STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Greenlake Management Lacey, LLC
Memory Care At The Lodges
4441 W. Airport FWY Ste 160
Irving, TX 75062

RE: Memory Care At The Lodges License # 2600

Dear Administrator:

This letter addresses Compliance Determination(s) 26485 (Completion Date 07/13/2023) and 21839 (Completion Date 04/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/13/2023 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-2120, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2130, WAC 388-78A-2130-5, WAC 388-78A-2130-5-a, WAC 388-78A-2130-5-b, WAC 388-78A-2130-5-c, WAC 388-78A-2130-5-d, WAC 388-78A-2130-5-e, WAC 388-78A-2130-6, WAC 388-78A-2130-6-a, WAC 388-78A-2130-6-a-i, WAC 388-78A-2130-6-a-ii, WAC 388-78A-2130-6-b, WAC 388-78A-2140, WAC 388-78A-2140-1, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-d, WAC 388-78A-2150, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2240, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-2, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2640, WAC 388-78A-2640-1, WAC 388-78A-2640-1-a, WAC 388-78A-2640-3, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2480, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2305-2, WAC 388-78A-2700, WAC 388-78A-2700-1-g, WAC 388-78A-2700-1-g-i, WAC 388-78A-2665, WAC 388-78A-2665-6, WAC 388-78A-2320-3, WAC 388-78A-2320-3-a, WAC 388-78A-2320-3-b, WAC 388-78A-2320-3-c, WAC 388-78A-2320-3-d, WAC 388-78A-2320-3-e, WAC 388-78A-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2, WAC 388-78A-2320-2-a, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-c, WAC 388-78A-2320-2-d, WAC 388-78A-2320-2-e, WAC 388-78A-2320-2-f, WAC 388-78A-3090, WAC 388-78A-3090-1, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-

3090-1-c, WAC 388-78A-2930-1-a, WAC 388-78A-2930-1-a-i, WAC 388-78A-2930-1-a-iii, WAC 388-78A-2610, WAC 388-78A-2610-1, WAC 388-78A-2610-2, WAC 388-78A-2610-2-a, WAC 388-78A-2610-2-b, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-d, WAC 388-78A-2610-2-e, WAC 388-78A-2610-2-f, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-d

The Department staff who did the on-site verification:
Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2600	Compliance Determination # 21839
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 1 of 39	Licensee: Greenlake Management Lacey, LLC	04/27/2023

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 03/28/2023, 04/11/2023, and 04/17/2023 of:
Memory Care At The Lodges
1530 Carpenter Rd SE
Lacey, WA 98503

This document references the following SOD dated: 04/27/2023

The following sample was selected for review during the unannounced on-site visit: 6 of 61 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Cory Cisneros, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

05/10/2023
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.

Yvonne King-Lee
Administrator (or Representative)

5-24-2023
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor residents' well-being and take appropriate actions for 2 of 6 sampled residents (Resident 7 and Resident 14). This failure placed Resident 14, Resident 7, and all other residents at risk for unmet care needs and potential lack of response for decline in residents' condition.

Findings included...

Record review of the facility policy and procedure, titled, "alert charting", dated 08/10/2021, showed alert charting would be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Alert charting procedures would be initiated if a resident exhibited a change in condition, had fallen, exhibited a change in the resident's expected or customary pattern in physical, emotional, behavioral, or mental function. The facility's alert charting process included that the resident would be placed on alert charting and monitored for at least 48 hours following the initiation of the alert charting. There was to be an alert charting entry in the residents record each shift.

Resident 14 (R14)

Record review of Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R14 admitted to the facility on [redacted]/2021.

Record review of the face sheet for R14 showed, they had a medical diagnosis of [redacted]

Record review of the document titled, Care Plan Assessment, dated 03/02/2023, Memory and Orientation section showed R14 had severe memory impairments. Under the section titled, "Falls", showed R14 wore their shoes incorrectly and that increased their risk for falls. Staff were to ensure R14's shoes were on properly and perform safety checks. Under the section titled, "Significant Behaviors", showed R14 wandered throughout the Lodges (two separate buildings connected with a courtyard and the buildings are referred to as Lodges) both daytime and evening. Staff were to re-direct R14 back into the building if they were exit seeking (trying to leave the building).

In an observation on 03/28/2023 at 5:07 PM, R14 was wandering around outside in the gated courtyard without any shoes. R14 paced back and forth between Lodge 1 and the back side of Lodge 2. R14 stumbled onto the fence of Lodge 2 and used the fence to balance himself. Staff U, Medication Technician, exited Lodge 2 at 5:09 PM. R14 had gone up an inclined part of the yard near the fence of Lodge 1. R14 lost their balance causing them to fall toward the ground. R14 then hit their head on the fence and again on the ground. Staff U helped R14 up from the ground. Staff U was observed to push R14's hair away from their forehead to check for injury. Staff U walked with R14 inside of Lodge 2 and asked Staff CC, Cook, to sit with R14. R14 was restless and would not remain seated. R14 continued to pace throughout the hallway.

In an interview on 03/28/2023 at 5:15 PM, Staff CC, stated it was R14's baseline to pace back and forth throughout the facility.

In an interview on 03/29/2023 at 8:15 AM, Staff C, Medication Technician, stated that during the verbal shift exchange there were not any incidents that were reported from the night prior. Staff C stated there were not any reported falls from evening shift on 03/28/2023.

Record review of R14's Alert Charting log, on 03/29/2023 showed no record that R14 was placed on alert after the fall that took place on 03/28/2023.

Record review of a Charting Note, dated 03/28/2023 at 10:19 PM, showed Staff AA, Medication Technician, charted that R14 did not have any discomfort or pain. R14 was up walking and running around in and out of lodge 1 and 2. Staff U did not mention R14's fall that took place on 03/28/2023. The charting note did not document that R14 was placed on alert charting and monitoring related to their fall.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director, was unaware of R14's fall that took place the day prior on 03/28/2023.

Resident 7 (R7)

Record review of the document titled, Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R7 moved into the facility on [redacted]/2022.

Record review of the face sheet for R7 showed they had multiple medical diagnoses including [redacted]

[redacted] and [redacted]

Record review of the document titled, Care Plan and Assessment for R7, dated 02/28/2023, showed under the section titled, "Gastrointestinal", staff were to monitor R7 for pocketing food (holding food in their mouth without swallowing), and spitting food out. Staff were to downgrade (change) R7's diet as needed and were to notify the licensed nurse and Advanced Registered Nurse Practitioner of any diet downgrades or concerns.

Record review of a charting note, dated 03/15/2023 at 5:59 AM, showed that R7 was up most of the night vomiting (throwing up) and had loose bowel movements. Resident 7 was on alert due to vomiting and loose stools.

Record review of the charting notes, dated 03/16/2023 through 03/28/2023, showed there were no other alert charting notes to show R7 was monitored for recent loose bowel movements and vomiting episodes.

In an interview on 03/29/2023 at 8:15 AM, Staff C, Medication Technician, stated that any resident that had a fall, change in condition, vomiting and loose bowel movement would be monitored and placed on alert charting with daily chart notes on the resident's condition.

This is an uncorrected deficiency previously cited on 01/10/2023 and recurring deficiency previously cited 08/05/2022.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023

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

Yvonne Hing-Hee — Administrator (or Representative)

5-24-2023 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

(e) Staff designated by the assisted living facility.

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to involve the resident or resident's responsible party in the process of updating a Negotiated Service Agreement (NSA) for 3 of 6 sampled residents (Resident 11, Resident 13, and Resident 14). This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included...

Record review of the facility's policy, titled "Resident Assessment and Negotiated Service Agreement", dated 08/10/2022, under section 11 showed, "the wellness director ensures the negotiated service agreement is signed and dated by the community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party."

Resident 11 (R11)

Record review of R11's Care Plan Assessment (NSA), dated 01/20/2023, showed it was not signed by the resident, the resident's responsible party, or facility Staff members.

In an interview on 04/06/2023 at 1:05 PM, Collateral Contact 3 (CC3), Durable Power of Attorney, stated that they hadn't signed any documents since R11 moved into the facility in [redacted] 2022. CC3 stated that they were not given a copy of the care plan, were not asked to review the care plan, and was not requested to sign the Care Plan Assessment that was dated for 01/20/2023. CC3 stated they were unaware that a new Care Plan Assessment had been completed. CC3 stated they have been asking to see what care and services were being provided and charged for R11 but had not been provided a copy of the care plan.

Resident 13 (R13)

Record review of R13's Care Plan Assessment, dated 03/02/2023, showed it was not signed by the resident, the resident's responsible party, or facility Staff members.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director, stated R13's Care Plan Assessment dated for 03/02/2023 was not signed by Collateral Contact 2 (CC2), R13's representative because they had experienced health issues and were not responsive to the facility calls.

Record review of R13's progress notes showed no documented attempts from staff to contact CC2.

In an interview on 03/29/2023 at 12:25 PM, CC2, stated they had not attended a care conference for R13's Care Plan Assessment dated for 03/02/2023. CC2 stated the facility did not ask CC2 to sign R13's Care Plan Assessment. CC2 stated they were at the facility on 03/27/2023 to have a meeting with Staff I, Business Office Manager (BOM), regarding R13's finances but was not asked to review or sign R13's care plan.

In an interview on 03/29/2023 at 12:42 PM, Staff I, stated CC2 was at the facility on 03/27/2023 to discuss R13's finances.

Resident 14 (R14)

Record review of R14's Care Plan Assessment dated 03/02/2023, showed it was not signed by the resident, the resident's responsible party, or facility Staff members.

In an interview on 04/11/2023 at 1:26 PM, Collateral Contact 5 (CC5), Durable Power of Attorney, stated they did not attend a care conference for R14's Care Plan Assessment dated for 03/02/2023. CC5 stated the facility sent a copy of R14's Care Plan Assessment via email and requested CC5 to sign it. CC5 stated they did not sign the document because R14's name was misspelled. CC5 stated they informed Staff A, that R14's name was misspelled. CC5 stated they received another copy of the Care Plan Assessment with R14's name still being misspelled therefore CC5 was not going to sign it.

This is an uncorrected deficiency previously cited on 01/10/2023 for subsections (5)(a)(b)(e) (6)(a)(i)(ii)(b).

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Yvonne Hinz-Hill — Administrator (or Representative)

5-24-2023 — 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:

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

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.

(d) The plan to provide necessary health support services, if provided by the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Negotiated Service Agreements (NSA) the plan to provide necessary health support services from outside providers and specific resident identified care and services needs for 3 of 6 residents (Resident 7, Resident 13, and Resident 14). Failure to develop a complete NSA placed these residents at risk for unmet care and services.

Findings included...

Resident 7 (R7)

Record review of Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R7 admitted to the facility on [redacted]/2022 and received nurse delegated services.

Record review of a face sheet for R7 showed they had multiple medical diagnoses including [redacted] and [redacted]

Record review of the document titled, Physician Communication, dated 12/04/2022, showed R7 was on a puree diet (foods that were blended and don't need to be chewed).

In an observation on 03/29/2023 at 8:20 AM, Staff P, Activity Director, was assisting R7 with eating. The food that R7 had been served was pureed.

Record review of R7's Care Plan/Assessment (facility version of the negotiated service plan), dated 02/28/2023, under section titled "Oral", showed that R7's diet was to be downgraded (changed) to mechanical soft (food that is soft and easy to eat without biting

or chewing) to decrease choking episodes. There care plan did not show that R7 needed assisting with eating and that their current diet was puree. R7's Care plan did not show what nurse delegated services the resident required.

Resident 13 (R13)

Record review of the document titled, Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R13 admitted to the facility on [redacted]/2021.

Record review of the Personal Information Face sheet, undated, showed R13 had a medical diagnosis of [redacted]

Record review of an Outpatient Referral Form for R13, dated 11/02/2022, showed a referral to Home Health which was electronically signed by R13's physician.

Record review of R13's Personal Information Face sheet, undated, showed no information regarding R13's home health services. There was no information regarding what home health clinic is utilized, their address, phone number, fax number, and email address. The Personal Information Face sheet did not indicate when and how often R13 received services.

Record review of the document, Negotiated Service Agreement, dated 03/02/2023, under the section tilted, "Toileting", showed R13 had a foley catheter and home health was to manage the catheter. The Care Plan Assessment did not include the home health providers contact information such as their name, address, phone number, fax number, and email address. The Care Plan Assessment did not indicate when and how often R13 received home health services.

In an interview on 03/29/2023 at 12:25 PM, Collateral Contact 2 (CC2), R13's Responsible Party, stated R13 was on home health services. CC2 was unsure of the name of the home health provider or how often they come to the facility to provide services for R13.

In an interview on 03/29/2023 at 1:31 PM, Staff A, Executive Director stated home health should provide R13 services bi-weekly.

Resident 14 (R14)

Record review of the Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R14 admitted to the facility on [redacted]/2021.

Record review of the Personal Information Face sheet, undated, showed R14 had a medical diagnosis of [redacted]

In an interview on 03/11/2023 at 1:26 PM with Collateral Contact 5, Durable Power of Attorney for R14, stated R14 was on hospice services.

Record review of R14's Personal Information Face sheet, undated, showed no information regarding R14's hospice services. There was no information regarding what hospice service was utilized, their name, address, phone number, fax number, and email address. The

Personal Information Face sheet did not indicate when and how often R14 received hospice services.

Record review R14 s Negotiated Service Agreement, dated 03/02/2023, showed no information regarding R14's hospice services. There was no information regarding what hospice service was utilized, their address, phone number, fax number, and email address. The Preference and Choices Assessment did not indicate when and how often R14 received hospice services.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Administrator (or Representative) — Date: 5-24-2023

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the Negotiated Service Agreement (NSA) for 5 of 6 sampled residents (Resident 11, Resident 7, Resident 12, Resident 13, and Resident 14) were agreed to and signed at least annually by the resident, resident s representative, and representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included...

Record review of the facility's policy "Resident Assessment and Negotiated Service Agreement", dated 08/10/2022, showed, "the assisted listing facility must involve each resident or prospective resident, to extent possible, along with any appropriate resident representative to the extent he or she is willing and capable, in the preadmission assessment and on-going assessment process. Under section 11 showed, "the wellness director ensures the negotiated service agreement is signed and dated by the community.

representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party."

Resident 11 (R11)

Record review of R11's Care Plan/Assessment (the facility's version of the Negotiated Service Agreement (NSA)), dated 01/20/2023, showed the document was not signed by the resident, the resident's responsible party, or facility staff members.

In an interview on 04/06/2023 at 1:05 PM, Collateral Contact 3 (CC3), Durable Power of Attorney for R11, stated that they hadn't signed any documents since R11 moved into the facility in [redacted] 2022. CC3 stated that they were not given a copy of the care plan, were not asked to review the care plan, and was not requested to sign the Care Plan Assessment that was dated for 01/20/2023. CC3 stated they were unaware that a new Care Plan Assessment had been completed. CC3 stated they had been asking to see what care and services were being provided and charged for R11, but no documentation was provided by the facility.

Resident 7 (R7)

Record review of R7's Care Plan/Assessment, dated 02/28/2023, showed the document was not signed by the resident, the resident's responsible party, or facility Staff members.

Resident 12 (R12)
Record review of R12's Care Plan/Assessment, dated 03/15/2023, showed the document was not signed by the resident, the resident's responsible party, or facility Staff members.

In an interview on 03/30/2023 at 9:14 AM, Collateral Contact 1 (CC1), Emergency Contact, stated they did not sign a care plan for R12.

Resident 13 (R13)

Record review of R13's Care Plan/Assessment, dated for 03/02/2023, showed the document was not signed by the resident, the resident's responsible party, or facility staff members.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director stated R13's Care Plan/ Assessment, dated for 03/02/2023 was not signed by Collateral Contact 2 (CC2), R13's responsible party, because CC2 had been experiencing health issues and had not been responsive to facility calls.

In an interview on 03/29/2023 at 12:25 PM, CC2, stated they had not attended a care conference for R13 Care Plan/Assessment dated 03/02/2023. CC2 stated the facility did not ask CC2 to sign R13's Care Plan Assessment.

Resident 14 (R14)

Record review of R14's Care Plan/Assessment, dated 03/02/2023, showed the document was not signed by the resident, the resident's responsible party, or facility Staff members.

In an interview on 04/11/2023 at 1:26 PM, Collateral Contact 5 (CC5), Durable Power of Attorney stated the facility sent a copy of R14's Care Plan/Assessment, dated 03/02/2023, via email and requested CC5 to sign it. CC5 stated they did not sign the document because R14's name was misspelled. CC5 stated they informed Staff A, Executive Director, that R14's name was misspelled. CC5 stated they received another copy of the Care Plan/Assessment with R14's name still being misspelled.

In an interview on 03/28/2023 at 10:28 AM, Staff A, stated they had not had a chance to go over every resident's annual Care Plan/Assessment. Staff A stated some resident's responsible party's were out of the country and others had not responded to Staff A's attempt to have a care conference. Staff A was requested to provide documentation that the facility attempted to contact resident representatives for care conferences and Staff A was unable to provide documentation.

In an interview on 03/28/2023 at 3:52 PM, Staff E, Resident Care Coordinator (RCC), stated Staff HH, Health Service Director (HSD) was responsible for following up on resident care plans. Staff E stated that the resident's responsible party should have signed the Care Plans/Assessments.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Administrator (or Representative) — Date: 5-24-2023

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 6 sampled resident's (Resident 12) prescribed medication was obtained in a correct and timely manner. This failure resulted in Resident 12 not receiving medications as prescribed and placed the resident at risk for medical complications.

Findings included...

Record review of the facility policy, titled, "Medication refills", dated 08/10/2021, showed that "medication refills will be obtained in a timely manner to ensure resident have all physician ordered medication available. Medication technician on duty was to contact pharmacy to obtain a refill at least seven days prior to running out of a medication. Medications are never allowed to run out unless directed to by the physician. When there is any delay in the receipt of the medications that results in the unavailability of the medication to be given, the Wellness director is notified."

Record review of the facility policy, titled, "Missed or refused medication", dated 08/10/2021, showed "No resident can be forced to take any medications. Steps will be taken to avoid missed or refused doses of medications and related adverse reactions." Under procedures, it showed "the prescribing physician is notified of missed medications immediately or in the time frame and according to the parameters as indicated by the physician. The responsible party is notified."

Resident 12 (R12)

Record review of Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R12 admitted to the facility on [redacted]/2023.

Record review of R12's Personal Information Face sheet, undated, showed R12 had a diagnosis of [redacted]

Record review of R12's Care Plan Assessment, dated 03/15/2023, under the section titled, "Self-Medication/Administration", showed R12 had a history of forgetting to take their medications and did not know what medications they take or when they need to take the medications. Staff were to administer R12 their medications as prescribed by their providers. Staff were to ensure medications were ordered and received in a timely manner. Under the section titled, "Pharmacy choice", showed Medication Technicians were to notify the provider when refills of medications were needed to prevent R12 from running out of their medications.

Record review of March Medication Administration Record (MAR) 2023, showed R12 did not take their Cal-Cit/Vit D3 315MG/200IU Tab (Calcium Citrate-Vitamin D3 315 milligrams/200 international unit tablet) from 03/17/2023 – 03/28/2023 as it was "waiting medication delivery".

Record review of a Discharge Medication List for Assisted Living Facility Transfers, dated [redacted]/2023, showed that R12 was prescribed lidocaine (pain relief) 5% patch on 03/17/2023. Details stated "Place 1 to 3 patches onto the skin daily. Apply for 12 hours, then remove for 12 hours."

Record review of Charting Notes, dated 03/23/2023 at 9:13 PM, showed Staff JJ, Medication Technician contacted the pharmacy about R12's missing medications. The lidocaine patches (pain patch) were not covered by the insurance and Staff JJ would contact R12's POA (Power of Attorney) about finances.

In an interview on 03/28/2023 at 3:47 PM, Staff JJ, called the pharmacy regarding R12's missing medications. Staff JJ stated they had not faxed R12's doctor about the missing medication. Staff JJ stated they had not contacted R12's POA regarding the missing medications.

In an interview on 03/28/2023 at 3:52 PM, Staff E, Resident Care Coordinator/Medication Technician, stated R12 had an order to receive lidocaine treatments 1-3 times daily starting on 03/20/2023. Staff E stated R12's insurance had not covered the lidocaine patch prescription because the order exceeded over $500.00. Staff E stated they had not contacted R12's POA regarding the missing medications. Staff E stated R12's representative would be in the facility later tonight on 03/28/2023 and they would talk to them then about the insurance not covering the medication.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director, stated if a resident's medication was out then the medication technician would fax the pharmacy three days in a row in attempt to obtain the medication. If the pharmacy stated they need a new order then the medication technician would reach out to the residents Primary Care Provider (PCP). If the pharmacy stated it was a financial issue, then the medication technician would reach out to the POA for how they would like to proceed. Staff A stated it should not take a week to get the medication issue resolved. Staff A stated the facility should get a response from the pharmacy within 24 hours. Staff A stated the Medication Technician should reach out to the residents PCP immediately if the prescription was out.

In an interview on 03/30/2023 at 9:17 AM, Collateral Contact 1 (CC1), R12's POA, stated they had not been contacted by the facility staff regarding R12's missing vitamin and lidocaine patch. CC1 stated they were at the facility on 03/28/2023 to pick up R12 and the Staff E did not mention anything about R12's missing medication.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Yvonne Ding-Lee
Administrator (or Representative)

5-24-2023
Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs - Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were administered their medications as ordered for 1 of 1 sampled diabetic (inability to regulate blood sugar levels) resident (Resident 1). The failure to ensure medications were administered as ordered caused harm to Resident 1 with an injury and placed other diabetic residents at risk for injury, rapid absorption of the medication, instability of blood sugars, and possible risk for hospitalization.

Findings included...

Record review of a Cleveland Clinic document, titled, "insulin pen injections", dated 08/08/2018, showed "an insulin pen is an injection device with a needle that delivers insulin into the subcutaneous tissue (the tissue between your skin and muscle)." Under the section titled, "where on the body do I inject with the insulin pen?", showed "recommended injection sites include the abdomen, front and side of the thighs, upper and outer arms and buttocks." Record review of Cleveland Clinic website article, titled, "Insulin Pen Injections", dated 08/08/2018, showed that the insulin pen needle was to be injected into the skin at a 90-degree angle.

Record review of a Medline Plus document, titled, "Human insulin injection", dated 10/15/2019, showed "do not inject human insulin into muscles, scars, or moles."

Record review of Healthline document, titled, "insulin injection sites: where and how to inject", dated 08/31/2021, showed that if the insulin was injected into the muscle, the body would absorb it too quickly. The insulin might not last as long within the body. This could lead to low blood sugar levels. The injection is usually more painful.

Record review of the facility's policy and procedure, titled, "Specific medication administration procedures", undated, showed under the section IIB16: "Subcutaneous medication administration; purpose: to administer a parenteral medication into the

subcutaneous tissue in order to promote slow medication absorptions and prolong medication action." The policy showed the documented sites of injection on the MAR (Medication Administration Report) included the sites, left buttock (LB), right buttock (RB), left arm (LA), right arm (RA), left thigh (LT), right thigh (RT), left abdomen (LS), and right abdomen (RS).

Resident 1 (R1)

Record review of a face sheet for R1 showed they moved into the facility on [redacted]/2019 with multiple medical diagnoses including [redacted] and [redacted]

Record review of R1's Care Plan, dated 02/21/2022, showed R1 was able to communicate their needs. They were able to understand their peers and Staff members. R1 was unable to manage their own medication administration. Medication technicians were to administer medications for R1.

Record review of R1's Medication Administration Record, dated March 2023, showed they had an order for Lantus insulin (long-acting insulin) to be injected subcutaneously every day. Review of the last page of the MAR showed "body location site key", showed "LD" was left deltoid (upper arm muscle) and "RD" was right deltoid. The MAR showed Lantus (long-acting insulin) insulin was administered in both deltoids for 8 of 29 days.

In an interview on 04/07/2023 at 9:09 AM, Staff F, Medication Technician, stated that they administered R1's insulin in the muscle on the upper arm.

In an interview on 04/07/2023 at 11:01 AM, Collateral Contact 6, Registered Nurse Delegator, stated that Staff F had not been trained and approved to administer nurse delegated tasks for all of the residents in the facility.

In an interview and observation on 04/11/2023 at 2:33 PM, R1 stated that the medication technicians administer their insulin in their arm and pointed to the upper deltoid arm area. Observation showed R1's left upper arm area was noted to have a red pinpoint dot with yellow bruising to the middle of the upper deltoid arm area. R1 stated that the yellow area was from their insulin injection.

This is an incorrected deficiency previously cited on 01/10/2023

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Shaunna King-Lee
Administrator (or Representative)

5-24-2023
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation, or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to investigate and document actions and findings for accidents, or incidents jeopardizing residents' health for 1 of 6 sampled residents (Resident 14). This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the resident during the course of the investigation.

Findings included:

Resident 14 (R14)

Record review of the facility Resident Characteristic Roster, undated, showed R14 admitted to the facility on [redacted]/2021.

Record review of the face sheet for R14 showed they had a medical diagnosis of [redacted]

Record review of R14's Care Plan Assessment, dated 03/02/2023, under the section titled, "Memory and Orientation", showed R14 had severe memory impairments. Under the section titled, "Falls", showed R14 would put their shoes on incorrectly and was at an increased risk for falls. Staff were to ensure R14's shoes were on properly and perform safety checks. Under the section titled, "Significant Behaviors wandering", showed R14 wandered throughout the Lodges (two separate buildings connected with a courtyard and the buildings are referred to as Lodges) both daytime and evening. Staff were to re-direct R14 back into the building if they were exit seeking (trying to leave the building).

In an observation on 03/28/2023 at 5:07 PM, R14 was wandering outside in the gated courtyard without shoes on. R14 paced back and forth between Lodge 1 and the back side of Lodge 2. R14 had gone up an inclined part of the yard. They then stumbled onto the fence of Lodge 2 and used the fence to regain their balance. Staff U, Medication Technician, exited Lodge 2 at 5:09 PM. R14 went up an inclined area of the yard near the fence of Lodge 1. R14 was observed to fall and hit their face on the fence and ground. Staff U helped R14 up. Staff U was observed to push R14's hair away from their forehead. Staff U walked with R14 inside of Lodge 2. Staff CC, Cook, was asked to sit with R14. R14 was restless and would not remain seated and continued to pace throughout the hallway. Staff CC and Staff V, Caregiver, attempted to encourage R14 to sit.

In an interview on 03/29/2023 at 8:15 AM, Staff C, Medication Technician, stated that during the verbal shift exchange that morning at 7 AM there were not any incidents that were reported from the night or evening prior. Staff C stated there were no reported falls.

Record review on 03/29/2023, Alert Charting log, showed no record that R14 was placed on alert from the fall that took place on 03/28/2023.

Record review on 03/29/2023, Incident Investigations showed there was not an investigation initiated for R14's fall that took place on 03/28/2023.

Record review of Charting Notes for R14, showed Staff U, Medication Technician charted on 03/28/2023 at 10:19 PM that R14 did not have any discomfort or pain. R14 was up walking and running around in and out of lodge 1 and 2. Staff U did not reference R14's fall that took place on 03/28/2023. The charting note did not indicate R14's POA or PCP were notified of the fall.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director, was unaware of R14's fall that had taken place the day prior on 03/28/2023.

In an interview on 04/11/2023 at 1:26 PM, Collateral Contact 5, R14's Power of Attorney, stated they were never informed that R14 had a fall outside on 03/28/2023.

This is an uncorrected deficiency that was previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Yaroslava Kipa-Kel — Administrator (or Representative)

5-24-2023 — Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to consult with the resident's representative, and the resident's physician as soon as possible when 2 of 6 sampled residents (Resident 13 and Resident 14) had a significant change in their medical condition. This failure to inform and consult with the residents' representative, or physicians placed the resident at risk for not having their resident representative involved in their care.

Findings included:.

Record review of the facility's "change in resident status" policy, dated 08/10/2022, under the section, "reporting significant change in a resident's condition", showed that "the assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever: a) there is a significant change in the resident's condition, the resident is relocated to a hospital or other health care facility. "

Record review of the facility's policy "internal incident report and state incident report", dated 08/10/2022, under Step 4 showed incident reports were to be reported immediately to the residents' family/responsible party and physician and to document the date and time the report was made to the family/responsible party and physician in the narrative charting section.

Resident 13 (R13)

Record review of the facility Resident Characteristic Roster, undated, showed R13 admitted to the facility on [redacted]/2021.

Record review of the Personal Information Face sheet, undated, showed R13 had a medical diagnosis of [redacted]

Record review of R13's Care Plan/Assessment (the facilities version of the Negotiated Service Agreement), dated 03/02/2023, under the section titled, "Recent Medical History and Significant Symptoms", showed R13 had a foley catheter. Under the section titled, "Memory and Orientation", showed R13 had mild memory impairment to both short and long term memory. Under the section titled, "Family Involvement", showed R13 had a family member appointed as their Power of Attorney.

Record review of the Charting Notes, dated 03/20/2023 at 1:35 AM, showed Staff AA, Medication Technician, charted R13 complained of pain and inability to urinate. The ambulance came and picked R13 up.

Record review of the Charting Notes, dated 03/20/2023 at 7:44 AM, showed Staff AA, Medication Technician, charted R13 returned to the facility later that day. The charting notes did not indicate facility staff called R13's responsible party.

Record review of the Charting Notes, dated 03/25/2023 at 9:09 PM, showed Staff JJ, Medication Technician, charted R13 complained of pain and inability to urinate. Charting notes indicated "All persons were notified."

Record review of Charting Notes, dated 03/26/2023 at 1:28 AM, showed Staff NN, Medication Technician, charted R13 returned to the facility on 03/26/2023 around 1:20 AM.

In an interview on 03/29/2023 at 12:25 PM, Collateral Contact 2 (CC2), R13's responsible party, stated the hospital called them last weekend and informed them R13 had been discharged again. CC2 stated the last time the resident was at the hospital no one from the facility called them. CC2 reiterated that they learned R13 was being discharged from the hospital staff and not the facility staff. CC2 stated this was not the first time they had learned R13 was in the hospital from hospital staff.

Resident 14 (R14)

Record review of Resident Characteristic Roster, undated, showed R14 admitted to the facility on [redacted]/2021.

Record review of the face sheet for R14 showed they had a medical diagnosis of [redacted].

Record review of R14's Care Plan/Assessment, dated 03/02/2023, under the section titled, "Memory and Orientation", showed R14 had severe memory impairments. Under the section titled, "Falls", showed R14 would put their shoes on incorrectly causing them to be at an increased risk for falls. Staff were to ensure R14's shoes were on properly and perform safety checks. Under the section titled, "Significant Behaviors wandering", showed R14 wandered throughout the lodges (two separate buildings connected with a courtyard and the buildings are referred to as Lodges) both daytime and evening. Staff were to re-direct R14 if they were exit seeking.

In an observation on 03/28/2023 at 5:07 PM, R14 had wandered outside in the gated courtyard without shoes on. R14 paced back and forth between Lodge 1 and the back side of Lodge 2. R14 stumbled onto the fence of Lodge 2 and used the fence to regain their balance. Staff U, Medication Technician, exited Lodge 2 at 5:09 PM. R14 went up an inclined part of the yard near the fence of Lodge 1. R14 was observed to fall and hit their face on the ground. Staff U witnessed the fall and helped R14 up from the ground. Staff U was observed to pull away R14's hair from their forehead. Staff U walked with R14 inside of Lodge 2.

Record review of Charting Notes, dated 03/28/2023 at 10:19 PM, showed Staff U, Medication Technician, charted that R14 did not have any discomfort or pain. R14 was up walking and running around in and out of Lodge 1 and 2. Staff U did not reference R14's fall that took place on 03/28/2023. Charting notes did not indicate R14's Power of attorney (POA) or primary care provider (PCP) were notified of the fall that took place on 03/28/2023.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director, was unaware of R14's fall that took place on 03/28/2023.

In an interview on 04/11/2023 at 1:26 PM, Collateral Contact 5, R14's Power of Attorney, stated they were never informed that R14 had a fall outside on 03/28/2023.

This is an uncorrected deficiency previously cited on 01/10/2023 and a recurring citation previously cited on 08/25/2022.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6/02025

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

Roseanne King-Kee — Administrator (or Representative)

5-24-2023 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 6 sampled Staff (Staff A) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within three days of hire. This failure placed 61 of 61 residents and 36 staff at risk for exposure to TB.

Finding included:

Record review of Centers for Disease Control and Prevention (CDC) website, titled, "TB screening and Testing of Health Care Personnel", updated 08/30/2022, showed "All U.S. (United States) health care personnel should be screened for TB upon hire..."

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of Staff A, Executive Director, records showed they were hired on 09/19/2022. There was no documentation that Staff A had received their TB test within three days of hire.

Record review of Staff A's LabCorp QuantiFERON TB Gold test (blood test that aides in detection of tuberculosis), showed a specimen was collected on 06/05/2018 and date reported was on 06/09/2018.

In an interview on 03/29/2023 at 8:56 AM, Staff A stated they did not complete a TB test within 3 days of hire.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-16-2023

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

Administrator (or Representative) 5-24-2023 Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff received their food handlers training for 1 of 6 staff (Staff EE) records reviewed. This failure placed 61 of 61 residents at risk for receiving food that was incorrectly handled by an unqualified staff.

Findings included...

WAC 246-217-015 (1)
"(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

WAC 246-217-025 (1)(8)(9)
"(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant

must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee.

(8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials."

WAC 246-217-035 (1) (5)(c)
"(1) All initial cards are valid for two years from the date of issuance.
(5) The card shall be approximately three inches by five inches in size and contain the following information: (c) Printed (or typed written) name and signature of the food service worker;"

Record review of the facility's Plan of Correction, dated 02/06/2023 showed the Business Office Manager would refer to the staff matrix and ensure that all staff members had received their food handler's certification. The plan of correction stated this would be achieved by 02/04/2023.

Record review of Staff EE, Cook, Washington State Food Worker Card on 03/28/2023 at 1:40 PM, showed a signed expired Food Worker Card. The card was valid from 10/12/2020 - 10/11/2022.

Record Review of Staff EE records showed a new unsigned Washington State Food Worker Card for Staff E completed on 03/28/2023.

In an interview on 03/29/2023 at 10:00 AM, with Staff I, Business Office Manager, stated Staff EE's Food Worker Card expired in October 2022. Staff I stated Staff EE re-did the test but then lost the new Food Worker Card. Staff I stated they are unable to verify when Staff EE completed the food handler test. Staff I stated Staff D, Food Service Director, failed to follow up and make sure Staff EE completed the Washington State Food Worker Card.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6/10/2023

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

Yvonne King-Bell
Administrator (or Representative)

5-24-2023
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:

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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure all facility staff were trained on the facility's Emergency Preparedness Policy and Procedures. Failure to ensure staff were appropriately trained on what to do in an emergency placed 61 of 61 residents and 36 staff at risk for a delayed response in an emergency, which could lead to injury or death.

Findings included...

Review of the facility s Emergency Preparedness evacuation manual, revised October 2022 showed, "know the location of fire door in your area." The emergency preparedness evacuation manual showed to evacuate to the nearest point of safety and included a map of the facility's fire evacuation route. The emergency evacuation map was not included in the manual. The evacuation procedure showed "Resident evacuation – Ambulatory residents to dining room/parking lot." The evacuation manual did not indicate where non ambulatory residents were to evacuate or how to do so.

Record review of the facilities Plan of Correction, dated 02/06/2023, showed "Two in-services will be scheduled and all employees must attend one or the other. Emergency preparedness will be in-serviced to all Staff members with regards to how to handle emergencies, whom to notify, and who is responsible for each action" The Plan of Correction showed it would have been completed by 03/10/2023.

In an interview on 03/28/2023 at 3:43 PM, Staff LL, Caregiver, stated if there was an emergency where residents and staff needed to evacuate, they would evacuate to the outside driveway.

In an interview on 03/28/2023 at 3:47 PM, Staff JJ, Medication Technician, stated if residents and staff needed to evacuate the emergency location would vary. Staff JJ stated if there was a fire in Cottage 1 staff would evacuate the residents and Staff into Cottage 2. Staff JJ stated if needed they would evacuate the residents and staff to the front of the building or the back of the building. Staff JJ stated they had not participated in any emergency preparedness training since they were hired in February 2023.

In an interview on 03/28/2023 at 3:52 PM, Staff E, Resident Care Coordinator/Medication Technician, stated if there was an emergency where residents and staff needed to evacuate, they would evacuate to the business office.

In an observation on 03/28/2023 at 5:00 PM, there were no emergency evacuation routes posted in Lodge 1.

In an interview on 03/28/2023 at 5:04 PM, Staff AA, Medication Technician, confirmed there were no emergency evacuation routes posted in Lodge 1.

In an observation on 03/28/2023 at 5:12 PM, there were no emergency evacuation routes posted in Lodge 2.

This is an uncorrected deficiency previously cited on 01/10/2023

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Yvonne Ding-Lee — Administrator (or Representative)

5-24-2023 — Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to have a signed copy of the facility's Medicaid policy for 6 of 6 sampled Residents (Resident 11, Resident 7, Resident 12, Resident 13, Resident 14, and Resident 1). This failure placed these residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included:

WAC 388-78A-2665 "The assisted living facility must fully disclose the facility's policy on accepting Medicaid payments. The policy must:...(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point..."

On 03/28/2023 at 1:11 PM, an on-site review of the facility's resident records showed Resident 11, Resident 7, Resident 12, Resident 13, Resident 14, and Resident 1 did not have a Medicaid Policy in their records.

In an interview on 03/28/2023 at 11:22 AM, Staff A, Executive Director, stated the Medicaid policy for the residents were in the resident's disclosure of service agreements. They had the document signed on the last page by the resident or the resident's responsible party.

Resident 11 (R11)

Record review of R11 Disclosure of Services showed section 15, Medicaid Support, was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 7 (R7)

Record review of R7 Disclosure of Services showed section 15, Medicaid Support, was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 12 (R12)

Record review of R12 Disclosure of Services showed section 15, Medicaid Support, was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 13 (R13)

Record review of R13 Disclosure of Services showed section 15, Medicaid Support, was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 14 (R14)

Record review of R14 Disclosure of Services showed section 15, Medicaid Support, was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 1 (R1)

Record review of R1 Disclosure of Services showed section 15 Medicaid Support, was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

In an interview on 03/29/2023 at 8:48 AM, Staff A stated the facility s Medicaid policy was included with the disclosure of services that was signed by the resident's responsible party. They did not have a separate Medicaid Policy document

This is an uncorrected deficiency previously cited on 01/10/2023

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023

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

Yvonne Bingham — Administrator (or Representative)

5-24-2023 — Date

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

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

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

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

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

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(f) Availability of the supervisor, in person, by pager, or by telephone, to respond to residents' needs on the assisted living facility premises as necessary.

This requirement was not met as evidenced by:

Based on interviews and record review, the facility failed to ensure staff had the required Nurse Delegation training, supervision, and documentation by the Registered Nurse (RN) Delegator for 6 of 6 residents (Resident 1, Resident 15, Resident 12, Resident 3, Resident 17, Resident 18) receiving nurse delegated services. These failures placed all residents receiving RN delegated services at risk for harm and injury due to untrained and unsupervised care staff.

Findings included:

WAC 246-840-930

"Criteria for delegation.
(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).
(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.
(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.(8) Verify that the nursing assistant or home care aide:
(a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;
(b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;

(c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training
(d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and
(e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.
(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.
PLAN
(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.
(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:
(a) The rationale for delegating the nursing task;
(b) The delegated nursing task is specific to one patient and is not transferable to another patient
(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;
(ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order, and(iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not.
(k) How to document the task in the patient's record.
(l) Document teaching done and a return demonstration, or other method for verification of competency; and
(m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.
(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.
IMPLEMENT
(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.
(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).
EVALUATE
(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.
(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.
(18) The registered nurse delegator ensures safe and effective services are provided.

Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Resident 1 (R1)

Record review of R1's Care Plan Assessment, dated 02/21/2023, showed R1 had multiple medical diagnoses including [redacted] and [redacted] Under the section titled "self medication/administration", showed R1 required nurse delegation medication administration from the medication technicians for one or more of their medications.

Record review of the document titled, Nurse delegation: Nursing visit, dated 02/15/2023, showed R1 required all medications ordered to be administered by facility staff. Under the section titled "LTCW", showed 13 of 13 LTCW's had not been observed or demonstrated the administration of insulin for R1. Staff F, Medication Technician, and Staff BB, (former) Medication Technician, had incomplete documented training by Collateral Contact 6 (CC6), RN Delegator. There were notes in the box "other" that documented CC6 was awaiting additional verification training hours for Staff F and Staff BB.

On 03/29/2022, at 11:20 AM, review of R1's delegation records showed no records were found for nursing visits to supervise and evaluate any delegated staff for insulin injections weekly for the first four weeks following delegation to administering insulin injections.

Record review of R1's Medication Administration Record (MAR), dated 03/10/2023 – 03/31/2023, showed Staff F administered nurse delegated tasks to R1 for 9 of 20 days without required training and supervision.

Resident 15

Record review of the face sheet for R15 showed they had multiple medical diagnosis that included [redacted]

Record review of R15's MAR, dated 03/10/2023 – 03/31/2023, showed Staff F administered nurse delegation tasks for R15 for 9 of 20 days without required training and supervision.

Resident 12

Record review of the document, Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R12 moved into the facility on [redacted]/2023. The documented identified R12 had nurse delegation services.

Record review of the face sheet for R12, showed they had multiple medical diagnosis including [redacted]

Record review of R12's Care Plan Assessment, dated 03/15/2023, showed R12 required their medications to be nurse delegated and administered to her. Staff were to notify the delegated RN with any concerns regarding delegated tasks.

Record review of the document titled, "Nurse delegation: Consent for Delegation Process", dated 02/09/2023, showed the power of attorney (an appointed person designated to make decisions for someone) had consented to have delegated services for R12. There was no signature by the Registered Nurse Delegator on this document.

Record review of the nurse delegation binder on 04/11/2023 at 4:14 PM, showed there was no Nursing visit documents for R12. There was no other documentation that showed what LTCW's were qualified and approved to administer delegated tasks. There was no documentation that provided what specific nurse delegated tasks were required to be administered for R12.

Resident 3

Record review of the face sheet for R3 showed they had multiple medical diagnosis including [redacted]

Record review of R3's Care Plan Assessment, dated 02/19/2023, showed R3 required administration and delegation for their medications. R3 was unable to manager their own medications.

Record review of the document titled, "Nurse Delegation: Nursing Visit", dated 11/17/2022, showed R3 required nurse delegation for medications from all routes (a way something is given). Under the section titled, "LTCW" showed Staff F and Staff BB had not been cleared for "record review". "Record review" references that the LTCW was reviewed to have their documentation in place to be qualified to administer nurse delegated tasks per the RN nurse delegator. Under the other section, it showed "awaiting additional verification training hours." Review of the LTCW showed, Staff JJ, Medication Technician was not listed as a qualified and approved LTCW to administer nurse delegated tasks for R3.

Record review of R3's MAR, dated 03/10/2023 – 03/31/2023, showed Staff F administered nurse delegated tasks to R3 for 8 of 20 days. Staff JJ administered nurse delegated tasks to R3 for 13 of 20 days.

Resident 17

Record review of the document, Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R17 moved into the facility on [redacted]/2023. The document identified R17 had nurse delegation services.

Record review of the document titled, "Nurse delegation: Consent for Delegation Process", dated 03/06/2023, showed the power of attorney (an appointed person designated to make decisions for someone) had consented to have delegated services for R17. There was no signature by the Registered Nurse Delegator on this document.

Record review of the nurse delegation binder on 04/11/2023 at 4:14 PM, showed there was no Nursing visit documents for R17 to review. The was no other documentation that showed what nurse delegated tasks were to be administered by the LTCW for R17 to

review.

Resident 18

Record review of the face sheet for R18 showed they had multiple medical diagnoses including [redacted] and [redacted].

Record review of the document titled, "Nurse Delegation. Nursing Visit" dated 11/17/2022, showed R18 required nurse delegation for all medications. Under the section titled, "LTCW", showed Staff F and Staff BB did not have required documented trainings. The document noted, "awaiting additional verification training hours." Staff JJ, wasn't listed on the approved LTCW to administered delegated tasks.

Record review of R18's MAR, dated 03/10/2023 – 03/31/2023, showed Staff JJ administered delegated tasks to R18 for 13 of 20 days. Staff F administered delegated tasks to R18 for 9 of 20 days unsupervised.

In an interview on 03/28/2023 at 12:13 PM, Staff C, Medication Technician, stated that they had a zoom (online meeting via computer) meeting with CC6. They demonstrated application of the insulin needle and dialing of the dose on a writing pen on the zoom call. Staff C stated they have not had CC6 observe them administer insulin within the facility.

In an interview on 03/29/2023 at 12:26 PM, Staff E, Medication Technician, stated they had only virtual (online meetings) with CC6 for insulin administration and education. Staff E stated they would gesture the steps of administration of insulin. Staff E stated CC6 had not observed her to administer insulin to any of the residents in the facility.

In an interview on 04/07/2023 at 11:01 AM, CC6, stated they have only conducted in class trainings with the medication technicians for insulin administration. CC6 stated the box next to observation or demonstrated the administration on the Nurse delegation form would be checked if the medication technician had been observed. CC6 stated that they have asked the facility to provide the additional certifications of training for the Nurse Assistant Registered (NAR). CC6 stated that they did not qualify Staff F to work independently to administer nurse delegated tasks to the residents within the facility.

In an interview on 04/11/2023 at 3:37 PM, Staff JJ, Medication Technician, stated that they have not had anyone watch them administer medications or insulin injections to the residents. They stated that they were unaware that they could administer insulin in the arm and only aware of the areas in the stomach. Staff JJ stated that they have only had training by CC6 by zoom (online meeting)

This is an uncorrected deficiency previously cited on 01/10/2023 for subsections (1)(a)(b)(2)(a)(b)(c)(e)(f)(3)(a)(b)(c)(d)(e).

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023

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

Joanne Hockell
Administrator (or Representative)

5-24-2023
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;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 buildings (Lodge 1, Lodge 2, and outdoor shed). The facility failed to keep exterior grounds in good repair, facility free from odor, and equipment and furnishings clean. These failures resulted in all residents having a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of Lodge 1 Cook Biweekly/Monthly Cleaning Schedule, dated March 2023, showed staff were to initial for each task completed twice a month. The sweep/mop behind steam table, clean fans, and deep clean top of stoves section showed no initials from 03/01/2023 – 03/28/2023.

Record review of Lodge 1 Daily Cleaning Schedule, dated March 2023, showed task toaster, grill/oven, microwave, coffee pot area, dishwasher, dishwasher temps (temperatures), fridge/freezer temps, steam table, work area, tables/shelves, garbage cans, sweep floors, mop floors, ice machine, and stove top were all initialed as cleaned daily from 03/01/2023 -03/28/2023.

Record review of Lodge 2 Cook Biweekly/Monthly Cleaning Schedule, dated March 2023, showed initials for each task completed twice a month. The clean fans, wipe down front and back doors, deep clean all shelves, clean dry storage area, deep clean top of stoves, and clean behind all tables section showed no initials from 03/01/2023 – 03/28/2023.

Record review of Lodge 2 Daily Cleaning Schedule, dated March 2023, showed task toaster,

grill/oven, microwave, coffee pot area, dishwasher, dishwasher temps, fridge/freezer temps, steam table, work area, tables/shelves, garbage cans, sweep floors, mop floors, ice machine, and stove top were all initialed as cleaned daily from 03/01/2023 -03/28/2023

In an observation on 03/28/2023 at 11:42 AM Lodge 1 Sunshine room had a urine odor.

In an observation on 03/28/2023 at 11:43 AM Lodge 1 water fountain sinks had a white film surrounding the drains. In an observation on 03/28/2023 at 11:46 AM showed Lodge 1 back hallway near Resident 9 and Resident 10's room had a strong urine odor present.

In an observation on 03/28/2023 at 11:57 AM showed Lodge 1 dining area had two lights with debris and dead bugs inside of them.

In an observation on 03/28/2023 at 12:02 PM, Lodge 1 had a cabinet that had a sign that showed "First aid" on the outside. The cabinet had a locking device that was hanging from the left handle. Inside of the cabinet contained two 1 pound 5 ounce bottles of disinfectant deodorant spray.

In an observation on 03/28/2023 at 12:04 PM Lodge 1 had a scale chair (chair to weigh residents) and barber chair blocking the electrical room doorway. The weight chair was also impeding the entrance of Resident 8's room.

In an observation on 03/28/2023 at 12:13 PM, Lodge 1 Kitchen floor had a sticky substance on it. As the Department toured the area the Licensor's shoe stuck to the floor and it would make a noise with every step taken. There was a mop bucket with standing brown water at the bottom of the bucket. The left side of the refrigerator had a red substance on the bottom of the fridge, on the lip of the fridge, and the substance spilled onto the floor. The substance had dried and left red splatter marks. On the inside of the fridge door and on the inside of the wall showed varying sizes of unknown white marks. The inside of the fridge white racks had orange and brown substances embedded into it.

In an observation on 03/28/20233 at 12:28 PM, showed Lodge 1 refrigerator and freezer outside of the kitchen in the residents dining area showed melted blue popsicle juice inside of the freezer drawer. Inside of the refrigerator showed orange splatters covering the bottom shelving. Inside of the shelving showed dirt and other substances lining the edges.

In an observation on 03/28/2023 at 12:34 PM, the outside metal shed had five used cigarettes on the ground underneath the outdoor table and chairs.

In an observation on 03/28/2023 at 12:37 PM, Lodge 2 kitchen had a grey free standing storage unit that was covered in a sticky brown substance. The inside of the door was covered in a brown substance.

In an observation on 03/28/2023 at 12:43 PM, Lodge 2 kitchen garbage can had a brown substance covering the entire lid. The kitchen walls are splattered with varying sizes of orange, brown, and yellow substances. The inside of the microwave had a range of brown substances covering the top and bottom of the device.

In an interview on 03/28/2023 at 12:44 PM with Staff CC, Cook, stated the cooks and dietary aids clean the refrigerators every other day. Staff CC stated there was not a cleaning schedule for when the refrigerators needed to be cleaned. Staff CC stated the facility staff

used common sense on when the refrigerators needed to be cleaned.

In an observation on 03/28/2023 at 12:45 PM, Lodge 2 kitchen walls and ceiling were covered in brown and yellow food splatters above the holding table/prep area. The microwave was observed with dried brown debris splattered the inside.

In an observation on 03/28/2023 at 12:57 PM, the outside food shed showed the inside of the silver freezer had a strong pungent odor that penetrated through the Licensors face mask. The white fridge on the left side of the shed had a sticky substance on the shelving. The bottom of the fridge lip was broken exposing the insulation. The freezer had brown and yellow substance splattered on the wall and bottom shelving. The other freezer to the left side of the building had unknown food particles on the bottom shelving. There was an open food wrapper in the back corner of the unit. In the back of the unit had an orange substance. Donuts within the freezer were freezer burnt. There were premade omelets that were not labeled, and freezer burnt.

In an observation on 03/28/2023 at 1:00 PM, showed outside of the food shed, in the resident courtyard, was a ladder lying laid horizontally against the shed unsecured.

In an observation on 03/28/2023 at 1:12 PM, in Lodge 2 on the counter next to the resident's dining area there was a spray bottle that contained detergent disinfectant with a label that read "do not drink" on it. The bottle was unsecured. There were three residents within the vicinity of the bottle.

In an observation on 03/28/2023 at 1:13 PM, the Lodge 2 dining area had debris and dead bugs in three light fixtures.

In an observation on 03/28/2023 at 1:19 PM, in Lodge 2 by the electrical room door was an electric specialized wheelchair parked in front of the door. The specialized wheelchair was also impeding the entrance of Resident 7's room.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6.10.2023

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

Lyvonne Digg-Lee — 5-24-2023

Administrator (or Representative) — Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 6 of 6 sampled residents (Resident 11, Resident 7, Resident 12, Resident 13, Resident 14, and Resident 1) had the means to summon on duty staff on the corridors, common areas, and outdoor areas accessible to residents. This failure placed 61 of 61 residents at risk of not being able to summon staff when help was needed.

Findings included...

In an interview on 03/28/2023 at 10:28 AM, Staff A, Executive Director stated a call light system had been installed into the residents' rooms and bathrooms.

In an observation on 03/28/2023 at 1:25 PM, Lodge 2 (one of two buildings connected with a courtyard, buildings called Lodges) call light in the hallway was pushed to see if it was in working order.

In an interview on 03/28/2023 at 1:25 PM, Staff S, Caregiver, stated the hallway call light button in Lodge 2, no longer worked. Staff S stated the only call lights that worked were in the residents' bathrooms and bedrooms.

In an interview on 03/29/2023 at 8:05 AM, Staff DD, Caregiver, stated Lodge 1 did not have call lights in the common hallways. Staff DD stated the residents have call lights in their bedrooms and bathrooms they can utilize. Staff DD confirmed there were no call lights outside for the residents to utilize. Staff DD stated if they notice a resident going outside who's mobility was unstable they would try to re-direct them back inside for safety.

In an interview on 03/29/2023 at 8:20 AM, Staff P, Activity Director, stated there were not call lights in the common areas of the facility or outside for residents to utilize. Staff P stated independent residents can go outside at any time. Staff P stated residents who need assistance with mobility are accompanied by staff.

In an interview on 03/29/2023 at 8:56 AM, Staff A, Executive Director, stated there was no current system in place for staff to know when the residents go outside in the common courtyard.

This is an uncorrected deficiency previously cited on 01/10/2023

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6/10/2023

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

Yvonne King-Hill — Administrator (or Representative)

5-24-2023 — Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

(b) Restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage that is likely to be spread in the assisted living facility setting or by casual contact;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

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

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure all staff were fit tested for an N95 respirator. This failure resulted in 36 of 36 staff not being fit tested as required per infection control and prevention standards and placed them at risk to contract the virus. This placed 61 of 61 residents and 36 staff at risk of being infected and spreading COVID-19 virus (Coronavirus Disease, an infectious virus that can cause respiratory illness) or other communicable diseases.

Findings included...

Record review of the document titled, ""L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE", dated 03/30/2021, DOH 420-328 showed, "The Long-term care facilities (LTCF) are

required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 [Corona Virus Disease 2019- a respiratory illness] and other airborne hazards. COVID-19 is an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes." The "fit test" was to be completed every 12 months.

Record review of Centers of Disease Control and Prevention (CDC) document, titled, "Strategies for Optimizing the Supply of N95 Respirators", updated 09/16/2021, showed under the section titled, "Just-in-time fit testing", it was essential to have Healthcare professionals trained and fit tested prior to receiving or taking care of positive COVID-19 residents.

Record review of the Dear Provider (DP) Letter ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal Protective Equipment (PPE)", dated 04/30/2021, directed LTCF's under WAC 296-842-12005 to develop and maintain a respirator program which included initial fit testing and providing staff with their fit tested respirator.

Record review of the facility policy, titled, "Infection Control 17 – Respiratory Illness Outbreak Policy", dated 08/10/2021, showed "Always follow guidelines and recommendations from the CDC and your state and local public health department."

Record review of the Washington State Department of Health SARS-Cov-2 Healthcare Settings Toolkit, dated April 2023, showed under the section titled, "Setting Specific Checklists", long term care facilities were to consult with the LHJ when outbreaks were being managed. Long term care facilities were to report all positive cases to the Local Health Jurisdiction (LHJ).

Record review of the departments database showed Staff A, Executive Director, reported Resident 11 was positive with COVID- 19 on 03/09/2023.

Record review of Respiratory protection program (RPP) for N95 masks showed no facility N95 respirator fit testing or medical clearances were available for review.

In an interview on 03/21/2023 at 12:34 PM, Collateral Contact 7 (CC7), LHJ, stated that they were not notified by the facility that they had any positive COVID-19 cases with residents or staff.

In an interview on 03/28/2023 at 9:24 AM, CC7, stated that they called the facility to get the information about the positive COVID-19 resident. They stated that the facility never notified them.

In an interview on 03/28/2023 at 10:28 AM, Staff A, stated the facility was still out of compliance with N95 fit testing and medical clearances for the staff.

In an interview on 03/28/2023 at 11:05 AM, Staff A, stated that she reported Resident 11 was positive with COVID-19 late to the LHJ.

This is an uncorrected deficiency previously cited on 01/10/2023 for subsections (1)(2)(a)(c)(d)(f)

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6/10/2023.

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

Yvonne Bing-Lee — Administrator (or Representative)

5/24/2023 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide documentation on site for cardiopulmonary resuscitation (CPR) and first aid training requirements for 3 of 6 sampled staff (Staff C, Staff D, and Staff JJ). This failure placed 61 of 61 residents at risk for unqualified staff to provide emergency services to residents in need of medical attention.

Findings included...

Record review of Dear Provider Letter, titled, "Governor's Proclamations related to COVID-19 ending October 27," dated 09/09/2022 and amended on 10/07/2022, stated under the Category CPR and first aid training and Status of Requirements, "Facilities must be in compliance with WAC 388-112A-0720 by October 27."

Record review of the facility's Plan of Correction, dated 02/06/2023, showed the Executive Director would hold one class monthly for all employees. If employees CPR and First Aid class was expiring and they did not attend they would be required to obtain the certification on their own. The Executive Director was the primary person responsible for

implementing the change and the Business Office Manager was the secondary to ensure all re-certifications had been completed. The Plan of Correction stated the facility would be back in compliance on 03/10/2023.

In an interview on 03/28/2023 at 10:28 AM, Staff A, Executive Director stated staff's CPR and first aid certifications were up to date.

Record review of Staff C, Medication Technician, records showed there was not a First Aid document to review.

Record review of Staff D, Food Service Director, records showed there was not a First Aid document to review.

Record review of Staff JJ, Medication Technician, records showed Basic Life Support certification for CPR and AED (Automated External Defibrillator) program was expired. Staff JJ was issued the certificate on 01/14/2019 and the recommended renewal date showed 01/01/2021. Staff JJ did not have a First Aid document to review.

In an interview on 03/29/2023 at 10:00 AM, Staff I, Business Office Manager, stated that they did not have First Aid documents to provide for Staff C, Staff D, and Staff JJ. Staff I stated they were unaware staff needed to complete First Aid Certifications.

This is an uncorrected deficiency previously cited on 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 6-10-2023.

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

Yvonne King-Lee — Administrator (or Representative)

5-24-2023 — Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2600	Compliance Determination # 16946
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 1 of 60	Licensee: Greenlake Management Lacey, LLC	01/10/2023

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 12/06/2022 and 01/04/2023 of:

Memory Care At The Lodges
1530 Carpenter Rd SE
Lacey, WA 98503

The following sample was selected for review during the unannounced on-site visit: 9 of 62 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Kyle Gehlen, ALF Licensor - LTC
Celeste Vashey, ALF LTC Licensor
Jennifer Siharath, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

01/24/2023
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.

Yvonne M.L. Kung-Kee
Administrator (or Representative)

02/06/2023
Date

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a pre-admission assessment prior to the residents move in date for 1 of 2 sampled residents (Resident 6). This failure placed Resident 6 at risk for having unmet care needs.

Findings included...

Resident 6 (R6)
Review of R6 records showed R6 was admitted to the facility on [redacted]/2022 with various diagnoses including [redacted]

Record review of R6's chart showed an assessment, dated 10/19/2022. No preadmission assessment was found.

In an interview on 12/07/2022 at 12:20PM, Staff A, Executive Director (ED), stated initial assessments and care plan assessments were considered the same document. Staff A stated when they start an assessment, they use a fresh paper copy and then transfer the information to an electronic document.

On 12/08/2022 at 11:15AM, Staff A, ED, provided a copy of the assessment completed by the Department of Social and Human Services and not the facility. Staff A, ED, stated they do not have any other assessments for R6.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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

Yvonne M.L. Kung-Kee
Administrator (or Representative)

02/06/23
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor residents' well-being for 2 of 9 sampled residents (Resident 7 and Resident 8) reviewed. Failure to ensure the residents' well-being was being monitored placed both residents at risk for harm.

Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2022, showed "Assessments and Negotiated Service Agreements will be updated as frequently as necessary to ensure they reflect current resident care needs and preferences. Individualized Negotiated Service Agreements are used to plan for and meet resident needs using an interdisciplinary approach." Under the section, titled "Procedures", section three, showed formal reviews took place: every six months, and whenever there was a significant change in a resident's status. Section four showed, "an assessment specifically focused on a resident's identified problems and related issues must be completed: Whenever the Negotiated Service Agreement no longer addresses the resident's current needs and preferences and whenever the resident has an injury requiring the intervention of a practitioner." Under part six showed, "the Wellness Director updates the Negotiated Service Agreement whenever a change is noted, and service changes are necessary. The resident assessment is updated and completed at the same time as the Negotiated service agreement." Under section 10 showed, "Each resident's negotiated service agreement and fall risk assessment will be reviewed and updated whenever a resident has: repeated falls, a fall with injury requiring medical intervention/treatment, and a change in condition."

Resident 7 (R7)

Review of R7's record showed they moved into the facility on [redacted]/2022 with medical diagnoses to include [redacted], and [redacted].

Record review of the Care Plan/Assessment for R7, dated 11/01/2022, under the section titled, "Oral", showed "R7 doesn't like wearing their dentures- this impacts their eating regular texture foods. Diet downgraded to Mech soft [foods that are easily chewed up] to decrease choking episode." Under the section titled, "gastrointestinal" [stomach and intestine area], showed, "R7 has had their esophagus dilated [stretched in size] two times related to their chronic dysphagia. -monitor for pocketing [holding food in mouth], spitting food out, downgrade diet as needed, notify licensed nurse [LN] and advanced nurse practitioner [ARNP]." Under the section titled, "other issues", updated 08/24/2022, showed "R7 is at increased risk for aspiration pneumonia [condition when food or liquids are breathed into the lungs instead of swallowed] related to them not wanting to use their dentures. Diet has been downgraded to decrease aspiration. LN to monitor and assess lung sounds as needed. Staff to notify ARNP and LN for coughing with meals, further choking episodes, cough, fever." Under the section titled, "eating and drinking", updated 08/24/2022, showed "R7 requires set up with meals and encouragement." Under the section titled, "Memory", updated 08/25/2022, showed "R7 is very confused. Their safety awareness is poor and is at risk for unavoidable injury to self."

Record review of a charting note, dated 08/21/2022 at 6:26 PM, showed R7 had a choking episode that required the Heimlich (treatment in attempted to remove object in someone's airway). The note documented, "R7 did not have dentures in due to being resistant to care this morning. *Resident must have dentures to eat!!*"

Record review of the charting notes dated 08/21/2022 and 08/22/2022, showed there was no assessment from LN related to the choking episode that occurred on 08/21/2022.

Record review of a physician communication, dated 09/11/2022, showed that "R7 began choking on food. They seemed to have been pocketing food and not swallowing it. They began to vomit and seems to be okay now." Collateral Contact 1, Advanced Registered Nurse Practitioner [ARNP], had written on the physician communication, "noted, continue to monitor."

Record review of physician communication dated 09/12/2022, showed "downgraded diet to puree- resident had another choking issue this weekend. Will continue to monitor." Collateral Contact 1, wrote "noted, continue to monitor."

Record review of charting notes for 09/11/2022 and 09/12/2022, showed there was no documented assessment from the LN after incident of choking related to R7's high risk for aspiration.

Record review of a physician communication for R7, dated 09/15/2022, showed Collateral Contact 1 wrote a new order "okay to crush medications PRN [as needed]."

Record review of a physician "progress note", dated 09/13/2022, showed R7 was evaluated by Collateral Contact 1. Under the sections titled, "Diagnosis and assessment", showed "Patient [R7] with a choking episode over the weekend. Care staff report that patient has been holding medications and food in their mouth. Trial downgrade diet to pureed food started. Will send ST [Speech Therapy] referral, ok to crush medications, and monitor resident during mealtimes."

Record review of a physician communication dated 09/28/2022, showed that Collateral Contact 1 had written new orders for R7 to have a mechanical soft (foods that are easily chewed up) bite sized diet when they used their dentures. R7 was to have puree (blended food that doesn't need to be chewed) diet when they do not wear their dentures.

In an interview on 12/07/2022 at 12:34 PM, Staff C, Medication Aide, stated for R7 "last choking was with their dentures in, just this last weekend. They just got order yesterday to change diet to puree."

In an observation on 12/07/2022 at 1:13 PM, R7 was sitting at the table eating part of a muffin top. R7 was observed to not have their denture in while eating the muffin top. Staff C was asked if the muffin top was pureed. Staff C stated, "R7 must have stolen it. They were curious to see how they will do with a puree diet." Staff C was observed to not remove the muffin top from R7 or encourage them to not eat it. Staff C walked away from R7 while they were still eating the muffin top and left R7 unattended. There was no staff member in the general area of R7 to observe and monitor R7 if they were pocketing or coughing while they ate the muffin top.

In an interview on 12/08/2022 at 7:25 AM, Staff C stated they had a kitchen sheet in the kitchen of each cottage that showed all the residents' current diet and textures. Staff C stated three residents in cottage two were on pureed diet. Staff C stated R7 was one of the residents that required a puree diet.

In an observation on 12/08/2022 at 9:23 AM, R7 was sitting at the dining table with a plate of ground up sausage, scrambled eggs, and two half pieces of whole toast. R7 was eating the sausage and scrambled eggs unsupervised. There were no staff members around the area of R7 to monitor R7 for pocketing food or coughing while they ate their meal.

In an interview on 12/08/2022 at 9:25 AM, Staff S, Caregiver, stated R7 was on a mechanical soft (foods that are easier to chew and move around in the mouth) diet with small portions. Staff S stated R7 ate well if they used their dentures but didn't like the adhesive on them.

In an interview and observation on 12/08/2022 at 9:26 AM, Staff DD, Caregiver stated R7 was on a small portion mechanical soft diet. Staff DD was asked how they would know of a

diet change for a resident. Staff DD showed a red clip board with a computer-generated list of residents with their current diet and textures.

In an interview and record review on 12/08/2022 at 9:30 AM, of an untitled document, handwritten date of 12/08/2022, showed a computer generated diet list for residents that was attached to a red clip board. For R7, it showed under the column "texture", MS (mechanical soft). Under the column "diet", it showed regular diet for R7. Staff DD stated MS were initials for mechanical soft diet. Staff DD stated, "any diet changes they find out from Staff D, Food Services Director" would have been documented on this form attached to the red clip board. Observation of the food card that was hung on back of cottage two's kitchen door had R7's diet handwritten as "Mech Soft, small portions, regular." Staff DD, stated Staff D, updated the diet list once a week. There was no documentation on the form to show R7 was on puree diet.

In an observation on 12/08/2022 at 9:31 AM, Staff C, Medication aide, stated, "hi" to R7 while eating their scrambled eggs, toast, and ground up sausage. Staff C continued to walk by R7 without intervening and preventing R7 from eating the wrong textured food or monitor R7 while R7 ate. Staff C did not stay with R7 or ask another caregiver stay around R7 while R7 ate. No staff member was around to observe R7 for spitting their food out, coughing, or pocketing their food while R7 ate.

In an interview on 12/08/2022 at 9:37 AM Staff S, Caregiver stated, R7 was observed the week prior to be pocketing chicken and having a hard time swallowing.

In an interview on 12/08/2022 at 10:46 AM, Staff D, stated that the facility provided puree diets to residents with current orders. They stated the residents currently on pureed diets resided in cottage two. Staff D stated they were given a copy of the physician order to change R7's diet texture to puree on 12/06/2022. They stated they told Staff H, Caregiver/Cook, on 12/07/2022 that R7's diet texture had changed to puree. Staff D stated they review all new orders daily. They clarified the "MS" for texture was mechanical soft.

In an interview and observation on 12/08/2022 at 11:35 AM, Staff H in Cottage two kitchen, stated R7 was on a puree diet. Staff H showed the department the computer-generated untitled document with handwritten date of 12/08/2022, that was attached to the red clipboard. The sheet showed all the resident in cottage two's current diet and textures. Staff H stated that was the sheet the caregivers referenced at mealtimes to ensure all residents received the current and correct diet and texture. They stated the list was updated prior to breakfast every morning. Under the column "texture" for R7 showed, "MS". The MS was lined through with pen, and "puree" was handwritten off to the side. Observation of the untitled document with the handwritten date of 12/08/2022 showed, the document was altered since first observation at 9:30 AM when Staff DD, first showed the department the document. Staff H stated they were unsure what R7 had for breakfast. They stated R7 wasn't up for breakfast.

Resident 8 (R8)
Record review of an undated face sheet for R8 showed, they moved into the facility on [redacted]/2020 with multiple medical diagnoses including [redacted] and [redacted]

Record review of the internet site, American Heart Association, document titled, "Low blood pressure- when blood pressure is too low", dated 10/31/2016, showed low blood pressure can occur with nutritional deficiencies, nausea, vomiting (throwing up), dehydration (lack of fluid in the body), and fatigue (being excessively tired).

Record review of the internet site, Mayo clinic, document titled Low blood pressure (hypotension), undated, showed "low blood pressure is generally considered a blood pressure reading lower than 90 millimeters of mercury (mm hg) for the top number (systolic) or 60 mm Hg for the bottom number (diastolic)... The cause of low blood pressure range from dehydration to serious medical conditions." Under the section titled, "Conditions that cause low blood pressure", showed "blood loss. Losing a lot of blood, such as from an injury or internal bleeding, also reduces blood volume, leading to a severe drop in blood pressure... lack of nutrients in the diet. Low level or vitamin b-12, folate, and iron can keep the body from producing enough red blood cells (anemia), which can lead to low blood pressure."

Record review of a untitled document dated 08/09/2022, showed that R8 had a comprehensive evaluation by a nurse practitioner. It showed R8 had iron deficiency anemia (decrease in red blood cells in the body). Staff were to monitor for signs and symptoms of worsening anemia, blood loss, dyspnea (short of breath), increased fatigue (extreme tiredness).

Record review of R8's electronic record of the order for Lisinopril (to treat high blood pressure), dated 02/21/2022, showed the medication technicians were to check "patient's blood pressure prior to giving Lisinopril or Coreg. hold the medication if the systolic blood pressure was less than 100 or diastolic blood pressure was less than 60."

Record review of R8's Medication Administration Record, dated September 2022, showed R8 was on the following medications Aspirin (blood thinner), Plavix (blood thinner to help prevent blood clots), Amlodipine (treat high blood pressure), Coreg (treat high blood pressure), and Lisinopril.

Record review of R8's Medication Administration Record (MAR), dated September 2022, showed that R8 was administered their Coreg and Lisinopril on 09/16/2022 with a blood pressure of 97/42.

Record review of R8's Care Plan/Assessment, dated 10/25/2022, showed, under the section titled, "self-medication/administration", R8 was not able to handle their medications. Staff were to administer R8's medications. Staff were to monitor for any possible side effects, change in medications and notify the health services director and

primary care provider. The care plan didn't identify or address that R8 was on blood thinning medications. The care plan did not list the possible side effects to monitor for related to R8's use of blood thinners.

Record review of the charting notes dated 09/01/2022 – 09/17/2022 showed there was not documentation about the medication being held or that the physician was notified of the low blood pressure.

Record review of R8's MAR dated October 2022, showed during the date range 10/10/2022 - 10/29/2022, R8's Lisinopril and Coreg were both administered seven times outside of the prescribed parameters.

Record review of R8's charting note dated 10/25/2022, showed "R8 has been experiencing a decline and needing for assistance with ADL [activities of daily living]."

Record review of the charting notes dated 10/10/2022 – 10/29/2022 showed there was no documentation about R8's blood pressure being low and if any side effects related to the low blood pressure had occurred.

Record review of a charting note dated [redacted]/2022 at 11:13 AM, showed R8 threw up coffee color substance. R8 was sent out to the local hospital around 11:00 AM.

Record review of a charting note dated [redacted]/2022 at 8:09 PM, showed resident came back to the facility around 5:30 PM-6:00 PM from a hospitalization stay on [redacted]/2022.

Record review of a Care Plan/Assessment for R8, dated 10/25/2022, showed there was no documentation or interventions in place for the history of throwing up and their low blood pressure. The care plan and assessment was not updated upon R8's readmission to the facility from a 20 day hospitalization on [redacted]/2022.

In an interview on 12/07/2022 at 12:17 PM, Staff A, Executive Director, stated they updated the assessments and care plans every 3 months or with changes in condition.

In an interview on 12/08/2022 at 8:00 AM, Staff C, Medication aide, stated that R8 had just come back from the hospital for low blood pressures and throwing up. They stated that R8 had come back with an order to hold all medications if they ate less than 25 percent of their meals.

This is a recurring deficiency previously cited on 08/25/2022.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) ~~02/10/23~~ 03/22/23.

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

Yvonne M.L. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

(e) Staff designated by the assisted living facility.

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to involve the resident or resident's representative in the process of updating a Negotiated Service Agreement (NSA) for 8 of 8 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8). This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included...

Record review of the facility's policy "Resident Assessment and Negotiated Service

Agreement", dated 08/10/2022, under section 11 showed, "the wellness director ensures the negotiated service agreement is signed and dated by the community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party."

Resident 1 (R1)
Record review of a face sheet for R1 showed that they moved into the facility on [redacted]/2019 with a diagnosis of [redacted]

In an interview on 12/19/2022 at 12:10 PM, Collateral Contact 3, Family Member of R1, stated that they had not signed or discussed anything in-regards to the care and services the facility was providing for R1.

Resident 2 (R2)
Review of R2's records showed R2 admitted to the facility on [redacted]/2021, with a diagnosis of [redacted]

Record review of R2's care plan, dated 10/09/2022, showed no signature from the resident, resident's representative, case manager, or staff designated by the assisted living facility were found to show their involvement and agreement to the plan of care.

Record review of R2's charting notes, dated from 09/12/2022 through 11/05/2022, showed there were no entries charted about the updates or changes to the care plan/assessment that were discussed with R2 or R2's responsible party.

In an interview on 12/07/2022 at 4:27 PM, Collateral Contact 5 (CC5), family member of R2, stated they do not recall any calls regarding care plans for R2.
Resident 3 (R3)

Review of R3's records showed R3 admitted to the facility on [redacted]/2016 with a diagnosis of [redacted] and [redacted]

Review of R3's chart notes, dated 10/13/2022 – 11/30/2022, showed there were no entries charted about the updates or changes to the care plan/assessment that were discussed with R3 or R3's responsible party.

Resident 4 (R4)
Review of R4's records showed R4 admitted to the facility on [redacted]/2020 with a diagnosis of [redacted]

Record review of R4's care plan, dated 08/04/2022, showed no signature from the resident, resident's responsible party, case manager, or staff designated by the assisted living facility were found to show their involvement and agreement to the plan of care.

In an interview on 12/07/2022 at 4:49 PM, Collateral Contact 7 (CC7), family member of R4, stated the only care plan that they recall being involved with was the first care plan created when R4 had moved into the facility in [redacted] of 2020.

Resident 5 (R5)

Record review of R5's records showed R5 admitted to the facility on [redacted]/2022 with a diagnosis of [redacted]

Record review of R5's care plan, dated [redacted]/2022, showed no signature from the resident, resident's responsible party, case manager, or staff designated by the assisted living facility were found to show their involvement and agreement to the plan of care.

Resident 6 (R6)
Record review of R6's records showed they admitted to the facility on [redacted]/2022 with a diagnosis of [redacted]

Record review of R6's care plan, dated 10/19/2022, showed no signature from the resident, resident's responsible party, case manager, or staff designated by the assisted living facility were found to show their involvement and agreement to the plan of care.

Resident 7 (R7)
Record review of the face sheet for R7 showed they moved into the facility on [redacted]/2022 with a diagnosis of [redacted]

Review of R7's care plan, dated 11/01/2022, showed no signature from the resident or the responsible party for R7.

In an interview on 12/07/2022 at 3:40 PM, Contact Collateral 4, family member of R7, stated they hadn't signed any documentation about R7's care and services since they admitted to the facility.

Resident 8 (R8)
Review of the records for R8 showed that they moved into the facility on [redacted]/2020 with a diagnosis of [redacted]

Review of R8's care plan, dated 10/25/2022, showed no signature from the resident or the responsible party for R8.

In an interview on 12/07/2022 at 1220, Staff A, Executive Director, stated that families/responsible parties were notified of any changes with a scheduled 30-minute conversation over the phone to discuss the care plan and document the conversation in the charting notes.

Review of sampled residents' records showed no signatures from residents, residents responsible parties, case manager, and staff designated by the assisted living facility.

Record review of progress notes from September 2022 – December 2022 showed there were no documented 30 minutes conversations for the sampled residents or their responsible parties from Staff A.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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

Yvonne M. L. King-Kee — Administrator (or Representative)
02/06/2023 — 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:

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

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;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in the resident's Negotiated Service Agreements (NSA) the plan to provide necessary health support services from outside providers and specific resident identified care and services needs for 7 of 7 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7). This failure placed the residents at risk for unmet care needs and care and services not being provided per the NSA.

Findings included...

Resident 1 (R1)
Record review of a face sheet for R1 showed they moved into the facility on [redacted]/2019 with multiple medical diagnoses including [redacted]

[redacted] and [redacted]

Record review of R1's Care Plan/Assessment, dated 10/11/2022, showed no documentation about R1's history of falls. No documentation about R1's risk for pain related to compression fracture to the thoracic (upper back) area. There were no interventions or documentation that identified how the resident took their medication. R1 was identified as having nurse delegated services on the characteristic roster provided on 12/06/2022, per the column nursing services. Care plan did not show any nursing delegated services the resident required. The care plan did not identify R1's diabetes type 2 that required daily blood sugar checks with insulin injections.

In an interview on 12/07/2022 at 1:41 PM, R1 stated that the facility checked their blood sugar levels and gave R1 all their insulin injections.

In an interview on 12/07/2022 at 2:14 PM, Staff H, Medication Technician, stated that they check R1's blood sugars and administer their insulin injection.

In an interview on 12/19/2022 at 12:10 PM, Collateral Contact 3, Family Member, stated the facility provided R1 all of their medications, insulin injections, and blood sugar checks. R1 was unable to complete these tasks independently.

Resident 2 (R2)
Review of R2's records showed R2 admitted to the facility on [redacted]/2021, with a diagnosis of [redacted]

Record review of the facility's Resident Characteristic Roster, provided on 12/06/2022, documented R2 was receiving hospice services.

Review of R2's care plan, dated 10/09/2022, stated under Escorts, "the resident is currently in hospice." The care plan showed no other details, interventions, or services to be provided related to R2 receiving hospice services. In an interview on 12/07/2022 at 4:27 PM, Collateral Contact 5 Family Member, confirmed that R2 was currently on hospice.

Resident 3 (R3)
Review of R3's records showed R3, admitted to the facility on [redacted]/2016 with a diagnosis of [redacted] and [redacted]

Record review of R3's Care Plan, dated 10/09/2022, showed "R3 has CKD (chronic kidney disease: longstanding disease of the kidneys leading to renal failure) and required dialysis (process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer process these functions naturally) several times a week. They go to these appointments on their own and schedule their transportation on their own". The care plan did not indicate what clinic R3 went to for dialysis, how often they went, and details surrounding their method of transportation.

Resident 4 (R4)
Review of R4's records showed R4 admitted to the facility on [redacted]/2020, with a diagnosis of [redacted]

Record review of the facility's resident Characteristic Roster, provided on 12/06/2022, showed, R4 was receiving hospice services.

Review of R4's care plan, dated 08/04/2022, stated under Therapies, "R4 is on hospice at this time for failure to thrive and weight loss." The care plan showed no other details or plan to provide hospice services for R4.

Resident 5 (R5)
Record review of R5's records showed R5 admitted to the facility on [redacted]/2022 with a diagnosis of [redacted]

Review of the Characteristic Roster, provided on 12/06/2022, showed R5 received home health services.

Record Review of R5's care plan/assessment, dated [redacted]/2022, did not show what home health services R5 had received. The care plan did not indicate what nurse delegation services they were to be provided. The care plan did not indicate what kind of medication assistance the resident was supposed to have.

Resident 6 (R6)
Record review of R6's records showed they admitted to the facility on [redacted]/2022 with a diagnosis of [redacted]

The care plan/assessment, 10/19/2022 did not indicate what nurse delegation services they were to be provided. The care plan did not indicate what kind of medication assistance the resident was supposed to have.

Resident 7 (R7)
Record review of a face sheet for R7 showed they moved into the facility on [redacted]/2022 with medical diagnoses of [redacted] and [redacted]

Record review of R7's progress notes, dated 09/13/2022, showed R7 was evaluated by CC1(CC1), Family Member. Under the section titled, "Diagnosis and assessment", the note showed "Patient with a choking episode over the weekend. Care staff report that patient has been holding medications and food in their mouth. Trial downgrade diet to pureed food started. Will send ST (speech therapy) referral, ok to crush medications, and monitor resident during mealtimes."

Record review of a physician communication for R7, dated 09/15/2022, showed CC 1 wrote a new order that showed, "okay to crush medications PRN (as needed)."

Record review of the Care Plan/Assessment for R7, dated 11/01/2022, showed there was no documentation that identified what type of medication assistance that R7 required. There was no documentation that R7 required nurse delegation or that their medications needed to be altered as ordered by CC1. Review of section "eating and drinking", showed no documentation about caregivers needing to monitor resident during mealtimes as order by CC1.

Review of resident characteristic roster, provided on 12/06/2022, showed every resident in the facility was nurse delegated.

In an interview on 12/07/2022 at 1:20 PM, Staff F, Medication Technician, stated that there were three residents on insulin (hormone produced by the pancreas that controls the amount of glucose in the bloodstream) and that the medication technicians administered the insulin injections to those patients.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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

Yvonne M. L. Kung-Kee
Administrator (or Representative)

02/06/2023
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the Negotiated Service Agreement (NSA) for 8 of 8 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7 and Resident 8) were agreed to and signed at least annually by the resident, resident's representative, case manager, and representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included...

Record review of the facility's policy "Resident Assessment and Negotiated Service Agreement", dated 08/10/2022, showed under "procedure" part four, "the assisted listing facility must involve each resident or prospective resident, to extent possible, along with any appropriate resident representative to the extent he or she is willing and capable, in the preadmission assessment and on-going assessment process. Under section 11 showed, "the wellness director ensures the negotiated service agreement is signed and dated by the community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party."

Resident 1 (R1)
Record review of a face sheet for R1 showed that they moved into the facility on

[redacted]/2019 with a diagnosis of [redacted]

Record review of R1's Care plan/Assessment, dated 10/11/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

In an interview on 12/19/2022 at 12:10 PM, Collateral Contact 3, Family Member, stated that they had not signed or discussed anything in-regards to the care and services the facility was providing to R1.

Resident 2 (R2)
Review of R2's records showed R2 admitted to the facility on [redacted]/2021, with a diagnosis of [redacted]

Record review of R2's Care plan/Assessment dated, 10/09/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

In an interview on 12/07/2022 at 4:27 PM, Collateral Contact 5 , Family Member, stated they did not recall any calls regarding care plans, other than the call they received in October to let them know that they conducted a smoking assessment and R2 was no longer smoking.

Resident 3 (R3)
Record review of R3's Face Sheet, undated, showed R3, admitted to the facility on [redacted]/2016.

Record review of R3's Care Plan/Assessment, dated 10/09/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

Resident 4 (R4)
Review of R4's records showed R4 admitted to the facility on [redacted]/2020, with a diagnosis of [redacted]

Record review of R4's Care Plan/Assessment, dated 08/04/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

In an interview on 12/07/2022 at 4:49 PM, Collateral Contact 7 , Family Member, stated the only care plan that they recall being discussed with them, was the first care plan created when R4 had moved into the facility in [redacted] 2020.

Resident 5 (R5)
Record review of R5's records showed R5 admitted to the facility on [redacted]/2022 with a diagnosis of [redacted]

Record Review of R5's care plan, dated [redacted]/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

Resident 6 (R6)
Record review of R6's records showed they admitted to the facility on [redacted]/2022 with a diagnosis of [redacted]

Record review of R6's Care Plan, dated 10/19/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

Resident 7 (R7)
Record review of a face sheet for R7 showed they moved into the facility on [redacted]/2022 with a diagnosis of [redacted]

Record review of R7's Care Plan, dated 07/31/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

In an interview on 12/07/2022 at 3:40 PM, Collateral Contact 4(CC4), Family Member, stated "I have never signed a Service Agreement that showed what care and services the facility provided to R7." CC4 stated "they [the facility] don't tell me changes unless I ask."

Resident 8 (R8)
Record review of face sheet for R8 showed they moved into the facility on [redacted]/2020 with a diagnosis of [redacted]

Record review of the Care Plan for R8, dated 10/28/2022, showed no signature of the resident, resident's responsible party, case manager, and staff designated by the assisted living facility.

In an interview on 12/07/2022 at 12:19PM, Staff A, Executive Director, stated there was not a section on the care plans for resident or resident responsible party signatures.

In an interview on 12/07/2022 at 12:20PM, Staff A, Executive Director, stated that families/responsible parties were notified of any changes with a scheduled 30-minute conversation over the phone to discuss and the calls were documented in the charting notes.

Plan/Attestation Statement

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Yvonne M. L. King-Lee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 7 sampled residents (Resident 7) prescribed medication was obtained in a correct and timely manner. This failure placed this resident at risk for medical complications and instability of medical conditions.

Findings included...

Record review of the facility policy, titled, "Medication refills", dated 08/10/2021, showed that "medication refills will be obtained in a timely manner to ensure resident have all physician ordered medication available. Medication technician on duty was to contact pharmacy to obtain a refill at least seven days prior to running out of a medication. Medications are never allowed to run out unless directed to by the physician. When there is any delay in the receipt of the medications that results in the unavailability of the medication to be given, the Wellness director is notified."

Record review of the facility policy, titled, "Missed or refused medication", dated 08/10/2021, showed "No resident can be forced to take any medications. Steps will be taken to avoid missed or refused doses of medications and related adverse reactions." Under procedures, it showed "the prescribing physician is notified of missed medications immediately or in the time frame and according to the parameters as indicated by the physician. The responsible party is notified."

Record review of the face sheet for Resident 7 (R7), showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted].

Record review of the Characteristic Roster undated, showed under column "Medication" R7 required assistance.

Record review of R7's Care Plan, dated 07/31/2022, under the section for memory, showed R7 was very confused. Their safety awareness was poor. There was no documentation that showed how R7 was provided their medications.

Record review of R7's Medication Administration Record (MAR), dated September 2022, showed R7 was not administered the following medications plavix (medication to help thin the blood) and paroxetine (medication to help treat anxiety and feelings of sadness) for the dates 09/01/2022-09/13/2022. Under the section titled, "Notes", it showed "medication not available, waiting for delivery".

Record review of R7's charting notes, dated 08/27/2022-09/20/2022, showed no documentation that R7's physician or responsibly party was notified that R7 hadn't received their medications.

Record review of R7's MAR, dated October 2022, showed R7 had refused plavix, colace (stool softener), paroxetine, quetiapine (medication to help with mood/behaviors), senna (stool softener), vitamin b-12, and vitamin D all on 10/06/2022.

Record review of charting notes dated 09/28/2022-11/16/2022, showed there was no documentation that R7's responsible party or physician was notified.

In an interview on 12/07/2022 at 1:30 PM, Staff C, Medication Technician, stated that they try to reorder the residents' medications seven days before they are out of medication, unless the resident gets their medications delivered on the automatic cycle fill. They stated if a resident ran out of their medication, they would call the pharmacy to see when the medication would be delivered. Staff C stated that they would only fax the physician if a new prescription was needed.

In an interview on 12/07/2022 at 2:14 PM, Staff F, Medication Technician, stated that they reorder the residents' medications 5-7 days before the medication was out. They stated that if they medication was not available to administer, they would reorder from the computer. They stated that they try not to allow the medications to run out. Staff F stated that they would notify the nurse and check with the pharmacy if the medication was reordered and fax the physician for a new prescription.

In an interview on 12/07/2022 at 3:40 PM, Collateral Contact 4, Family Member, stated that the facility handled all the medications for R7.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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Yvonne M. L. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all

medications were stored and locked in a secure manner within the two buildings of the facility. The failure to secure medications placed 62 of 62 memory care residents at risk of access and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility's policy "Medication Storage of Centrally Stored Medications", dated 08/10/2021, showed "medications will be stored in a manner that ensures maintenance of both the integrity of the medication and the safety of all residents residing in the community. All medications, including over-the-counter, are kept in locked storage at all times. "

In an observation on 12/07/2022 at 1:00PM, of Resident 7's (R7) room showed a bottle with a prescription label for R7 for Nystatin (medicated powder to treat fungal infection) powder. The bottle was sitting on the shelf in the bathroom under the mirror unsecured.

In an observation on 12/07/2022 at 1:10 PM, showed the medication cart in Cottage two was unlocked without a staff member or medication technician around. Resident 10 was standing at the cart picking up an ink pen. Observation showed the top drawer of the medication cart was able to be opened, and inside the drawer was a Lispro insulin pen for Resident 8.

In an observation on 12/07/2022 at 2:10 PM – 2:14 PM, in Cottage one, showed the medication room door open, with the medication cart unlocked. There was no observed medication technician or staff member in the medication room.

In an interview on 12/07/2022 at 2:14 PM, Staff F, Medication Technician, stated that all medications were to be locked at all times when they were unattended. Staff F, stated the medication cart in the medication room held all of the residents medications that resided in Cottage one.

In an interview on 12/08/2022 at 7:38 AM, Staff C, Medication Technician, stated that all medicated powders and medications were to be locked in the top drawer of the medication cart.

Plan/Attestation Statement

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Yvonne M.L. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were administered their medications as ordered for 2 of 3 sampled residents with diabetes (Resident 1 and Resident 8). The failure to ensure medications were administered as ordered caused harm in the form of bruising and pain to one resident and placed other residents with diabetes at risk for injury, instability of blood sugars, and possible risk for hospitalization.

Findings included...

Record review of Cleveland Clinic document, titled, "insulin pen injections", dated 08/08/2018, showed "an insulin pen is an injection device with a needle that delivers insulin into the subcutaneous tissue (the tissue between your skin and muscle)." Under the section titled, "where on the body do I inject with the insulin pen?", showed "recommended injection sites include the abdomen, front and side of the thighs, upper and outer arms and buttocks."

Record review of Medline Plus document titled, "Human insulin injection", dated 10/15/2019, showed "do not inject human insulin into muscles, scars, or moles."

Record review of Healthline document titled, "insulin injection sites: where and how to inject", dated 08/31/2021, showed that if the insulin was injected into the muscle, the body would absorb it too quickly. The insulin might not last as long within the body. This can lead to low blood sugar levels. The injection is usually more painful.

Record review of the facility policy "Expired Medications", dated 08/10/2021, showed that expired medications would not be given to any resident or responsible party nor retained in the community. Under the section titled, "Procedure", showed expired medications were not to be used. All Nurses/medication technicians were to confirm expiration dates of medications during the medication pass and were to properly dispose of expired

medications.

Record review of a United States Food and Drug Administration website document, titled, "information regarding insulin storage and switching between products in an emergency", undated, showed insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 degrees and 86 degrees for up to 28 days and continue to work.

Record review of diabetes talk website, titled, "expired insulin side effects", dated 01/06/2018, showed that long and short acting insulin pens were to be used up to 28 days after first use.

Record review of the facility's policy and procedure, titled, "Specific medication administration procedures", undated, showed under the section IIB16: "Subcutaneous medication administration; purpose: to administer a parenteral medication into the subcutaneous tissue in order to promote slow medication absorptions and prolong medication action." The policy showed the documented sites of injection on the MAR (Medication Administration Report) included the sites, left buttock (LB), right buttock (RB), left arm (LA), right arm (RA), left thigh (LT), right thigh (RT), left abdomen (LS), and right abdomen (RS).

Record review of Cleveland Clinic website article, titled, "Insulin Pen Injections", dated 08/08/2018, showed that the insulin pen needle was to be injected into the skin at a 90-degree angle.

Resident 1 (R1)
Record review of a face sheet for R1 showed they moved into the facility on [redacted]/2019 with multiple medical diagnoses including [redacted] and [redacted]

Record review of R1's Care Plan, dated 10/11/2022, showed R1 was able to communicate their needs. They were able to understand their peers and staff members. There was no documentation that showed R7 had type 2 diabetes or what type of medication services the facility provided.

Record review of R1's MAR, dated September 2022, showed they had an order for Lantus insulin (long-acting insulin) to be injected subcutaneously every day. Review of the last page of the MAR showed "body location site key", showed "LD" was left deltoid (upper arm muscle) and "RD" was right deltoid. The MAR showed Lantus (long-acting insulin) insulin was administered in both deltoids for 29 of 30 days.

Record review of R1's MAR, dated October 2022, showed R1's Lantus was administered in both deltoids for 31 of 31 days.

Record review of R1's MAR, dated November 2022, showed R1's Lantus was administered in both deltoids for 30 of 30 days.

Record review of MAR, dated 12/01/2022 thru 12/07/2022, showed R1's Lantus was administered in both deltoids for 7 of 7 days.

In an interview on 12/07/2022 at 1:32 PM, R1 stated that the facility staff injected R1's insulin for them every day.

In an observation on 12/07/2022 at 2:10 PM, R1 pointed to their upper arm and pulled up their sleeve that showed a yellow, blue, pea size bruise with a red pinpoint dot in the middle of the upper arm where the deltoid muscle was located. R7 stated that some of the injections do "hurt at times."

In an interview and observation on 12/07/2022 at 2:15 PM, Staff F, Medication Aide, stated that they administered insulin in either the right or left deltoid area and pointed to the area in the middle of their upper arm. Staff F was asked if they were taught to administer the insulin injection straight into the skin. They stated, "yes". They stated that they were taught to administer insulin injections by Collateral Contact 1, Advanced Registered Nurse Practitioner/Nurse Delegator.

In an observation on 12/08/2022 at 8:26 AM in the sunshine room, Staff F, Medication Technician prepped R1's left upper arm, deltoid (muscular area of the upper arm) area with an alcohol pad, then turned to Staff GG, Licensed Practical Nurse/Health Services Director, and asked Staff GG to administer the insulin.

Resident 8 (R8)
Record review of a face sheet for R8 showed they moved into the facility on [redacted]/2020 with medical diagnoses including [redacted] and [redacted]

Record review of the Care Plan for R8, dated 10/25/2022, showed under the section titled, "Medical treatments Blood glucose monitoring", for staff to administer medications as ordered by MD (physician). R8 was a type 2 diabetic with insulin administration and required medication administration. Under the section titled, "Self-Medication /Administration", showed R1 required administration or delegation for one or more medications. R8 was not able to handle their medications. Staff were to administer medications and reorder as necessary.

Record review of R8's MAR, dated September 2022, showed R8 with an order for Lispro insulin given three times every day and Lantus insulin given two times daily.

In an observation on 12/08/2022 at 8:00 AM, showed in the top drawer of the medication cart one Lispro insulin pen and one Lantus insulin pen for R8 with a handwritten date "open 11/03/2022".

Record review of R8's MARs for Lispro injection site of administration, for date range 09/08/2022 – 12/07/2022, showed it was administered 37 times into the deltoid area of the arm. Review of R8's MARs for Lantus injection side of administration, for date range 09/19/2022-11/19/2022, showed it was administered in the deltoid of the arm 19 times while the insulin was expired.

In an interview on 12/08/2022 at 7:05 AM, Staff C, Medication Aide, stated that insulin can be injected into the deltoid. They stated, "the computer on the MAR gives me the option to give in that site." Staff C was asked what the difference between intramuscular (into the muscle) and subcutaneous injections was and Staff C stated they were not aware of what those words meant.

In an observation on 12/08/2022 at 7:43 AM, of the electronic MAR for R8 with Staff C,

showed a current order for Lispro. The order showed staff were to inject the Lispro insulin subcutaneously in bold letters. Staff C stated, "I don't know what that means," and was observed to google (internet search engine site) the definition of subcutaneous.

In an observation on 12/08/2022, at 7:55 AM, of R8's Lispro insulin pen showed a hand-written date opened of 11/03/2022. There were not any other Lispro insulin pens observed for R8 in the medication cart.

In an interview on 12/08/2022 at 8:03 AM, Staff C stated that insulin pens that were in the medication cart were good for 28 days after opening. They stated they handwrote the date of when the insulin pen was opened. Staff C stated the Lispro insulin pen for R8 should have been removed from the medication cart and discarded on 11/30/2022.Record review of R8's MAR, dated 11/30/2022-12/07/2022, showed R8's Lispro insulin pen was administered 23 times with the expired insulin.

In an interview on 12/08/2022 at 8:39 AM, Staff GG stated insulin injections were to be administered in the deltoid muscle, back of the arms, and stomach. Staff GG was asked to clarify where the subcutaneous injection sites were located on the body and Staff GG demonstrated that insulin injections were to be injected in the middle of the arm, in the deltoid muscle.

Plan/Attestation Statement

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Yvonne M.L. King-Lee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 1 of 7 sampled residents (Resident 7) refused their medication. This failure placed the resident at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

Record review of the facility policy titled "Missed or Refused Medication", dated 08/10/2021, showed "No resident can be forced to take any medications. Steps will be taken to avoid missed or refused doses of medications and related adverse reactions." Under the procedures section, showed the prescribing physician was to be notified of missed medications immediately or in the time frame and according to the parameters as indicated by the physician. The responsible party was to be notified.

Record review of a face sheet for Resident 7 (R7) showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted].

Record review of the Facility provided Characteristic Roster, undated, showed under the column "Medication" that R7 required medication assistance.

Record review of R7's Care Plan, dated 07/31/2022, under the memory section, showed R7 was very confused. Their safety awareness was poor. There was no documentation that showed how R7 was provided their medications.

Record review of R7's Medication Administration Record (MAR), dated October 2022, showed R7 had refused plavix (thins the blood), colace (stool softener), paroxetine (medication to help treat anxiety and feeling sadness), quetiapine (medication to help with mood/behaviors), senna (stool softener), vitamin b-12, and vitamin D on 10/06/2022.

Record review of R7's charting notes, dated 09/28/2022-11/16/2022, showed there was no documentation that R7's responsible party or physician was notified.

In an interview on 12/07/2022 at 3:40 PM, Collateral Contact 4, Family Member, stated that the facility handled all the medications for Resident 7.

In an interview on 12/07/2022 at 2:14 PM, Staff F, Medication Technician, stated that they only document on the MAR that the resident had refused their medications.

Plan/Attestation Statement

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Yvonne M.L. Kung-Lee
Administrator (or Representative)

02/06/2023
Date

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure all staff received their food handlers training when 3 of 5 sampled staff (Staff B, Staff C, Staff E) records were reviewed. This failure placed 62 of 62 residents at risk for receiving food that was incorrectly handled by an unqualified staff.

Findings included...

Record review of the facilities staff schedule dated December 2022, showed Staff B and staff C were scheduled to work the evening shifts.

Record review of the facility's staff roster, undated, showed Staff B, Caregiver, was hired on 11/16/2022. Review of Staff B's personal file showed, there was no documentation for the food worker card.

Record review of the facility's staff roster, undated, showed Staff E, Medication Aide/Interim Resident Care, was hired on 06/14/2021. Record review of Staff E's Washington State Food Worker Card showed that it was valid from 08/07/2019 to 08/07/2021.

Record review of the facility's staff roster showed Staff C, Medication Technician, was hired on 09/19/2022. Review of Staff C's Washington State Food Worker Card showed it was valid from 06/30/2020 to 06/30/2022.

In an interview on 12/06/2022 at 1:00PM, Staff A, Executive Director, stated that Staff B would serve food on their scheduled evening shifts. A Food worker card for Staff B would be required to have.

In an interview on 12/06/2022 at 1:54PM Staff A, Executive Director stated Staff E, will complete the food workers card that night. Staff A stated they were trying to get in contact

with Staff B and Staff C to complete their food worker card.

Plan/Attestation Statement

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Yvonne M. R. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

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:

(q) Regarding the management of pets in the assisted living facility, if permitted, consistent with WAC 388-78A-2620 ;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to implement emergency preparedness and pet policies. This failure placed 62 of 62 residents and 32 staff at risk of untrained staff in case of the event emergency and not having a system in place for visiting pets.

Findings included...

Emergency Preparedness Policy
Review of the facility's Emergency Preparedness Evacuation Manual, revised October 2022, under the Emergency Supplies: Water section showed, "For drinking purposes, the following should be used as a guide in determining the minimum amount of water needed: Eight ounces of water per person for each eight-hour period. Supply should be adequate for at least 5 days."

In an interview on 12/08/2022 at 10:50AM, Staff D, Food Service Director (FSD), stated the 3-day emergency food supply was stocked amongst the everyday food supply.

Observation of the facility's outside storage shed on 12/08/2022 at 10:55AM showed five, five-gallon water containers that had expired on 11/29/2005.

In an interview on 12/08/2022 at 11:08AM with Staff D, was informed that the emergency water supply was expired on 11/29/2005. Staff D, stated they would notify Staff J, Maintenance Director.

In an interview on 12/08/2022 at 12:22PM, Staff A, Executive Director stated the 3-day

emergency supply of food should be separated from the everyday food that the facility utilizes. Staff A stated Staff D, Food Service Director was responsible for telling Staff A when the emergency supply of food and water needed to be replaced.

Pet Policy
Review of the facility's policy, "Visiting Pets Policy", dated 08/10/2021, showed "Visiting pets or 'therapy animals' will be permitted providing the handlers adhere to the following guidelines: b) Copies of current veterinarian health certificates are to be maintained on file at the Community."

Review of the facility's Disclosure of Services, updated 2/01/2022, under Services Related to Pets, showed "Pets allowed by the assisted living facility must have regular veterinarian examinations and immunizations, appropriate for the species, and must be free of diseases transmittable to humans. The facility: Does not permit pets."

In an interview on 12/06/2022 at 11:32AM, Staff A, Executive Director, stated there were not any current pets residing in the facility. Staff A stated that there were not any current pets who visit the facility. Staff A stated pets were allowed in the facility with current documentation of up to date vaccinations.

Record review of Resident 4 (R4)'s care plan, updated on 08/11/2022, showed R4 participated in Pet Therapy (visiting animals).

In an interview on 12/07/2022 at 4:49 PM, Collateral Contact 7, Family Member, stated that they visit R4 every Sunday, and they bring their small puggle with them.

In an interview on 12/16/2022 at 1:48 PM, Staff R, Caregiver, stated that they do not work the cottage R4 resides on Sunday's but stated they had seen R4 visiting with a dog at the facility.

In an interview on 12/16/2022 at 1:58 PM, Staff W, Nursing Aid, stated that yes, they had seen the dog visit regularly with R4.

In an interview on 12/06/2022 at 11:32 AM, Staff A, Executive Director stated there was no pets that resided in the facility or visited. There was no documentation provided regarding vaccinations or pet records.

Plan/Attestation Statement

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

Yvonne M.Y. King-Kee — Administrator (or Representative)

02/06/2023 — Date

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;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide privacy and access to appropriate outside seating areas for 1 of 1 residents (Resident 1) reviewed. This failure placed all 62 of 62 residents at risk for not feeling comfortable in their home.

Findings included...

RCW 70.129.140 (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Resident 1 (R1)

Record review of a face sheet for R1, showed they moved into the facility on [redacted]/2019 with multiple medical diagnosis including [redacted]

Record review of an untitled document, dated 08/09/2022, showed the document was a face-to-face evaluation conducted by a nurse practitioner. R1 was documented to have chronic diagnoses of [redacted] and [redacted]

Record review of R1's Care Plan, dated 10/11/2022, showed R1 was alert and oriented to person, place, and time. They were able to communicate their needs. They understood their peers and staff members. R1 was independent with their activities of daily living needs. R1 preferred to work independently in their room. Staff were to preserve R1's resident rights.

In an observation during an interview with R1 in their apartment on 12/07/2022 at 1:51 PM, Staff F, Medication Aide, opened the door to R1's room without knocking or announcement. They used the key to unlock the door and walked inside.

In an interview on 12/07/2022 at 1:55 PM, R1 stated, "all the time they come into the room unannounced. Never have any privacy." R1 stated that was the reason why they keep their door locked.

In an interview on 12/07/2022 at 2:14 PM, Staff F, Medication aide, stated that they were trained to knock on a resident's door, announce who they were, and wait for permission before entering the resident's room.

In an interview on 12/07/2022 at 1:41 PM, R1 stated "sometimes I feel like I'm in prison, I can't go sit on the benches." R1 stated, they "don't use the metal shed in the courtyard, because there are always people smoking cigarettes." R1 stated that they just want to sit

on the bench that they can see from their room. Outside of the window of R1's room, observed a red bench that was near the entrance of cottage one.

In an observation on 12/08/2022 at 10:05 AM, general tour of the outside common areas for the residents to use showed, the only covered area for them to sit at was the same metal shed designated for resident and employees that smoked. There was a strong odor of cigarettes at the entrance of the metal shed. There was smoke observed to be coming out of one of the cigarette disposable receptacles.

In an interview on 12/08/2022 at 12:29 PM, Staff A, Executive Director stated there were no other covered areas for the residents to use other than the metal shed that was also designated for smoking.

Plan/Attestation Statement

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

Yvonne M.R. King-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to investigate and document actions and findings for any accident or incident jeopardizing residents' health for 2 of 7 sampled residents (Resident 4 and Resident 7). This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the resident during the course of the investigation.

Findings included...

Record review of the facility's policy "Internal incident report and state incident report", dated 08/10/2022, showed "policy: injury and unusual incident will be reported in compliant with state regulatory requirements." Under the procedures section, under step one showed an internal incident report was to be completed by staff for all unusual occurrences, injuries, and incidents. Step 4 showed, incident reports were to be reported immediately to family/responsible party and physician, and to document the date and time the report was made to the family/responsible party and physician in the narrative charting section.

Resident 4 (R4)
Record review of an incident report for R4, dated 09/24/2022, showed incomplete sections of the report. The date and time of the incident were left blank. The sections for notifications, follow-up, documentation for who submitted the report, and the wellness director's review were left blank. The attached temporary care plan was left blank. On the Incident Report Analysis, the section for the Wellness Director, Heath Services Director and/or Executive Director was left blank. There was no documentation if the incident needed to be reported to the State, if so, what the confirmation number was and a copy of the Online State Incident Report.

Resident 7 (R7)
Record review of a face sheet for R7 showed they moved into the facility on [redacted]/2022 with medical diagnoses of [redacted] and [redacted]

Record review of a charting note for R7, dated 08/21/2022 at 8:52 AM, showed "resident is on alert for choking incident and injuries/psych harm due to possible harm from roommate." R7 was moved out of the room due to accusations of abuse toward their roommate.
Record review of a charting note for R7, dated 08/23/2022 at 2:53 PM, showed "resident does have bruising on arm unknown from where it came from. Health services director is aware of the bruising."

In an interview on 12/08/2022 at 8:14 AM, Staff C, Medication Aide, stated that if a resident had bruising, an incident report would have been completed. Staff C stated, "they consult the nurse and then do what they say" after an incident or any change with a resident.
In an interview on 12/08/2022 at 9:05 AM, Staff A, Executive Director, was requested to provide August 2022 and September 2022 incident reports for R7 since their admission on [redacted]/2022.

In an interview on 12/08/2022 at 12:00 PM, Staff A stated there were no incident reports for August or September 2022 that they could locate.
Record review of the facility's Incident report analysis, dated 11/16/2022, showed that R7 had a skin tear on their right forearm/wrist area. The incident report analysis didn't have any documentation of measures the facility was taking to prevent similar situations from occurring. There wasn't a clear determination as to how the skin tear occurred.

Plan/Attestation Statement

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Yvonne M.R. Kung-Ku — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

(2) The assisted living facility must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report to the Compliant Resolution Unit (CRU) for 3 of 7 sampled residents (Resident 2, Resident 4 and Resident 7). This failure to notify CRU prevented the Department from being able to evaluate systems that were in place to protect residents.

Finding included...
Record review of the facilities policy, "Medical Emergency", dated 08/10/2022, showed that "the resident will receive emergency medical care when needed to prevent further injury or illness." Under procedure showed list of medical emergencies that included fall with deformity, severe pain, or head injury, and choking. Part 13 showed that an internal incident report is completed and presented to the wellness director. Part 14 showed that a state incident reporting is completed if required per state regulations.

Resident 7 (R7)
Record review of face sheet for R7 showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses [redacted] and [redacted]

Record review of charting notes for R7 dated 08/21/2021 at 6:26 PM, showed "at 5:30 PM

resident had a choking incident and was given the Heimlich."

Record review of charting note dated 08/23/2022 at 2:53 PM, showed "resident does have bruising on arm unknown from where it came from. Health services director is aware of the bruising."

Record review of charting note dated 12/04/2022 at 8:17 PM, showed "resident had choked on some food during lunch and resident was hacking up lots of phlegm around dinner time."

Record review of the RCS department database showed, there was not a report filed regarding the incidents for R7 that were documented in the charting notes.

Resident 2 (R2)
Record review of incident report for R2, dated 09/27/2022, showed R2 had a fall with a skin tear to the forehead. On the Incident Report Analysis under "Does this incident need to be reported to the State: Yes or No (Circle One)" nothing was circled.

Record review of incident report for R2, dated 10/25/2022, showed R2 had a fall with right eye swelling. On the Incident Report Analysis under "Does this incident need to be reported to the State: Yes or No (Circle One)" nothing was circled.

Record review of incident report for R2, dated 11/02/2022, showed R2 had a fall with a laceration to the forehead and a large bump with a laceration to the rear of the skull. On the Incident Report Analysis under "Does this incident need to be reported to the State: Yes or No (Circle One)" "Yes" was circled. Under the next line that reads "If so, what is the CONFIRMATION NUMBER?" no confirmation number was provided. The Incident Report Analysis states "Please print out the online state Incident Report."

Record review of the department application STARS, showed no intakes were found for the incident on 09/27/2022, 10/25/2022 or 11/02/2022 being reported by the facility to CRU.

Resident 4 (R4)
Record review of incident report for R4, dated 09/24/2022, showed R4 had an altercation with another resident and was "hit on top of R4 eye" resulting in a "bump on R4's eye" and "had a cut." On the Incident Report Analysis under "Does this incident need to be reported to the State: Yes or No (Circle One)" nothing was circled.

Record review of the department application STARS, showed no intake was found for the incident on 09/24/2022 being reported by the facility to CRU.

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Yvonne M. L. Kung-Ku
Administrator (or Representative)

02/06/2023
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible when 2 of 7 sampled residents (Resident 2 and Resident 7) had accidental injuries or a significant change in their medical condition. This failure to inform and consult with the residents' representative, physicians, or any residents' designees, placed both residents at risk for not having their current needs evaluated and at risk for harm and hospitalization.

Findings included...
Record review of the facility's "change in resident status" policy, dated 08/10/2022, under the section, "reporting significant change in a resident's condition", showed that "the assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever: a) there is a significant change in the resident's condition, the resident is relocated to a hospital or other health care facility. "

Record review of the facility's policy "internal incident report and state incident report", dated 08/10/2022, under Step 4 showed, incident reports were to be reported immediately to family/responsible party and physician and to document the date and time the report was made to the family/responsible party and physician in the narrative charting section.

Resident 2 (R2)
Review of R2's records showed R2 admitted to the facility on [redacted]/2021, with a diagnosis of [redacted]

Record review of an incident report for a fall for R2, dated 11/02/2022, showed no documentation that the family member/responsible party was notified.

In an interview on 12/07/2022 at 4:27 PM, Collateral Contact 5, Family Member, stated that they did not receive a call about the incident on 11/02/2022.

In an interview on 12/16/2022 at 3:44 PM, Collateral Contact 6 (CC6), Family Member, stated that when they call the facility to check in on R2, staff stated, "oh he's fine" and don't report anything about falls. CC6 stated that they find out about falls from CC5.

Resident 7 (R7)
Record review of the face sheet for R7 showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses of [redacted] and [redacted]

Review of R7's face sheet showed R7 had a POA (power of attorney) of healthcare (someone that makes medical decisions for someone when they are deemed unable to). Collateral Contact 4 was identified as R7's POA.

Record review of R7's Care Plan, dated 11/01/2022, showed under the section "memory and orientation", that R7 was very confused. R7 could recall their daughter, but also had delusional thoughts. R7's safety awareness was poor and was at risk for unavoidable injury to self. R7 knows who they are. They can remember their daughter, but unaware of the date and time.

Record review of a charting note for R7, dated 08/23/2022 at 2:53 PM, showed "resident does have bruising on arm unknown from where if came from. HSD (Health Services Director) is aware of the bruising."

Record review of charting notes for R7, dated 08/23/2022-09/11/2022, showed there was no documentation that R7's responsible party or R7's physician was notified about the bruising on their arm.

Record review of a charting note for R7, dated 09/16/2022 at 4:10 PM, showed "resident tested positive for covid [an infectious disease caused by a virus causing respiratory illness with symptoms of cough, fever, and headache]. No s/s [sign and symptoms] at this time. Faxed pcp [primary care provider] about results."

Record review of a charting note for R7, dated 09/19/2022 at 3:12 PM, showed "resident continues to be positive for covid and is on ABX [antibiotics] for covid. No symptoms at this time. No other concerns."

Record review of charting notes for R7, dated 09/16/2022 -09/28/2022 showed, there was no documentation that R7's responsible party was notified that R7 was positive with COVID and required antibiotics.

Record review of a charting note for R7, dated 11/16/2022 at 9:36 PM, showed, "resident walked out of room with a fresh skin tear on right forearm."

Record review of a charting note, dated 11/17/2022 at 2:32 PM, showed, "did notify ED (Executive Director) about skin tear that was mentioned from 11/16/2022 at 9:36 PM. Said they didn't know how it happened." There was no documentation that resident's responsible party was notified of the skin tear.

Record review of the incident report analysis for R7, dated 11/16/2022 at 9:36 PM, under the section "was a family member/responsible party notified", showed nothing was documented or checked that indicated family had been notified. The section was incomplete and blank.

Record review of a physician communication for R7, dated 12/04/2022, showed R7's diet was changed to puree on 12/05/2022.

Record review of charting note dated 12/04/2022 at 8:17 PM, showed "R7 had choked on some food during lunch and resident was hacking up lots of phlegm around dinner time."

Record review of charting notes for R7, dated 12/04/2022- 12/06/2022, showed no documentation that R7's responsible party was notified about the choking episode during lunch on 12/04/2022 and the new diet change.

In an interview on 12/07/2022 at 12:34 PM, Staff C, Medication Aide, stated for R7, "last choking was with R7's dentures in, just this last weekend. They just got order yesterday to change diet."

In an interview on 12/07/2022 at 3:40 PM, Collateral Contact 4 stated they were not called or notified about R7's skin tear. They had come into the facility, and they saw the skin tear on R7's arm and then asked about it. They said that R7 was complaining of their arm's hurting during a visit, when they noticed the bruising to R7's arms. CC4 stated that they didn't know that R7 had a recent choking episode and that they were now on a puree diet. CC4 stated they had asked how R7 had gotten the bruising. CC4 stated they were not notified that R7 was positive for covid until CC4 showed up at the facility and was not allowed to come in due to covid outbreak. CC4 stated, "the facility doesn't tell me about any changes unless I ask them."

In an interview on 12/07/2022 at 12:19PM, Staff A, Executive Director, stated that the charting notes would reflect when a facility representative contacted the physician and resident's family member. Staff A stated the residents care plan would have been updated, if a change was needed.

This is a recurring deficiency previously cited on 08/25/2022.

Plan/Attestation Statement

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Yvonne M. L. King-Lee
Administrator (or Representative)

02/06/2023
Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 4 of 5 sampled Staff (Staff A, Staff B, Staff C, and Staff E) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within three days of hire. This failure placed 62 of 62 residents and staff at risk for exposure to TB.

Finding included...

Review of Dear Provider Letter titled "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, states "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff TB testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of staff roster and staff records showed the following:
- Staff A, Executive Director (ED) was hired on 09/19/2022.
- Staff B, Caregiver (CG), was hired on 11/16/2022.
- Staff C, Medication Technician, was hired on 12/15/2021.
- Staff E, Medication Technician, was hired on 06/14/2021.

On 12/06/2022, review of staff records showed there was no documentation that Staff A, Staff B, Staff C, and Staff E had received their TB test within three days of hire.

In an interview on 12/06/2022 at 1:01 PM, Staff A, ED, stated that they were not able to find any record of TB testing for Staff A, B, C, and E and that the plan was to retest all the staff that day 12/06/2022.

Plan/Attestation Statement

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Yvonne M.L. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 5 sampled staff (Staff D) received their fingerprint background check. Failure to ensure all fingerprint checks were completed and maintained in the facility placed 62 of 62 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of Staff D's, Food Service Director, personnel file showed that they were hired on 07/25/2018. There was no record that a fingerprint background check had been done for Staff D.

In an interview on 12/06/2022 at 1:00 PM, Staff A, Executive Director, stated they would need to get Staff D's background check from the corporate office.

The Department gave the Executive Director until 12/06/2022 by 2:00 PM to provide the document.

The department had not received the document as of 12/12/2022 at 4:00 PM.

Plan/Attestation Statement

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

Yvonne M.L. King-Lee
Administrator (or Representative)

02/06/2023
Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure all staff received their food handlers training when 3 of 5 sampled staff (Staff B, Staff C, Staff E) records were reviewed. This failure placed 62 of 62 residents at risk for receiving food that was incorrectly handled by an unqualified staff.

Findings included...

Record review of staff roster undated showed Staff B, Caregiver, was hired on 11/16/2022. Review of Staff B's personal file showed, there was no documentation for the food worker card.

Record review of staff roster undated showed, Staff E, Medication Aide/Interim Resident Care, was hired on 06/14/2021. Record review of Staff E's Washington State Food Worker Card showed that is was valid from 08/07/2019 to 08/07/2021.

Record review of staff roster showed Staff C, Medication Technician, was hired on 09/19/2022. Review of Staff C's Washington State Food Worker Card showed it was valid from 06/30/2020 to 06/30/2022.

In an interview on 12/06/2022 at 1:00PM, Staff A, Executive Director, stated that Staff B would serve food on their scheduled evening shifts. A Food worker card for Staff B would be required to have.

In an interview on 12/06/2022 at 1:54PM Staff A, Executive Director stated Staff E, will complete the food workers card that night. Staff A stated they were trying to get in contact with Staff B and Staff C to complete their food worker card. Staff A stated "they could complete the food worker card that evening for $10.00."

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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

Yvonne M. L. Kruger
Administrator (or Representative)

02/06/2023
Date

WAC 388-112A-0240 What documentation is required for facility orientation training?

(1) The adult family home, enhanced services facility, and assisted living facility must maintain documentation that facility orientation training has been completed as required by this chapter. The training and documentation must be issued by the home or service provider familiar with the facility and must include:

(a) The name of the student;

(b) The title of the training;

(c) The number of hours of the training;

(d) The signature of the instructor providing facility orientation training;

(e) The student's date of hire; and

(f) The date(s) of facility orientation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide documentation on site for the Facility Orientation training requirements for 2 of 5 sampled staff (Staff A and Staff B). This failure placed all residents at risk of care and services being provided by untrained staff.

Findings included...

On 12/06/2022, review of staff records showed the following staff did not have documentation that a Facility Orientation was completed:
- Staff A, Executive Director (ED) was hired on 09/19/2022.
- Staff B, Caregiver (CG), was hired on 11/16/2022.

During an interview on 12/06/2022 at 1:01 PM, Staff A, ED, stated that they have a folder with all their credentials and training at their home.

On 12/06/2022 at 2:00 PM, no other information or documentation was received that showed Staff A and/or Staff B had received their Facility Orientation.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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Yvonne M. L. Kung. RN — Administrator (or Representative)

02/06/2023 — 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:

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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure all facility staff were trained on the facility's Emergency Preparedness Policy and Procedures. Failure to ensure staff were appropriately trained on what to do in an emergency placed 62 of 62 residents and 32 staff at risk for a delayed response in an emergency, which could lead to injury or death.

Findings included...

Review of the facility's Emergency Preparedness evacuation manual, revised October 2022 showed, "know the location of fire door in your area." The emergency preparedness evacuation manual showed to evacuate to the nearest point of safety and included a map of the facility's fire evacuation route . The emergency evacuation map was not included in the manual. The evacuation procedure showed "Resident evacuation – Ambulatory residents to dining room/parking lot." The evacuation manual did not indicate where non ambulatory residents were to evacuate or how to do so.

In an observation on 12/06/2022 at 11:00 AM, during the general tour of Cottage one, there was no posted emergency evacuation routes in the event of an emergency.

In an observation on 12/07/2022 at 1:15 PM, during the general tour of Cottage two, there was no posted emergency evacuation route in the event of an emergency.

In an interview on 12/08/2022 at 9:56 AM, Staff C, Medication Aide, was asked where the meeting place was in the event of an evacuation of the facility. Staff C stated, "I don't know, they always make us go to the middle common courtyard." Staff C stated, "never been told a meeting site."

In an interview on 12/08/2022 at 10:50 AM, Staff D, Food Service Director , stated the meeting place for emergency evacuation was outside the facility, across the parking lot by the main office building.

In an interview on 12/08/2022 at 3:26PM, Staff A, Executive Director, stated if the evacuation routes were posted they would be inside of the medication technician room. Staff A stated the meeting site was in the common courtyard of the facility. Staff A stated the keys to unlock the common courtyard fence were in the medication technician room.

Plan/Attestation Statement

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Yvonne M.L. Kong-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(i) Giving residents opportunities for privacy, socialization, and common spaces that account for wandering behaviors;

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 1 of 62 residents had access to their own rooms without staff assistance. The facility failed to provide the resident the opportunities for privacy. This failure resulted in this resident being at risk for having a diminished quality of life.

Findings included...

During an observation on 12/07/2022 at 12:56 PM, staff had to unlock R2's room to allow Residential Care Licensor and R2 access to the room.

Record review on care plan dated 10/09/2022 showed there was no documentation regarding R2's room needing to be locked.

In an interview on 12/07/2022 at 4:27 PM, Collateral Contact 5 (CC5), Family Member, stated that they had never seen R'2 room. CC5 stated that at their last visit in August, R2's room was locked.

In an interview on 12/16/2022 at 3:44 PM, Collateral Contact 6 (CC6), Family Member, stated that they had never been in R2's room. CC6 stated that they had wanted to go in but that staff would "stir us away."

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2024 .

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

Yvonne M. L. Kung-Ku — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to have a signed copy of the facility's Medicaid policy for 4 of 7 sampled Residents (Resident 1, Resident 5, Resident 6, and Resident 7). This failure placed these residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included...

On 12/06/2022 at 1:11 PM, an on-site review of the facility's resident records showed Resident 1, Resident 5, Resident 6 and Resident 8 did not have a Medicaid Policy in their records.

Resident 1 (R1)
Review of face sheet for R1 showed, that they moved into the facility on [redacted]/2019.

Record review of the facilities residence and care agreement for R1 dated 12/16/2021, showed there was not a signed Medicaid policy.

Resident 5 (R5)
Review of R5's records showed they were admitted into the facility on [redacted]/2022.

Record review of the facilities residence and care agreement for R1 dated 12/07/2021, showed there was not a signed Medicaid policy.

Resident 6 (R6)
Review of R6's records showed they were admitted into the facility on [redacted]/2022.

Record review of the facilities residence and care agreement for R1 dated 12/07/2021, showed there was not a signed Medicaid policy.

Resident 7 (R7)
Review of R7's records showed they were admitted into the facility on [redacted]/2022.

Record review of the facilities residence and care agreement for R1 dated 7/22/2021, showed there was not a signed Medicaid policy.

In Interview on 12/06/2022 at 1:00PM with Staff A, Executive Director, stated the Medicaid policy for the residents would be in their residence and care agreements.

Plan/Attestation Statement

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

Yvonne M.L. King-Lee
Administrator (or Representative)

02/06/2023
Date

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

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

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

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

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

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(f) Availability of the supervisor, in person, by pager, or by telephone, to respond to residents' needs on the assisted living facility premises as necessary.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had received nurse delegation training. Failure to ensure staff were nurse delegated placed 49 of 49 residents living in the facility with delegated tasks at risk of harm for receiving care from a potentially unqualified caregivers and unmet medical care needs resulting in

hospitalization.

Findings included...

WAC 246-840-930
Criteria for delegation.
(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE.
ASSESS
(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).
(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.
(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.
(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.
(8) Verify that the nursing assistant or home care aide:
(a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;
(b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;
(c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training;
(d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and
(e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.
(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.
PLAN
(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.
(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:
(a) The rationale for delegating the nursing task;
(b) The delegated nursing task is specific to one patient and is not transferable to another patient;

(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;
(d) The nature of the condition requiring treatment and purpose of the delegated nursing task;
(e) A clear description of the procedure or steps to follow to perform the task;
(f) The predictable outcomes of the nursing task and how to effectively deal with them;
(g) The risks of the treatment;
(h) The interactions of prescribed medications;
(i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
(j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
(i) How to notify the registered nurse delegator of the change;
(ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and
(iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
(k) How to document the task in the patient's record;
(l) Document teaching done and a return demonstration, or other method for verification of competency; and
(m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.
(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.
IMPLEMENT
(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.
(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).
EVALUATE
(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.
(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.
(18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.
(19) The registered nurse must supervise and evaluate the performance of the nursing

assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

Record review of the facility characteristic roster, undated, provided on 12/06/2022 at 10:34AM, showed 49 current residents received nurse delegated nursing services.

In an interview on 12/06/2022 at 10:34 AM, Staff A, Executive Director (ED), stated under column "nursing services" the "ND" was abbreviation for "nurse delegation".

In an interview on 12/06/2022 at 10:54 AM, Staff A, ED, stated that Collateral Contact 2 (CC2) was the current nurse delegator for the facility. Collateral Contact 1 (CC1) was the previous nurse delegator.

In an interview on 12/07/2022 at 10:10 AM, Staff A, ED, stated that they did not have the nurse delegation binders on site.

In an interview on 12/07/2022 at 10:15AM, Staff A stated the nurse delegation binder for previous nurse delegator CC1 had taken them home to update, but then fell ill and has yet to return them back to the facility. The current nurse delegator binder under CC2 had not yet been completed. Staff A stated CC2 had taken over nurse delegation as of 11/17/2022.

In an interview on 12/07/2022 at 1:20 PM, Staff F, Medication Technician, stated that the "med techs" administer the insulin to the residents. Staff F stated that they were last delegated by CC1.

In an interview on 12/08/2022 at 8:12 AM, Resident 9 (R9), stated that they moved into the facility in [redacted] of 2021 and had been on insulin the entire time they have lived at the facility. R9 stated that the "med techs" have been administering their insulin.

In an observation on 12/08/2022 at 8:26 AM, in the sunshine room, showed Staff F prepped Resident 1 (R1)'s left upper arm, deltoid (muscular area of the upper arm) area, with an alcohol pad, then turned to Staff GG, Licensed Practical Nurse Health Services Director, and asked Staff GG to administer the insulin.

In an interview on 12/08/2022 at 8:38 AM, Staff GG stated that they didn't need to give the insulin to R1 and that Staff F could have.

In an interview on 12/08/2022 at 7:25 AM Staff C, Medication Aide, stated they hadn't been watched by CC2, RN, Nurse Delegator. They had a phone review with CC2 on the medication technician process.

Resident 7 (R7)
Record review of a face sheet for R7 showed they moved into the facility on [redacted]/2022 with medical diagnoses of [redacted] and [redacted]

Review of R7's Care Plan, dated 11/01/2022, showed that under the section "treatments, therapies, medicines, and appointments" there was not documentation to identify what medications or services were needed to be nurse delegated to trained care staff.

Record review of a progress note for R7, dated 09/13/2022, showed R7 was evaluated by CC1. Under Diagnosis and assessment", showed "Patient [R7] with a choking episode over the weekend. Care staff report that patient has been holding medications and food in their mouth. Trial downgrade diet to pureed food started. Will sent ST (speech therapy) referral, ok to crush medications, and monitor resident during mealtimes."

Record review of a physician communication for R7, dated 09/15/2022, showed CC1 wrote new order "okay to crush medications PRN (as needed)."

The facility was unable to provide required nurse delegation and staff training documents on delegation for 49 of 49 nurse delegated residents to show any training and delegation on nursing tasks were completed to meet the appropriate medical care needs of these residents.

Plan/Attestation Statement

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

Yvonne M.L. Kung-Lee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident records contained sufficient information as required to meet resident care needs for 1 of 7 residents (Resident 3). This failure placed the resident at risk for unmet care needs.

Findings included...

Record review of a face sheet for Resident 3 (R3) showed they moved into the facility on [redacted]/2016, with multiple medical diagnoses including [redacted] and [redacted]

[redacted]

Record review of document titled, Making lower sodium choices, undated, showed a picture reference of prefered choices resident was supposed to follow. R3 was to avoid pancakes, sausage, frozen food, canned food, fast food burgers, fast food fries, salty snacks, and salt.
Record review of R3's Care Plan, dated 10/09/2022, showed "R3 is careful with their diet due to their dialysis". The care plan did not indicate information regarding what a dialysis diet consisted of.

Record review of dialysis clinic physician order for R3, dated 08/09/2020, showed "R3 may have a peanut butter sandwich three times a week".

In an interview on 12/07/2022 at 12:55 PM, R3 stated they go to dialysis three times a week on Tuesdays, Thursday's, and Saturdays. R3 stated they were supposed to follow a dialysis diet. R3 could not reiterate what a dialysis diet consisted of. R3 stated they go to the local shopping center every week to purchase their snacks. R3 stated that they keep their snacks underneath their bed.

Observation on 12/07/2022 at 1:00 PM, showed clear containers underneath R3's bed with cookies and crackers inside of it.

In an interview on 12/07/2022 at 2:00 PM, Staff A, Executive Director, stated R3 was on a dialysis diet. Staff A provided an Emergency Meal Plan that was to be implemented if R3 cannot receive a dialysis treatment. Staff A provided a document titled making lower sodium choices that was provided by the dialysis clinic that R3 was to referrence. Staff A provided a physician order that showed R3 may have a peanut butter sandwich three times a week. Staff A stated R3 deviated from their diet by going to weekly grocery trips on their own and would hide crackers and cookies under their bed. Staff A stated the facility had attempted to educate R3 on making better eating choices. Staff A stated these conversations had not been documented in charting notes or the care plan.

Plan/Attestation Statement

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Yvonne M. C. Kung-Kee — Administrator (or Representative)

02/06/2023 — 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;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on interview and observation, the facility failed to provide a safe, sanitary, and well-maintained environment for 62 of 62 residents. The facility failed to keep exterior grounds in good repair, facility free from odor, and equipment and furnishings clean. This failure resulted in all residents having a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

In an observation on 12/06/2022 at 10:35 AM, during the general tour of the facility, when entering cottage one a strong pungent odor of urine that permeated through Residential Care Services (RCS) licensors surgical facial masks.

In an observation on 12/06/2022 at 10:38 AM, near the ceiling was observed a large amount of small gnats and bugs entangled in a cobweb near the exit door of cottage 1 to the common courtyard that residents utilize. There were gnats imbedded into cobwebs outside of the exit door in the alcove for Cottage one and Cottage two.
In an observation of Resident 2's room on 12/07/2022 at 12:56 PM, a strong odor of urine was present upon entrance. The floor of the bathroom had a sticky substance that caused the RCS Licensor's shoes to stick to the floor while walking to the sink.

In an observation on 12/07/2022 at 1:05 PM, in Resident 7's (R7's) room, showed multiple dead bugs and a dead butterfly in the window seal. R7's head of the bed was near the window seal.

In an observation on 12/07/2022 at 1:13PM, of Resident 4's room, showed the faucet in the room had rust calcification surrounding the base of the faucet and handles. When the water was turned on, water started to leak from the back base of the faucet. By the time the RCS Licensor was finished checking the temperature of the water, the leaking water was flowing on to the counter.

In an observation on 12/08/2022 at 7:05 AM, upon entering the front doors of cottage one a strong pungent odor of urine was present.

In an observation on 12/08/2022 at 7:15 AM, in Cottage one, the water fountain had a black film surrounding the drain grate.

In an observation on 12/08/2022 at 7:48 AM, while sitting in Cottage one's medication room, a strong odor of urine wafted the air enough to permeate through the RCS Licensor's surgical facial mask.

In an observation on 12/08/2022 at 10:21 AM, showed a black substance inside the back of the ice machine. RCS Licensor's inquired about the substance to Staff D, Food Service Director (FSD). Staff D, was observed to grab white paper towel and wiped inside the back of the ice machine without using gloves. The white paper towel was observed to have thick, pink and black gel like substance that was removed. The back of the ice machine was observed to show some of the black substance had been removed.

In an interview on 12/08/2022 at 10:21 AM, Staff D stated that Staff J, Maintenance Director and themselves, cleaned the ice machine on a weekly basis. Staff D stated that once a month Staff J and themself, take the ice out of the machine, take apart the machine, and clean the inside thoroughly. Staff D stated they do not keep records of when the ice machine was cleaned for either weekly or the monthly cleanings. Staff D was unable to recall specific date when the ice machine was last cleaned.

In an interview on 12/08/2022 at 10:39 AM, Staff D stated with the help of Staff J, they deep cleaned the kitchen on a weekly basis. Staff D stated they pull every piece of equipment out from the wall to clean them and scrub the floors during the monthly deep clean. Staff D stated they do not keep records of when and what they clean.
In an observation of Cottage one's kitchen, on 12/08/2022 at 10:42 AM, showed an orange and brown splatter alongside the exit doorway. The light switch fixture had brown spots varying in length and size. There was a fan attached to the wall, that had grey fuzzy substance covering the device.

In an observation on 12/08/2022 at 11:00 AM, the freezer of one of four refrigerators in the outside storage shed showed a brown and yellow substance inside covering the bottom. In one of the refrigerators showed a carton of eggs that had a pooling brown liquid on top of the plastic egg container. There were unpackaged peppers inside of the crisp container sitting on a hardened brown substance. In the freezer of one of the refrigerators showed a brown substance that covered the right side of the wall and the bottom shelving. In a refrigerator of one of four refrigerators showed a bright red hardened substance covering the bottom of the fridge. The freezer of one of four refrigerators, showed a hardened brown substance with food particles on top, covering the bottom of the freezer.
In an interview on 12/08/2022 at 11:07 AM, Staff D, observed the inside of the refrigerators and freezers in the outside storage shed. Staff D stated "it's been a while" since they were cleaned.

In an observation on 12/08/2022 at 11:10 AM, of the common courtyard showed there

were wooden chairs that had green, brown, and black substances covering them.
In an observation on 12/08/2022 at 11:14 AM, the beautician sink was observed to have dried water calcification surrounding the handle. The drain was observed to have a thick black substance.

In an interview on 12/08/2022 at 11:17 AM, with Staff G, Housekeeping, stated that the kitchen staff were responsible for cleaning the refrigerators and freezers for the facility. They stated that the common sink for Cottage one was also used by the beautician for the resident's hair services. Staff G stated that they attempted to get the black substance out of the inside of the drain. Staff G stated that the sink was worse than before. Staff G stated, "try to clean as much as they can, when they can." Staff G stated they were the only housekeeper for cottage one.

In an interview on 12/08/2022 at 12:22 PM, Staff A, Executive Director, stated that the cooking staff were responsible for cleaning the refrigerators and freezers. Staff A stated the cleaning should occur on a weekly basis.

Plan/Attestation Statement

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Yvonne M. L. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 1 of 7 sampled residents (Resident 1) had the means to summon on duty staff in the bathroom, corridors, common areas, and outdoor areas accessible to residents. This failure placed 62 of 62 residents at risk of not being able to summon staff when help was needed.

Findings included...

Record review of face sheet for Resident 1 (R1), showed they moved into the facility on [redacted]/2019 with multiple medical diagnoses including [redacted]

Record review of Care Plan dated 10/11/2022, showed R1 was alert and oriented to person, place, and time. They were able to communicate their needs. They understand their peers and staff members. R1 was independent with their activities of daily living needs. They use a cane when they walk.

Record review of untitled document dated 08/09/2022 conducted by Nurse practitioner, showed R1 had a history of falling. The facility was to provide a safe surrounding included staff-accompanied or facilitated transfer and monitoring.

In an interview with R1 on 12/07/2022 at 1:41 PM, stated they don't take showers. They stated the shower bench gets very slippery when water and soap was on it. They stated they have nearly fallen from the shower bench being slippery.

In an observation of R1's room on 12/07/2022 at 1:45 PM, there was no pull cord or call light located in the bathroom. Observed the call light system that was located by the front door halfway up the wall. There was a button that needed to be pushed to activate call system to request assistance from staff. Observed there was no cord or call light system accessible from the R1's bed or their roommate's bed.

In an interview on 12/07/2022 at 1:50 PM, R1 was asked how they would call for assistance from staff if they needed. R1 stated "they would go to the door and yell out for a caregiver." They stated they weren't aware of any pull cord that was available, other than the button by the front door. They stated if they were to fall beside their bed or within their room, "it depends on how injured I was, if I could crawl and get up to push the button by the door to get help." R1 stated they didn't have a pendent or button they could push to requested assistance from caregivers.

Plan/Attestation Statement

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Yvonne M. L. Kung-Kee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

(b) Restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage that is likely to be spread in the assisted living facility setting or by casual contact;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

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

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure all staff were fit tested for an N95 respirator. This failure resulted in 28 staff not being fit tested and 4 staff with expired fit test as required per infection control and prevention standards. This placed 62 of 62 residents and 32 staff at risk of being infected and spreading COVID-19 virus (Coronavirus Disease, an infectious virus that can cause respiratory illness.)

Findings included...

Record review of the document titled, ""L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE", dated 03/30/2021, DOH 420-328 showed, "The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 and other airborne hazards. COVID-19 is an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes." The "fit test" is to be completed every 12 months.

Record review of Centers of Disease Control and Prevention (CDC) document, titled, "Strategies for Optimizing the Supply of N95 Respirators", updated 09/16/2021, showed under the section titled, "Just-in-time fit testing", it was essential to have Healthcare professionals trained and fit tested prior to receiving or taking care of positive COVID-19 residents.

Record review of the Dear Provider (DP) Letter dated 04/30/2021, ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal

Protective Equipment (PPE)", directed LTCF's under WAC 296-842-12005 to develop and maintain a respirator program which included initial fit testing and providing staff with their fit tested respirator.

Record review of Infection Control 17 – Respiratory Illness Outbreak Policy Date 08/10/2021 showed "Always follow guidelines and recommendations from the CDC and your state and local public health department."

Record review of the facilities fit test binder showed four staff (Staff G, Staff N, Staff Y and Staff U) had fit test record dated 11/29/2022 that were expired. There were no medical evaluations or fit test records for the other 28 staff members (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, Staff V, Staff X, Staff Z, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG).

In an interview on 12/08/2022 at 7:36 AM, Staff DD, Caregiver, stated they were not fit tested for an approved N95 respirator.

In an interview on 12/08/2022 at 3:45 PM, Staff A, Executive director, stated not all staff have been fit tested for an approved N95 respirator. The facility does not have a designated person to conduct fit testing. There was no plan in place to get the staff fit tested.

In an interview on 12/16/2022 at 1:48 PM, Staff R, Care Giver, stated that they had not been fit tested at the facility. Staff R stated that the last time they were fit tested was when they were employed across the street at the nursing home.

In an interview on 12/16/2022 at 1:58 PM, Staff W, Caregiver was asked if they had been fit tested. Staff W, stated "um, no."

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 03/23/2023 .

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

Yvonne M. L. King-Lee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide documentation on site for Cardiopulmonary resuscitation (CPR) and first aid training requirements for 3 of 5 sampled staff (Staff B, Staff C, and Staff E). This failure placed 62 of 62 residents at risk for unqualified staff to provide emergency services to resident in need of medical attention.
Findings included...

On 12/06/2022, review of staff records, showed that CPR and first aid training for Staff E, Medication Aide, hired 06/14/2021 `had expired on 10/30/2021.
In an interview on 12/06/2022 at 1:54 PM, Staff A, Executive Director (ED), stated that they spoke to Staff E, who stated they will take care of it that evening.

Record review of Dear Provider Letter titled "Governor's Proclamations related to COVID-19 ending October 27," dated 09/09/2022 and amended on 10/07/2022, states towards the top of page two under Category CPR and first aid training and Status of Requirements "Facilities must be in compliance with WAC 388-112A-0720 by October 27."

Record review on 12/06/2022 at 1:00 PM of staff records, showed there was no documentation of first aid and CPR cards for Staff B Caregiver, and Staff E Medication Aide/Interim Resident Care. First aide and CPR card for Staff C, Medication Aide, showed an expiration date of July 2022.

In an interview on 12/06/2022 at 1:54 PM Staff A Executive Director, stated "we will have to have a class here" to update staff's CPR and first aid course. There was no documentation provided on 12/07/2022 of Staff B, Staff C, or Staff E's current first aid and CPR card.

Plan/Attestation Statement

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

Yvonne M. L. Kung-Lee — Administrator (or Representative)

02/06/2023 — Date

WAC 388-78A-2420 Record retention.

(1) The assisted living facility must maintain on the assisted living facility premises in a resident's active record(s) all relevant information and documentation necessary for meeting a resident's current assessed needs.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to maintain all nurse delegation documentation necessary for meeting residents current assessed needs at the facility and available for review. This failure placed 3 of 7 sampled residents (Resident 2, Resident 4, and Resident 7) at risk of proper care needs being unmet.
Findings included...
Resident 2 (R2)

Review of R2's records, showed R2 admitted to the facility on [redacted]/2021, with a diagnosis of [redacted]

Record review of Nurse delegation: Consent for Delegation process dated 03/26/2022, showed R2 required nurse delegation services.

Record review of R2's care plan dated 10/09/2022, showed R2 required administration or delegation for one or more medications.

Resident 4 (R4)
Review of R4's records, showed R4 admitted to the facility on [redacted]/2020, with a diagnosis of [redacted]

Record review of R4's care plan dated 08/04/2022, showed R4 requires administration or delegation for one or more medications.

Resident 7 (R7)
Review of records for R7 showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses including [redacted]

Record review of Nurse delegation: Consent for Delegation process dated 07/22/2022, showed R7 required nurse delegation services.

In an interview on 12/07/2022 at 10:15AM, Staff A, Executive Director, stated the nurse delegation binder was not on campus. Staff A stated Contact Collateral 1 (CC1), former nurse delegator, had taken the binder home to update the documents. CC1 had become sick and has yet to return the binder with the nurse delegation documents back to the facility. Staff A stated that Colleterial Contact 2 (CC2) was the current nurse delegator 11/17/2022. Staff A stated CC2 had not completed their updated nurse delegation binder.

Plan/Attestation Statement

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Yvonne M. L. King-Lee
Administrator (or Representative)

02/06/2023
Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure that the designated smoking area was 25 feet away from the building per Washington State law. This failure placed 62 of 62 residents at risk for exposure to smoke.

Findings included...

RCW 70.160.075 titled "Smoking prohibited within twenty-five feet of public places or places of employment - Application to modify presumptively reasonable minimum distance. "Smoking is prohibited within a presumptively reasonable minimum distance of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited so as to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means."

In an observation on 12/08/2022 at 1:04PM, the entrance of the metal shed to the building under a residents bedroom window of Cottage two, measured at 18 feet and 9 inches. Staff H, Caregiver/Cook was observed to be using the smoking area during the measurement. There was a strong odor of cigarette smoke. The smoking post that tobacco products were disposed in was located at the entrance of the metal shed and was observed to have smoke coming out of the opening on the top.

In an interview on 12/08/2022 at 12:22PM, Staff A, Executive Director, stated the designated smoking area for the facility staff and residents was in the metal shed in the outside enclosed courtyard between Cottage one and Cottage two. Staff A stated the smoking shed was 25 feet away from Cottage two. They were told this, when they were hired in September 2022. They stated they have not measured the distance of the shed to the building Cottage two.

This is a recurring deficiency dated 08/25/2022.

Plan/Attestation Statement

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

Yvonne M. L. King-Kee
Administrator (or Representative)

02/06/2023
Date

Plan of Correction

Agency Name	**Citation Date**
Memory Care at The Lodges	01/25/2023
Submitted by	**Date of POC Submission**
Yvonne King-Kee	02/06/2023
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-2070 Timing of preadmission assessment	
What *initial or immediate actions* were taken to address concerns affecting clients?	Initial assessments performed by qualified assessor will be kept on file with date information and entered into system prior to admission.
How will you apply the correction to all clients you support?	**Qualified assessors will be trained to perform this function as of date 3/10/2023**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director and Health Services Director will be oversight. Executive Director will be primary oversight ensuring that resident information is complete and accurate prior to resident admission.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Cory Cisneros, Field Manager
Region 3, Unit E
6639 Capital Blvd. SW Point Plaza West
Tumwater, WA 98501

Plan of Correction

Agency Name	Citation Date
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Submitted by	**Date of POC Submission**
Yvonne King-Kee	02/06/2023
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-2120 Monitoring residents' well-being.	
What *initial or immediate actions* were taken to address concerns affecting clients?	All resident changes that are reported to Health Services Director will be reported to Executive Director to ensure that changes to care plans are being monitored and followed through. Each day, ED will ensure that communications to all med techs of changes to care plans are sent and broadcast to care givers. All hospitalizations and changes to care will be reviewed by Executive Director to ensure that care plans have been updated to meet the needs of residents. All diet changes will be reported at standup meeting or directly to HSD and all dining staff and clinical staff will be notified of these changes and instructed to remove any foods that do not fit within resident's requirements. All parameters/vitals to resident medication orders will be reported to ED and will communicate to Nurse Delegator any re-education.
How will you apply the correction to all clients you support?	**All hospitalizations and changes of care are reported in incident reports. ED will review all changes of care and incident reports and communicate with responsible parties and resident to ensure that these changes meet the needs of our residents.** ED will also monitor one meal per day and one med pass each day on differing shifts to ensure that medications are being administered properly. ED will review care plans on a monthly basis to ensure all changes have been included in care plans.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive director reviews all incidents and chart notes from previous 72 hours on a daily basis. ED will also monitor one meal a day (different meal times per day) and watch one med pass (different med passes each day) to ensure that medication restrictions are being followed.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2130 Service Agreement Planning.	
What *initial or immediate actions* were taken to address concerns affecting clients?	ED will contact each responsible party or resident and provide copy of care plan for signature. If the responsible party or resident would like to discuss changes to care plan, they will make an appointment with ED to make appropriate changes.
How will you apply the correction to all clients you support?	**All signed care plans will be held within a folder in the Health Services Director Office separated by appropriate annual assessment date. These care plans will be monitored and discussed with resident or responsible party on an annual bases.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Health Services Director will be responsible for scheduling time to discuss care plan with resident families prior to anniversary date either in person, phone, or email.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2140 Negotiated service agreement contents	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Executive director will request all care plans for current residents receiving outside provider service and will enter into the resident care plan. Hospice and home health agencies will be requested to have meeting with Executive Director once they have accepted a resident for care. This will be communicated to all outside providers.**
How will you apply the correction to all clients you support?	Home Health/Hospice providers chart in folder kept in med tech stations. ED will review once a week to ensure all care plans have been input and any changes are marked. ED will also review for any new residents that may have been accepted but provider has not communicated with ED.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	ED will schedule this matter into calendar for weekly checks and will request meetings with all outside providers.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2150 Signing negotiated service agreement	
What *initial or immediate actions* were taken to address concerns affecting clients?	ED to speak with responsible parties and residents regarding care plans and have them signed off annually.
How will you apply the correction to all clients you support?	**All care plans will be organized in folder by anniversary date and ED will contact all those that are past due to update and HSD will be responsible for contacting resident families to ensure that the care plans have been agreed upon and signed.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	ED will go through care plans monthly to determine who is due for annual and HSD will contact resident or responsible party prior to anniversary date to schedule meeting.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2240 Nonavailability of medications	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Medication refill requests and doctor renewal requests are placed into Communications binder kept in med tech room. ED monitors folders for any communications that have not been replied to and either calls or visits doctor's office to ensure continuity of medications. If insurance issue, ED calls responsible party.**
How will you apply the correction to all clients you support?	All clients receive medication services. All communications regarding medications will be noted in communication binders. Med Techs will be trained to let ED know that medications are running out 7 days prior.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director will implement change and continue to monitor daily,
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2010 Medication Services	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Executive Director will monitor one med pass per week/shift (one monitoring for AM, PM, and NOC) to ensure that medications are being administered per doctor's orders.**
How will you apply the correction to all clients you support?	**Executive Director will implement and quality assurance document for med techs to fill out to ensure that they are reading doctor's orders appropriately and following medication administration as requested.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director will perform audit weekly to ensure that medication guidelines are followed.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2230	
What *initial or immediate actions* were taken to address concerns affecting clients?	Medication refusals are noted in charting system. ED to review each morning and ensure that fax documentation has gone out to primary care physician when resident has refused 3x.
How will you apply the correction to all clients you support?	**This will apply to all residents. Each are in system and receiving medications.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	ED is responsible for ensuring that all medications that have been refused have notification in communications binder to show that provider has been notified.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2350	
What *initial or immediate actions* were taken to address concerns affecting clients?	**All employees who have expired food handlers services are required to have certification in house no later then 02/04/23**
How will you apply the correction to all clients you support?	**Employee matrix with all certification expiration dates is being created by Business Office Manager (BOM). BOM will notify all at a minimum of 14 days prior. Refusal or delay will result in the employee being taken off of schedule until certification has been renewed.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Susan Berry, Business Office Manager will be responsible for ensuring that notifications are sent out and employees are adhering to WAC requirements.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2600 Policies and Procedures	
What *initial or immediate actions* were taken to address concerns affecting clients?	All staff will be retrained in emergency preparedness guidelines and pet policies. All families will be notified that pets are not allowed in the facility without prior authorization and current vaccination records. All employees will be in-serviced to understand that they are not to allow pets into the facility unless they have received notification from administration office that the pet is allowed in the building.
How will you apply the correction to all clients you support?	**An email is being sent out to all responsible parties and any pet therapy groups that we must have current vaccination records and a picture of the pet in order to enter our facility. Care staff will be trained to speak with any family members that do not have current vaccination records and bar the animal from the facility. Pet pictures of approved pets will be posted on the back of the med tech door so that all approved pets can be recognized.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director will be responsible for notifying all resident families and responsible parties. Activities Director will notify all pet therapy groups. Business Office Manager will procure picture of pets who have been granted access. All new residents and families will be notified of our pet policy and sign off that they understand this.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2660 Resident Rights	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Appropriate outdoor seating will be provided for residents in resident courtyard. Caregivers and med techs will be in-serviced on respecting resident rights and knocking before entering premises. Resident and staff smoking area will be moved towards outside of restricted egress and residents will be allowed if accompanied by caregiver. Current smoking shed will be transformed into resident space with no smoking capabilities within the community.**
How will you apply the correction to all clients you support?	Responsible parties will be notified and any residents that smoke cigarettes will be notified and told of new policy. Employees will be in-serviced about new policy.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director will be responsible for ensuring that all residents and employees are aware of the changes and inservice will be performed regarding resident privacy.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2371 Investigations	
What *initial or immediate actions* were taken to address concerns affecting clients?	**HSD or ED to review incidents within 24 hours. Reports to state will be made within that time. ED to do monthly audit of all incidents to ensure that they have been investigated properly and reported to RCS, as needed.**
How will you apply the correction to all clients you support?	**ED to handle finalization of all incidents and keep incident log. ED to review to look for possible needed changes to care plan.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	HSD responsible for immediate response, if not available, ED to handle review. ED to review at end of month to ensure all investigations have completed, reports to state have been made, and any changes to care plans have occurred.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2630	
What *initial or immediate actions* were taken to address concerns affecting clients?	**ED to complete in-service for reporting abuse and neglect allegations. ED to ensure that all injuries have been reported to ED/HSD, POA, and resident primary care physician. Reports of significant issue or possible abuse and neglect will be reported by ED.**
How will you apply the correction to all clients you support?	**All employees will be inserviced regarding abuse and neglect and how to report. Policy will be re-iterated to employees and examples of abuse and neglect will be included in inservice.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	ED will be responsible for inservice.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2640	
What *initial or immediate actions* were taken to address concerns affecting clients?	**All incidents of significant change of condition will be reported to ED and ED to handle all communication between responsible party. Med Techs will be required to notify the primary care and ED will review communications binder to ensure communication will be handled.**
How will you apply the correction to all clients you support?	**Communications binder will be reviewed and matched to each incident. ED to chart communications with responsible parties and med tech's will be in-serviced to ensure that charting of report to primary care is noted. ED to review to ensure reporting has occurred.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director, Health Services Director, and Resident Care Coordinator will be responsible for ensuring that the process has been reviewed and completed.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: 388-78A-2480 Tuberculosis	
What *initial or immediate actions* were taken to address concerns affecting clients?	**All employees will undergo a facility wide tuberculosis 2-step testing by a licensed nurse and documentation will be included in employee paperwork.**
How will you apply the correction to all clients you support?	**This will apply to all employees and they will receive this during their in-service meeting. Licensed nurse will return within three day period to review reactions, then return in 2 weeks from initial skin test to administer again and return three days later.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Licensed nurse from sister community will assist with this.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Region 3, Unit E
6639 Capital Blvd. SW Point Plaza West
Tumwater, WA 98501

Plan of Correction

Agency Name	Citation Date
Memory Care at The Lodges	01/25/2023
Submitted by	**Date of POC Submission**
Yvonne King-Kee	02/06/2023
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-24642 Background checks National fingerprint background check.	
What *initial or immediate actions* were taken to address concerns affecting clients?	BOM will review matrix and notify any staff member 14 days prior to expiration of background check. BOM will have staff member fill out background authorization and enter into the system then make an appointment for the employee and will retrieve results and input into employee file.
How will you apply the correction to all clients you support?	**This will apply to all staff members and Business Office Manager will report to ED any staff member who is not adhering to WAC.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	BOM will be responsible for updating matrix and reporting to ED. ED will review matrix monthly for anyone that has not received their fingerprint background check back. ED will work with Resident Care Coordinator to remove staff member from schedule until they are in compliance.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2305 Food sanitation.	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Business manager will refer to staff matrix and ensure that all staff members have received their food handlers certification.**
How will you apply the correction to all clients you support?	**This certification will be reminded to staff members at in-service meeting.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	BOM will be primary, ED secondary and reviewer.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-112A-0240 What documentation is required for facility orientation training?	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Full staff in-service will be provided in which facility training will occur. All staff members will be required to attend 1 of 2 meetings and documentation will be included in their staff folders.**
How will you apply the correction to all clients you support?	**This will apply to all staff members.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Business Office Manager will be initial oversight, maintenance director secondary, Executive Director will be tertiary.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2700	
What *initial or immediate actions* were taken to address concerns affecting clients?	Two inservices will be scheduled and all employees must attend one or the other. Emergency preparedness will be in-serviced to all staff members with regards to how to handle emergencies, whom to notify, and who is responsible for each action.
How will you apply the correction to all clients you support?	**This will apply to all staff members and a sign in log will be recorded.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director and Maintenance Director will be responsible for handling in-service meeting.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2381 General design requirements for memory care.	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Outdoor smoking shelter is being turned into a non-smoking area and any smokers will be escorted by caregiver outside of fence in new smoking area away from building. All doors with locks will be exchanged for doors without locks unless required by care plan.**
How will you apply the correction to all clients you support?	**This will be relayed in email to all responsible parties and all residents will be informed by Activities Director**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director will be responsible for changing outdoor enclosure and creating new smoking area.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2665 Resident Rights	
What *initial or immediate actions* were taken to address concerns affecting clients?	**During care plan meetings, new policy will be created to show that we accept Medicaid as a form of payment. This will be signed by residents, if able, or responsible party.**
How will you apply the correction to all clients you support?	**This will apply to all residents and BOM is responsible for ensuring that all resident files have applicable policy with signatures.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director will be responsible with Business Office Manager as secondary.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2320 Intermittent Nursing Services	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Nurse Delegator has finished binder and it is on site and ready to view.**
How will you apply the correction to all clients you support?	**Nurse Delegation Binder is available in administration office for viewing.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Angela Arruda-Matthenge, RN Delegator
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2410 Contents of Resident Record	
What *initial or immediate actions* were taken to address concerns affecting clients?	**All care plans are being updated to include diet and lifestyle information as well as external provider information.**
How will you apply the correction to all clients you support?	**Executive Director to oversee care plans and records to ensure that orders receive match resident care plans.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director and Health Services Director will oversee that this is maintained.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-3090 Maintenance and Housekeeping	
What *initial or immediate actions* were taken to address concerns affecting clients?	Daily, Weekly, and Monthly cleaning schedules are being used and signed off on by dining and maintenance staff. Additional carpet cleaning machine has been purchased for upholstery.
How will you apply the correction to all clients you support?	**Executive Director will audit staff to ensure cleanliness and schedule is being adhered to.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2930	
What *initial or immediate actions* were taken to address concerns affecting clients?	**New call light system is being installed 02/13/23 to resident rooms and bathrooms.**
How will you apply the correction to all clients you support?	**Call light system will be monitored for accurate usage and adequate power supply**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director with Maintenance Director as secondary.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2381 Infection Control	
What *initial or immediate actions* were taken to address concerns affecting clients?	**ED has requested for DOH to fit test all employees.**
How will you apply the correction to all clients you support?	Facility to continue requesting fit testing when we have 3 or more new hires.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	BOM will provide primary oversight by adding to employee matrix and ED will be secondary to ensure that all employees have been tested.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2474 Training and Home Care Aide Certification Requirements.	
What *initial or immediate actions* were taken to address concerns affecting clients?	Executive Director to hold ORSA, CPR, and First Aid class onsite.
How will you apply the correction to all clients you support?	**Executive Director will hold one class monthly for all employees. If employees that are expiring do not hold this class then they will be required to obtain the certification on their own.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director is primary, Business Office Manager is secondary to ensure all those that require re-certification have been completed.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2420 Record Retention	
What *initial or immediate actions* were taken to address concerns affecting clients?	Nurse delegation binder with nurse delegation forms for all residents is on file and available for inspection. Nurse delegator has been instructed not to remove binder and make adjustments while on the property.
How will you apply the correction to all clients you support?	**Executive Director reviews binder monthly to ensure all residents have the appropriate documentation and all staff have been properly delegated.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director is responsible for ensuring this process continues.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation. **3/10/2023**
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Citation: WAC 388-78A-2040 Other requirements	
What *initial or immediate actions* were taken to address concerns affecting clients?	Residents will now smoke accompanied by caregiver outside of restricted egress. Internal shelter is altered for all community access.
How will you apply the correction to all clients you support?	**Executive Director will find appropriate covered unit for residents to smoke in.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director is responsible for this action.
Date by which lasting correction will be achieved	Enter the date when you expect the lasting correction (including system to prevent future problems) to be complete. This must be within 45 days of the citation **3/10/2023**
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