STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Sound
Keystone
3515 Woodland Park Ave N
Seattle, WA 98103

RE: Keystone License # 2599

Dear Administrator:

This letter addresses Compliance Determination(s) 47167 (Completion Date 09/16/2024) and 44546 (Completion Date 08/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/16/2024 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

The Department staff who did the on-site verification:
Lisa Hauk, Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Keystone
Provider Type: Assisted Living Facility
License/Cert.#: 2599
Compliance Determination #: 44546
Intake ID: 136220
Investigator: Lisa Hauk
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 07/23/2024 through 08/01/2024
Complainant Contact Date(s):

Allegation(s):
Named Resident 1 (NR1) and NR2 had an altercation at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 4 Closed records sample size: 1
Observations:	Residents Activities Staff to resident interactions Resident to resident interactions
Interviews:	Administration Identified resident Nursing staff Residents
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:
Interview and record review showed the ALF responded to the resident to resident altercation timely and reported the incident per regulations. The ALF separated and protected the residents, called 911 and NR1 was arrested and transported to jail. See citation for WAC 388-78A-2660(1) Resident's Rights. The ALF did not issue NR1 a discharge letter, but informed NR1 she was not allowed to return to the ALF.

Conclusion / Action:

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

☐ N/A

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2599	Compliance Determination # 44546
Plan of Correction	Keystone	Completion Date
Page 1 of 3	Licensee: Sound	08/01/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 07/23/2024 and 07/23/2024 of:

Keystone
3515 Woodland Park Ave N
Seattle, WA 98103

This document references the following complaint number(s): 136220, 139990

The following sample was selected for review during the unannounced on-site visit: 4 of 61 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer — Residential Care Services

8/1/2024 — 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.

Statement of Deficiencies	License #: 2599	Compliance Determination # 44546
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* Courtney Francis, asst. admin. - signing for Deborah Parks

Administrator (or Representative)

8/12/2024
Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide a discharge letter that included all required information, directly to 1 of 4 residents (Resident 1). This failure prevented Resident 1 and her representatives from understanding their rights related to discharge from the facility.

Findings included...

NOTE: Revised Code of Washington (RCW) RCW 70.129.110 - Disclosure, transfer, and discharge requirements. (1) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (b) The safety of individuals in the facility is endangered; (c) The health of individuals in the facility would otherwise be endangered; (d) The resident has failed to make the required payment for his or her stay; or (e) The facility ceases to operate. (2) All long-term care facilities shall fully disclose to potential residents or resident representatives the service capabilities of the facility prior to admission to the facility. If the care needs of the applicant who is Medicaid eligible are in excess of the facility's service capabilities, the department shall identify other care settings or residential care options consistent with federal law. (3) Before a long-term care facility transfers or discharges a resident, the facility must: (b) Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; (c) Record the reasons in the resident's record; and (d) Include in the notice the items described in subsection (5) of this section. (4)(a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged. (b) Notice may be made as soon as practicable before transfer or discharge when: (i) The safety of individuals in the facility would be endangered; (ii) The health of individuals in the facility would be endangered; (iii) An immediate transfer or discharge is required by the resident's urgent medical needs; or (iv) A resident has not resided in the facility for thirty days. (5) The written notice specified in subsection (3) of this section must include the following: (a) The reason for transfer or discharge; (b) The effective date of transfer or discharge; (c) The location to which the resident is transferred or discharged; (d) The name, address, and telephone number of the state long-term care ombuds; (f) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the protection and advocacy for mentally ill individuals act.

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Record review of the ALF's Involuntary Move-outs/Administrative Hearing policy, dated 11/06/2023, showed that if a person served was asked to move from the facility, the facility would provide written notification to the person served, the person's legal representative, and case manager. If there is no legal representative, a copy of the notice to move-out will be sent to the State Long-Term Care Ombuds.

Record review showed the ALF admitted Resident 1 on [redacted]/2024 with [redacted] diagnoses. An admission assessment, dated [redacted]/2024, showed that Resident 1 was independent with Activities of Daily Living (a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.), and had auditory and visual hallucinations.

Review of a Progress Note (PN), dated [redacted]/2024, showed Resident 1 became angry and assaulted another resident at the facility and 911 was called. Review of a PN, dated [redacted]/2024, showed police arrived at the ALF the next day and arrested Resident 1.

In interview, on 07/23/2024 at 1:22 PM, Staff A (Residential Supervisor) said that Resident 1 was in jail. Staff A stated to ensure the safety of the other residents, Resident 1 was being immediately discharged.

On 07/29/2024 at 10:07 AM, when asked if the ALF issued Resident 1 a discharge letter, Staff A confirmed a written discharge letter was not provided to Resident 1.

This citation previously cited on 03/01/2022.

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, Keystone is or will be in compliance with this law and / or regulation on (Date) 8/30/2024 .

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

Administrator (or Representative) Deborah Pauley Date 8-9-2024