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

Covington ALC LLC
Vineyard Park of Covington
17016 SE Wax Rd
Covington, WA 98042

RE: Vineyard Park of Covington License # 2593

Dear Administrator:

This letter addresses Compliance Determination(s) 42735 (Completion Date 06/14/2024) and 39426 (Completion Date 04/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/14/2024 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-e, 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-b, WAC 388-78A-2474-2-a, WAC 388-112A-0269-1, WAC 388-78A-2620-2-b, WAC 388-78A-2620-2-c

The Department staff who did the on-site verification:
Kathy Young, 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

Covington ALC LLC
Vineyard Park of Covington
17016 SE Wax Rd
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RE: Vineyard Park of Covington License # 2593

Dear Administrator:

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The Department completed a follow-up inspection of your Assisted Living Facility on 06/14/2024 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-e, 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-b, WAC 388-78A-2474-2-a, WAC 388-112A-0200-1, WAC 388-78A-2620-2-b, WAC 388-78A-2620-2-c

The Department staff who did the on-site verification:
Kathy Young, 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

Statement of Deficiencies	License # 2593	Compliance Determination # 39426
Plan of Correction	Vineyard Park of Covington	Completion Date
Page 1 of 5	Licensee: Covington ALC LLC	04/08/2024

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 04/08/2024 and 04/08/2024 of:
Vineyard Park of Covington
17016 SE Wax Rd
Covington, WA 98042

This document references the following SOD dated: 04/08/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI
Kathy Young, 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

04/12/2024 — 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

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

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;

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

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:

(a) Orientation and safety;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 3 staff (Staff F) completed continuing education training requirements. This failure placed all residents at risk of receiving inadequate care and services from unqualified staff.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 02/01/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 03/30/2024.

Review of the facility's policy titled, "Staff Training and Education", revised 02/01/2015, showed the facility provided staff with sufficient training to provide appropriate care and services for the residents. The policy specified staff, as required by the state regulations, must complete 12 hours of continuing education relevant to the resident population yearly, from birthday to birthday.

STAFF F
Review of the facility's employee roster showed the facility hired Staff F, Medication Technician, on 06/29/2022. Review of the facility's undated Med Tech job description showed Staff F had responsibilities that worked directly with residents.

Review of Staff F's employee records showed no documentation that Staff F completed any continuing education credits from their [redacted] 2022 birthday to their [redacted] 2023 birthday. Review of the care staff schedule from 01/31/2024 through 04/05/2024, showed Staff F worked 21 shifts as a Med Tech and 25 shifts as a Caregiver providing care and services to the residents.

During an interview on 04/08/2024 at 10:30 AM, Staff I, Business Office Manager, stated that they did not have any documentation that showed Staff F completed their continuing education courses.

During an interview on 04/08/2024 at 11:59 AM, Staff A, Executive Director, stated they were unable to confirm that Staff F completed their continuing education. Staff A stated that despite no confirmation of completed training, the facility continued to schedule Staff F to provide resident care.

During an interview on 04/08/2024 at 1:17 PM, Staff J, Director of Nursing, stated that they were unaware that Staff F did not complete their continuing education.

This is an uncorrected deficiency previously cited on 02/01/2024 for subsection 2(e) and WAC 388-112A-0611 .

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, Vineyard Park of Covington 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-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:

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

(c) Are restricted from central food preparation areas.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled pets (Pet 2, Pet 3, and Pet 4) received regular examinations, vaccines, and were veterinarian certified to be free of diseases transmittable to humans. These failures placed all residents at risk of contracting illnesses spread by pets.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 02/01/2024. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 03/30/2024.

Review of the facility's policy titled, "Pet Policy", revised 02/01/2015, showed there must be yearly proof all dogs were vaccinated for distemper, parvo, hepatitis, parainfluenza, and rabies. The policy showed there must be yearly proof all cats were vaccinated for distemper, rhinotracheitis, and panleukopenia. Review of the facility's Pet Agreement showed each resident with a pet was required to provide management with records of all veterinarian visits. The resident was to ensure their pet received regular examinations and immunizations appropriate for the species. The resident was to provide proof their pet was veterinarian certified free of disease transmittable to humans.

Review of the Pet Policy letter, dated 03/27/2024, sent to the resident pet owners, showed the residents were required to provide updated vaccination records to the facility within 30 days. The letter did not include any request for the residents to provide veterinary records

that showed the pets received regular veterinarian examinations and were certificated to be free of diseases transmittable to humans.

PET 2
Review of the facility's veterinary records for Pet 2 showed that on 10/10/2023, Pet 2 was past due for a Bordetella vaccine. The facility provided no record showing Pet 2 had received a veterinary examination. There was no documentation in the records that showed Pet 2 was veterinarian certified to be free of diseases transmittable to humans.

PET 3
Review of the facility's veterinary records for Pet 3 showed that on 02/11/2023, Pet 3's Bordetella vaccine was past due. There was no documentation in the records that showed Pet 3 received a veterinary examination. There was no documentation in the records that showed Pet 3 was veterinarian certified to be free of diseases transmittable to humans.

PET 4
Review of the facility's veterinary records for Pet 4 showed no documentation that Pet 4 received any vaccinations or a veterinary examination. There was no documentation in the records that showed Pet 4 was veterinarian certified to be free of diseases transmittable to humans.

During an interview on 04/08/2024 at 10:52 AM, Staff I, Business Office Manager, stated that on 03/27/2024, they sent out letters to pet owners requesting updated pet records. Staff I stated that the residents had 30 days, until 04/26/2024, to comply with the request.

During an interview on 04/08/2024 at 1:15 PM, Staff A, Executive Director, stated that they were unaware the letter sent to the pet owners did not request all required veterinarian records.

This is an uncorrected deficiency previously cited on 02/01/2024.

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, Vineyard Park of Covington 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 01/22/2024 and 01/29/2024 of:

Vineyard Park of Covington
17016 SE Wax Rd
Covington, WA 98042

The following sample was selected for review during the unannounced on-site visit: 7 of 48 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI
Kathy Young, 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 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

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;

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

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:

(a) Orientation and safety;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 4 staff (Staff A, Staff B, Staff E, and Staff F) completed all long-term care workers training requirements. This failure placed all residents at risk of receiving inadequate care and services from unqualified staff.

Findings included…

Review of the facility's policy titled, "Building Orientation", revised 02/01/2015, showed the facility required each employee completed with a thorough facility orientation. The policy showed the facility covered special needs of the resident population, fire and life safety, infection control, residents' rights, and vital job requirements. The facility retained an orientation record in each staff's employee file.

Review of the facility's policy titled, "Staff Training and Education", revised 02/01/2015, showed the facility provided staff with sufficient training to provide appropriate care, services, and ensure the environment was homelike for the residents. The policy specified that all staff received facility orientation prior to routine interaction with the residents. The policy specified staff, as required by the state regulations, must complete 12 hours of continuing education relevant to the resident population yearly, from birthday to birthday.

STAFF A
Review of the facility's employee roster showed the facility hired Staff A, Medication Technician (Med Tech), on 03/01/2022. Review of the facility's undated Med Tech job description showed Staff A worked directly with residents.

Review of Staff A's employee records showed no documentation that Staff A completed any continuing education credits from their [redacted] 2022 birthday to their [redacted] 2023 birthday.

Observation on 01/25/2024 at 1:05 PM, showed Staff A administered medications to residents.

During an interview on 01/25/2024 at 1:05 PM, Staff A stated that they worked three shifts, Thursday through Saturday, each week.

Staff A confirmed that they did not provide the facility with any documentation of continuing education training certificates that showed they completed of 12 hours of continuing education training between their [redacted] 2022 birthday to their [redacted] 2023 birthday. Staff A stated that the facility permitted them to continue working as a caregiver with residents despite the lack of evidence they completed 12 hours of continuing education.

STAFF B
Review of the facility's employee roster showed the facility hired Staff B, Caregiver, on 04/18/2022. Review of the facility's undated caregiver job description showed Staff B assisted residents with personal care.

Review of Staff B's employee records showed Staff B completed the facility orientation on

06/29/2023, 437 days after date of hire.

Observation on 01/23/2024 at 8:46 AM, showed Staff B delivered a breakfast tray to a quarantined resident.

During an interview on 01/23/2024 at 1:58 PM, Staff B stated that they worked five shifts per week. Staff B stated that they were unable to recall the circumstances surrounding the delay in completing the facility orientation. Staff B stated that the facility permitted them to continue working as a caregiver directly with residents prior to completing the facility orientation.

STAFF E
Review of the facility's employee roster showed the facility hired Staff E, Resident Care Coordinator, on 12/09/2021. Review of the facility's undated Resident Care Coordinator job description showed Staff E had responsibilities that included providing residents with direct care.

Review of Staff E's employee records showed Staff E completed the facility orientation on 07/16/2023, 584 days after hire. The records showed no documentation that Staff E completed any continuing education credits from their [redacted] 2022 birthday to their [redacted] 2023.

During an interview on 01/23/2024 at 1:17 PM, Staff E stated that they were unable to recall the circumstances surrounding the delay in completing the facility orientation. Staff E stated that they had their continuing education certificates were offsite. Staff E stated that they did not turn in their continuing education certificates to the facility's administration. Staff E stated that the facility permitted them to continue working as a Resident Care Coordinator without completion of facility orientation and without proof of their yearly continuing education. During an interview on 01/25/2024 at 1:46 PM, Staff E stated that they had only taken continuing education courses that had not been approved by Washington State.

STAFF F
Review of the facility's employee roster showed the facility hired Staff F, Medication Technician, on 06/29/2022. Review of the facility's undated Med Tech job description showed Staff F had responsibilities worked directly with residents.

Review of Staff F's employee records showed no documentation that Staff F completed any continuing education credits from their [redacted] 2022 birthday to their [redacted] 2023 birthday.

Observation on 01/25/24 at 2:38 PM, showed Staff F administered medications to residents.

During an interview on 01/25/24 at 2:38 PM, Staff F stated that they did not provide the facility with any documentation of continuing education certificates that showed they completed 12 hours of continuing education training between their [redacted] 2022 birthday to their [redacted] 2023 birthday. Staff F stated that until the full inspection began, no one in facility administration had checked on their continuing education completion status.

During an interview on 01/25/2024 at 1:40 PM, Staff I, Business Office Manager, not could describe a system that ensured staff completed the facility orientation prior to direct work with the residents. Staff I stated the facility that they did not know to assign staff with continuing education courses that were approved by Washington State.

During an interview on 01/29/2024 at 1:55 PM, Staff J, Director of Nursing, stated that staff who failed to complete their annual continuing education training by their birthday were removed from the care schedule. Staff J stated that these staff were not allowed to provide direct care to the residents until the staff completed their continuing education requirements.

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, Vineyard Park of Covington 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-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 4 long-term care staff sampled (Staff A, Staff B, and Staff E) completed a national fingerprint background check within 120 days of hire. This failure placed all the residents at risk for abuse and neglect from staff with unknown backgrounds.

Findings included…

STAFF A
Review of the facility's employee roster showed the facility hired Staff A, Medication Technician (Med Tech) on 03/01/2022. Review of the facility's undated job description for Med Techs showed Staff A worked directly with residents.

Review of Staff A's employee records showed a national fingerprint background check was completed on 08/12/2022, 164 days after hire.

Observation on 01/25/2024 at 1:05 PM, showed Staff A administered medications to residents.

During an interview on 01/25/2024 at 1:05 PM, Staff A stated that they worked three shifts, Thursday through Saturday, each week. Staff A stated that they were unable to recall the circumstances surrounding the delay in obtaining fingerprints. Staff A stated that the facility permitted them to continue working as a Med Tech directly with residents beyond 120 days from hire.

STAFF B
Review of the facility's employee roster showed the facility hired Staff B, Caregiver, on 04/18/2022. Review of the facility's undated job description for caregivers showed Staff B assisted residents with personal care.

Review of Staff B's employee records showed a national fingerprint background check was completed on 09/26/2022, 161 days after hire.

Observation on 01/23/2024 at 8:46 AM, showed Staff B delivered a breakfast tray to a quarantined resident.

During an interview on 01/23/2024 at 1:58 PM, Staff B stated that they worked five shifts per week. Staff B stated that they were unable to recall the circumstances surrounding the delay in obtaining fingerprints. Staff B stated that the facility permitted them to continue working as a Caregiver directly with residents beyond 120 days from their hire.

STAFF E
Review of the facility's employee roster showed the facility hired Staff E, Resident Care Coordinator, on 12/09/2021. Review of the facility's undated job description for the Resident Care Coordinator showed Staff E provided residents with personal care.

Review of Staff E's employee records showed a national fingerprint background check was completed on 08/15/2022, 249 days after hire.

During an interview on 01/23/24 at 1:17 PM, Staff E stated that the facility permitted them to continue working as a Resident Care Coordinator with residents beyond 120 days from hire.

During an interview on 01/25/2024 at 1:40 PM, Staff I, Business Office Manager, could not describe a system for ensured staff completed the National Fingerprint Background Check within 120 days of hire, or the facility removed staff from duties with direct access with residents.

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, Vineyard Park of Covington 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-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 5 staff (Staff A) completed a Tuberculosis (TB) test within three days of hire. This failure placed all residents at risk of exposure to TB.

Findings included…

STAFF A
Review of the facility's employee roster showed the facility hired Staff A, Medication Technician (Med Tech) on 03/01/2022. Review of the facility's undated Med Tech job description showed Staff A worked directly with residents.

Review of Staff A's employee records showed that on 12/28/2022, Staff A completed the first step of the two-step TB test, 302 days after Staff A started their employment at the facility.

Observation on 01/25/2024 at 1:05 PM, showed Staff A administered medications to residents.

During an interview on 01/25/2024 at 1:05 PM, Staff A stated that they worked three shifts each week, Thursday through Saturday. Staff A stated that they were unable to recall the circumstances as to why they received the TB test months after their employment start date at the facility. Staff A stated that the facility permitted them to continue working as a Med Tech directly with residents before they completed the TB screening tests.

During an interview on 01/23/2024 at 2:17 PM, Staff J, Business Office Manager, stated that Staff A's late TB test was completed before they were hired. Staff J stated that they did not know the circumstances that caused Staff A's TB test to be administered late.

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, Vineyard Park of Covington 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-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 observation, interview, and record review, the facility failed to ensure that 1 of 1 staff (Staff B) with positive Tuberculosis (TB) results, received a chest X-ray within seven days, were evaluated for TB signs and symptoms, and followed the recommendation of their health care provider. This failure placed all residents at risk for exposure to TB.

Findings included…

Review of the facility's employee roster showed the facility hired Staff B, Caregiver, on 04/18/2022. Review of the facility's undated job description for caregivers showed Staff B provided residents with direct personal care.

Review of Staff B's employee records showed that on 04/21/2022, Staff B tested positive for TB. The records showed no documentation that Staff B completed an evaluation for the signs and symptoms of TB. There was no documentation that showed Staff B obtained a chest X-ray within seven days. There was no documentation that Staff B obtained and followed the recommendations of their health care provider. The records showed that on 10/26/2018, Staff B previously completed a chest X-ray. The record showed that Staff B was referred to a local hospital's TB clinic to determine whether treatment of inactive disease was required. There was no documentation in the records that showed Staff B followed up with the recommended referral.

Observation on 01/23/2024 at 8:46 AM, showed Staff B worked directly with residents. Observation showed Staff B delivered a breakfast tray to a quarantined resident.

During an interview on 01/23/2024 at 1:58 PM, Staff B stated that they worked five shifts per week, directly with residents. Staff B stated that they did not follow up with the recommended referral. Staff B stated that the provider who reviewed the X-ray informed Staff B that they did not have to do anything to address the positive TB test for five years.

During an interview on 01/23/2024 at 2:17 PM, Staff J, Business Office Manager, stated that they were unaware of the needed requirements when staff tested positive for TB.

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, Vineyard Park of Covington 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-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:

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

(c) Are restricted from central food preparation areas.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 4 pets (Pet 1, Pet 2, Pet 3, and Pet 4) received regular examinations, vaccines, and were veterinarian certified to be free of diseases transmittable to humans. These failures placed all residents at risk of contracting illnesses spread by pets.

Findings included…

Review of the facility's policy titled, "Pet Policy", revised 02/01/2015, showed there must be yearly proof all dogs were vaccinated for distemper, parvo, hepatitis, parainfluenza, and rabies. The policy showed there must be yearly proof all cats were vaccinated for distemper, rhinotracheitis, and panleukopenia. Review of the facility's Pet Agreement showed each resident with a pet was required to provide management with records of all veterinarian visits. The resident was to ensure their pet received regular examinations and immunizations appropriate for the species. The resident was to provide proof their pet was veterinarian certified free of disease transmittable to humans.

PET 1
Review of the facility's veterinary records for Pet 1 showed that on 11/28/2023, Pet 1's rabies vaccine was past due. There was no documentation in the records that showed Pet 1 received any vaccinations or veterinary examinations. There was no documentation in the records that showed Pet 1 was veterinarian certified to be free of diseases transmittable to humans.

Observation on 01/24/2024 at 12:22 PM, showed Pet 1 in the resident's apartment.

PET 2
Review of the facility's veterinary records for Pet 2 showed that Pet 2's rabies vaccine was current. The veterinary records showed that on 10/10/2023, Pet 2 was past due for a Bordetella vaccine. The facility provided no record showing Pet 2 had received a veterinary examination. There was no documentation in the records that showed Pet 2 was veterinarian certified to be free of diseases transmittable to humans.

Observations on 01/22/2024 at 1:00 PM and 01/24/2024 at 11:00 AM, showed Pet 2 in the residents' apartment. Observation showed Pet 2 interacted with all who entered.

During an interview on 01/24/2024 at 11:00 AM, the resident stated that Staff G, Executive Director, handled the initial receipt of Pet 2's veterinary records.

PET 3
Review of the facility's veterinary records for Pet 3 showed that on 02/11/2023, Pet 3's Bordetella vaccine was past due. There was no documentation in the records that showed Pet 3 received a veterinary examination. There was no documentation in the records that showed Pet 3 was veterinarian certified to be free of diseases transmittable to humans.

Observation on 01/29/24 at 1:15 PM, showed Pet 3 was seated by the feet of the resident who was seated on a bench in the first-floor hall.

PET 4
Review of the facility's veterinary records for Pet 4 showed no documentation that Pet 4 received any vaccinations or a veterinary examination. There was no documentation in the records that showed Pet 4 was veterinarian certified to be free of diseases transmittable to humans.

During an interview on 01/24/2024 at 10:40 AM, Staff I, Business Office Manager, stated that Staff G managed the pet records. During an interview on 01/24/2024 at 10:50 AM, Staff G stated that Staff I managed the pet records.

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, Vineyard Park of Covington 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-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure hot water temperatures were no lower than 105 degrees Fahrenheit (F) and no higher than 120 degrees F. This failure placed all the residents at risk of a diminished quality of life and burns from scalding water.

Findings included…

Review of the facility's document titled Monthly Water Temperature Log showed the facility checked the water temperature of one resident apartment and four common resident accessible locations each calendar month. The December 2023 log showed the last water temperature was taken on 12/06/2023.

LOW TEMPERATURES
Observation on 01/22/2024 at 12:33 PM, showed the hot water temperature in Apartment 434 measured 101.3 degrees F. Observation on 01/23/2024 at 9:13 AM, showed the hot water temperature in Apartment 435 measured 101.9 degrees F. Observation on 01/23/2024 at 10:00 AM, showed the hot water temperature in Apartment 435 measured 101.6 degrees F.

During interviews on 01/22/2024 and 01/23/2024 at the time of the water temperature measurement observations, Staff H, Maintenance Director, acknowledged the low readings.

HIGH TEMPURATURES
Observation on 01/22/2024 at 1:31 PM, showed the hot water temperature in Apartment 331 measured 139.7 degrees F. Observation on 01/22/2024 at 1:39 PM, showed the hot water temperature in Apartment 329 measured 137.3 degrees F. Observation on 01/22/2024 at 1:46 PM, showed the hot water temperature in Apartment 323 measured 135.5 degrees F. Observation on 01/22/2024 at 3:08 PM, showed the hot water temperature in the Activity Room sink measured 132.5 degrees F. Observation on 01/23/2024 at 8:24 AM, showed the hot water temperature in Apartment 225 measured 139.0 degrees F. Observation on 01/23/2024 at 8:28 AM, showed the hot water temperature in Apartment 218 measured 136.2 degrees F. Observation on 01/23/2024 at 8:40 AM, showed the hot water temperature in Apartment 218 measured 137.6 degrees F. Observation on 01/23/2024 at 8:48 AM, showed the hot water temperature in Apartment 105 measured 135.1 degrees F.

During interviews on 01/22/2024 and 01/23/2024 at the times of the water temperature measurement observations, Staff H stated that the facility had no water temperature policy. Staff H confirmed that the water temperatures were out of range of the regulation guidelines.

During an interview on 01/23/2024 at 9:04 AM, Staff G, Executive Director, stated that they discovered the two hot water tanks which supplied water to the residents were set at 150 degrees F. Staff G stated that when discovered, they turned the thermometer on the two tanks down to 120 degrees F to lower the water temperature and avoid potential burns to the residents.

During an interview on 01/24/2024 at 11:12 AM, Resident 8 stated that Resident 1 and Resident 8's shared apartment's water temperature had been really hot until the day before. Resident 8 stated that the water stayed hot for a long time. Resident 8 stated that the hot water was so hot, it could burn someone.

During an interview on 01/25/2024 at 9:00 AM, Staff G stated that the plumber believed when the facility experienced the power outage earlier in the month and the generator kicked on, the water tanks reset to 150 degrees F. During an interview on 01/29/2024 at 8:53 AM, Staff G stated that plumbers determined faulty mixing valves were responsible for apartments with low hot water temperatures. Staff G stated that they concluded testing one resident apartment per month was not enough to spot an issue.

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

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess the need and safety risks of a medical device for 1 of 1 resident (Resident 6). This failure placed Resident 6 at risk for harm or injury from improper use of the medical device.

Findings included…

Review of the facility's policy titled, "Assessments-Full Assessments", revised 10/01/2020, showed that residents were assessed within 30 days after admission to evaluate for any changes needed in resident care or services not previously identified. Review of facility's undated disclosure of services showed that a nurse must approve and assess resident's safety use of a medical device (transfer pole).

Review of Resident 6's negotiated service plan, dated 12/03/2023, showed the facility admitted Resident 6 on [redacted]/2023. Review of Resident 6's service plan showed medical diagnoses that include [redacted] ([redacted]). Resident 6's service plan showed that staff provide total assistance with transfers (assistance to move in and out of bed or from a sit to stand position).

Observation of Resident 6's apartment on 01/24/2024 at 2:27 PM showed a transfer pole with curved handle on the left side at the end of the bed. The pole was installed with its top end fixed to the ceiling and its lower end fixed to the floor. During an interview at the same time, Resident 6 stated that they used the pole to pull themselves up from a sitting position and transfer between the bed and the wheelchair. Resident 6 stated that their family installed the transfer pole when they moved into the facility. Collateral Contact 1 (CC1, resident representative), who was present during Resident 6's interview, stated that the facility staff were aware Resident 6 used a transfer pole.

During an interview on 01/25/2024 at 1:15 PM, Staff J, Director of Nursing and Staff E, Resident Care Coordinator, stated that they were unaware Resident 6 used a transfer pole. Staff J confirmed that Resident 6 was not evaluated for safe transfer pole use.

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

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure it provided safe and well-maintained exterior walking paths and common areas and housekeeping rooms with functioning mechanical ventilation to the outside of the facility. These failures placed all residents at risk of potential fall and injury and respiratory distress.

Findings included…

EXTERIOR
Observation on 01/23/2024 at 9:38 AM showed several items created tripping hazards on a walking path used by residents: a water hose laid across the path near the resident's smoking area; a wooden pallet, surrounded by dirt and leaves, sat on the ground in front the smoking area; a thorny vine grew across the path, and the path was littered with tree branches and pinecones. Observation on 01/25/2024 at 11:59 AM, showed the walking path remained covered with scattered tree branches and pinecones. Observation on 01/23/2024 at 9:41 AM, showed a resident ambulated with a walker along the path.

During an interview on 01/23/2024 at 9:48 AM, Staff H, Maintenance Director, stated that the debris on the walking path was due to the windstorm earlier in the month. Staff H stated that they did not clear the pathway as they were more focused on managing the generator to keep the building operational due to a power outage.

Review of the city's website showed that on 01/11/2024, the area where the facility was located experienced a power outage.

During an interview on 01/25/2024 at 9:00 AM, Staff G, Executive Director, stated that the facility lost power likely on that date. During an interview on 01/25/2024 at 12:20 PM, Staff G, Executive Director, stated the facility had no policy related to maintaining the exterior areas of the facility.

HOUSEKEEPING CLOSETS
Observation on 01/22/2024 at 1:07 PM, showed the vent in the fourth-floor housekeeping closet did not function. Observation on 01/23/2024 at 8:35 AM, showed the vent in the second-floor housekeeping closet did not function. The second-floor closet smelled like chemicals.

During interviews at the time of the observations, Staff H confirmed that the vents in the two housekeeping closets did not function to ventilate the air to the outside of the facility.

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

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

(1) The residents' characteristics and needs;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure the hazardous chemicals and a battery-powered drill in 1 of 1 maintenance office. These failures placed residents at risk for harm had they accessed and ingested the hazardous chemicals or potential injury had they attempted to use the power equipment.

Findings included…

Review of the facility's Resident Characteristic Roster showed the facility provided care and services to 12 residents with dementia, Alzheimer’s Disease, or other cognitive impairment.

Observation on 01/22/2024 at 11:23 AM of the Utility Room located on the first-floor hall showed the door was propped open with a rubber wedge. Observation showed the room contained chemical cleaning products. Observation showed there were two containers of industrial carpet cleaning and spot removal products. The warning labels indicated the products could be harmful if swallowed and caused serious eye irritation.

Observation on 01/23/2024 at 9:02 AM, showed the first-floor Utility Room door was propped open with a rubber wedge. Observation showed a battery-powered drill and a container of industrial strength drain cleaning product. The cleaning product label warned harmful if swallowed, may cause serious burns on contact, and may burn eyes, skin, and mucous membranes (tissues that secrete fluids).

Observation on 01/23/2024 at 9:28 AM, showed a wooden pallet in front of the resident's smoking area. The pallet contained two bags of ice melt, one opened and one unopened. The warning label stated rubber gloves were needed to handle the product instead of direct skin contact. The warning label stated the product was harmful if swallowed.

During an interview on 01/23/2024 at 9:02 AM, Staff H, Maintenance Director stated that the room labeled, "Utility Room" was their maintenance office. Staff H stated that they propped the door open during their shifts.

During an interview on 01/25/2024 at 12:20 PM, Staff G, Executive Director, stated that after reviewing all the facility policies, Staff G determined the facility had no policy related to the safe storage of hazardous chemicals.

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

WAC 388-78A-2970 Garbage and refuse disposal. The assisted living facility must:

(1) Provide an adequate number of garbage containers to store refuse generated by the assisted living facility:

(c) Cleaned and maintained to prevent:

(i) Entrance of insects, rodents, birds, or other pests;

(ii) Odors; and

(iii) Other nuisances.

(3) Provide for safe and sanitary collection and disposal of:

(a) Garbage and refuse;

(b) Infectious waste; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the garbage collection area was maintained in safe and clean condition. This failure placed residents at risk of a diminished quality of life, potential injury, and potential risk of illnesses from an unclean environment.

Findings included…

Observations on 01/23/2024 at 9:38 AM and 01/25/2024 at 11:57 AM, showed the garbage dumpster in exterior garbage collection area had open lids. There were used single-use gloves, wet carboard pieces, plastic flatware, plastic condiment cups, and chards of mirror glass were on the ground by the dumpster.

Observation on 01/23/2024 at 9:41 AM, showed a resident ambulated with a walker to the dumpster. The resident disposed of their bag of garbage in the dumpster.

During an interview on 01/24/2024 at 9:38 AM, Staff H, Maintenance Director, acknowledged that the ground by the dumpster was cluttered. Staff H stated that residents used the dumpster to dispose of their own garbage.

During an interview on 01/24/2024 at 11:36 AM, Resident 5, stated that facility staff collected trash from the apartments once a week. Resident 5 stated that residents were responsible to put any extra trash beyond the once weekly trash collection into the dumpster.

During an interview on 01/25/2024 at 12:20 PM, Staff G, Executive Director, stated the facility had no policy related to maintaining the garbage collection area.

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

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:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in the Negotiated Service Agreements (NSA) the care needs and interventions for 2 of 2 sampled residents (Resident 6 and Resident 7). This failure placed Resident 6 and Resident 7 at risk for unmet care needs and potential for worsening of medical condition.

Findings included…

Resident 6
Review of Resident 6's December 2023 and January 2024 eMAR (electronic medication administration record) showed Resident 6 was diagnosed with [redacted] ([redacted]). Review of the eMARs showed Resident 6 received Enteric Coated Aspirin [EC, ASA, (coating around the tablet to all the medication to pass through the stomach to the small intestine before dissolving), 81 milligrams (mg) daily, by mouth. There was no documentation on the eMARs that explained the reason for the medication.

Review of Resident 6's negotiated service plan, dated 12/03/2023, showed no documentation that Resident 6 received daily aspirin therapy. Review of the plan showed no documentation about the possible side effects from the use of aspirin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 6 exhibited any of side effects. There were no staff instructions about when to report any signs and symptoms of side effects to the nurse.

During an interview on 01/25/2024 at 1:30 PM, Staff J, Director of Nursing, stated that residents on anticoagulants and aspirin therapy needed a safety plan documented on the resident's eMAR and service plan.

Resident 7

During an interview on 01/24/2024 at 12:49 PM, Resident 7 stated that a private caregiver (PCG) helped them once a week on Fridays from 8:00 AM until 3:00 PM. Resident 7 stated that during this time, the PCG helped them to get dressed, shower and tidy the apartment. Resident 7 stated that the PCG went with them everywhere.

Review of Resident 7's negotiated service plan, dated 08/10/2023, showed the facility admitted Resident 7 on [redacted]/2022. The plan showed a diagnosis of [redacted] and [redacted]. The plan did not document any alternate plan about who provided care and services to Resident 7 when the PCG was unavailable. There was no documentation that explained the services provided by the PCG.

During an interview on 01/25/2024 at 1:45 PM, Staff J stated that they were aware no alternate plan was documented on Resident 7's service plan.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow the required state and federal regulated infection control standards in long term care facilities. These failures placed 48 of 48 residents (Resident 1 to Resident 48) at risk of contracting and spreading a potentially life-threatening disease.

Findings included…

MEDICAL TEST SITE WAIVER (MTSW)
Review of the facility records showed the facility did not have an MTSW certificate that included the clinical laboratory improvement amendments (CLIA) to meet the requirements.

Review of the facility's record showed that on 01/09/2024, the facility staff tested a resident who showed symptoms of COVID-19.

Review of the Department of Social and Health Services Dear Provider Letter (DPL) titled "Medical Test Site Waiver Regulatory Requirements", dated 08/03/2022, showed that assisted living facilities were required to have a medical test site waiver certificate to administer point-of-care COVID-19 testing and report the test results. The DPL showed the Washington State MTSW certificate meets both federal and state requirements and included both the state license and CLIA number to meet the requirements.

During an interview on 01/24/2024 at 10:45 AM, Staff G, Executive Director, stated that the facility did not have a MTSW waiver certificate. Staff G stated they were unaware a MTSW certificate was required for the facility staff to test and read results. Staff G confirmed that that the facility used point-of-care-testing (POC) that included rapid COVID-19 test for residents, as needed.

RESPIRATORY PROTECTION PROGRAM
Review of the facility's undated policy titled "Respiratory Protection Program for use by health care providers during COVID-19 Pandemic", showed that the Executive Director or their designee served as the Program Administrator. Review of the policy showed the Program Administrator maintained responsibility for oversight of the respiratory protection program. Review of the policy showed the duties of the Program Administrator included arranging and or conducting respirator fit testing. Review of the policy showed staff respiratory fit tests were repeated in accordance with State and Federal guidance. Review of the facility's RPP staff records showed June 2022 was the last respiratory fist test date.

Review of the Department of Social and Health Services Dear Provider Letter titled "Provider Responsibilities for Provisions of Personal Protective Equipment (PPE), Respiratory Protection Program (RPP), and Changes to Department of Health RPP Resources", dated 09/14/2023, showed employers were responsible to identify respiratory hazards in the workplace, provide appropriate respiratory protection equipment, and follow regulations pertaining to respiratory protection. The letter showed the end of the public health emergency (PHE) did not end the need for protection from respiratory viruses spread through droplets or air. The letter provided a link to the Occupational Safety and Health Administration (OSHA) site for respiratory protection requirements.

During an interview on 01/23/2024 at 10:46 AM, Staff G stated that they reviewed all the documents left from the facility's previous nurse. Staff G stated that they were unable to find any updates on the facility's RPP plan.

Plan/Attestation Statement

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_____ _____

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

02/15/2024

Covington ALC LLC
Vineyard Park of Covington
17016 SE Wax Rd
Covington, WA 98042

RE: Vineyard Park of Covington # 2593

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/01/2024 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-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:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

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

(vi) Emergency communication plan.

The facility failed to complete its disaster manual outline by filling in blank spaces for contacts and emergency phone numbers, duty assignments for “Advanced Preparation”, and the locations of its various disaster supplies. During the full inspection, the facility completed the disaster manual.

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