified as a resident apartment and potentially no longer meet code requirements should the facility choose to switch the room use back to its original intended purpose, resident apartment use, placing the resident at risk.

Findings included...

Observation on 05/06/2024 at 9:00 AM, showed the facility operated as a secured memory care facility. During the entrance tour at 9:47 AM, observation showed room 108, located on the first floor, was labeled with a sign that the room was used by an outside rehabilitation services company.

During the full inspection on 05/06/2024, 05/07/2024, 05/08/2024, and 05/09/2024, between 9:00 AM and 3:00 PM, observation showed therapy staff inside room 108. Observation showed the therapy staff worked with residents in the hallway outside of room 108.

Review of the facility's Characteristics Roster did not list room 108. The roster did not show room 108 was used for rehabilitation therapy services.

During an interview on 05/09/2024 at 12:57 PM, Staff A, Administrator, stated that the facility did not submit a change of room use to CRS for review or approval. Staff A stated that they did not have documented approval for the change of use of a resident room. Staff A stated that the room use was temporary. Staff A stated that if the room was needed for a resident, the rehabilitation services would be relocated.

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, Silverado - Bellevue is or will be in compliance with this law and / or regulation on (Date) 6/30/2024 .

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

Administrator (or Representative) — Date: 6/6/2024

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

05/29/2024

Bellevue Associates LLC
Silverado - Bellevue
14428 NE 8th St
Bellevue, WA 98007

RE: Silverado - Bellevue # 2573

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/16/2024 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.

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

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.

The Assisted Living Facility failed to post a copy of the last Department of Social and Health Services inspection report in an accessible place within the facility. The report was locked up in the Administrator office. There was signage that showed the Department of Social and Health Services last inspection report was available. During the inspection, the facility staff relocated the binder so that it was readily available upon request.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

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

Enclosure