



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

03/14/2025

Centralia Point Operating Company LLC
Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

RE: Centralia Point Assisted Living and Memory Care # 2609

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 56368 (Completion Date 03/14/2025) and 51373 (Completion Date 12/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/14/2025 and found no deficiencies.

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

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

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

The Department staff who did the On Site verification:

Anissa Bearden, Licensors

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 #: 2609	Compliance Determination # 51373
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 1 of 4	Licensee: Centralia Point Operating Company LLC	12/09/2024

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

The department completed data collection for an unannounced on-site follow-up on 12/09/2024 and 12/09/2024 of:

Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

This document references the following SOD dated: 12/09/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 49 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licenser
Celeste Vashey, ALF LTC Licenser

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

12/19/2024
Date

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

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Administrator (or Representative)

*Bayan Bani*Date *12-26-2024***WAC 388-78A-2260 Storing, securing, and accounting for medications.**

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications were stored and locked in a secure manner in 1 of 3 residents (Resident 1 [R1]) rooms. This failure placed 35 of 35 assisted living residents at risk of potential ingestion of harmful substances and risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 09/25/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2260] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 10/18/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 11/08/2024."

Record review of the facility's Plan of Correction, dated 09/25/2024, showed the facility sent out a reminder notice to all of the resident's representatives reminding them that that they could not store medication in their loved one's room without the approval of the resident's ordering physician as well as the facility registered nurse assessment. The facility resident care management would audit all the resident's units monthly for medications. The medication technicians and caregivers were trained to inform the resident care manager, the registered nurse, and the executive director immediately if they were to locate any medications in the residents unit. Management would review orders and assessments if required and would ask the staff member to remove the medication and contact the power of attorney.

Record review of the facility provided document titled, "assisted living resident characteristic roster and sample selection", dated 12/09/2024, showed there were 35 residents that resided in the assisted living side of the facility. The facility documented

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that there were four residents residing on the assisted living side of the facility that had a diagnosis of [REDACTED]

Record review of R1's Service Agreement, dated 10/29/2024, showed R1 had multiple medical diagnoses that included [REDACTED], and [REDACTED]. Under the section titled, "cognition", showed R1 was alert and oriented to person, place, time, and situation. R1 did complain of some intermittent memory impairment, but was able to make their needs known. Under the section titled, "wellness checks", showed staff were to check on R1 two times a shift and assist with any needs R1 may need. Under the section titled, "Medication: Set-Up", showed R1 received medication assistance. The facility assisted R1 with obtaining medications and communications with the pharmacy and primary care provider as needed. R1's medications would be set up for administration in accordance with the physician's medication/treatment orders. The facility would provide medication set-up services to support safe and effective medication administration practices.

Record review of R1's Master Assessment, dated 10/29/2024, under the section titled, self-medication evaluation", showed R1 had not requested to self-administer medication. R1 had not been evaluated and approved for self-medication administration by the nurse.

In an observation and interview on 12/09/2024 at 9:36 AM, inside R1's apartment next to the left side of their lounge chair on the their bedside table was a bottle that had a label that showed "Robitussin nighttime cough DM" (a medicated liquid to help reduce coughing, runny nose, and help with sleep) and a bottle with a red lid of "Tylenol" (a medications to help with pain and mild aches.) R1 stated that they took the Tylenol at times when they could not sleep from their knee pain. R1 stated they took the Robitussin nighttime DM for their chronic allergies they have. R1 stated that the facility locked up all of their medications and administered their medications to them except for the Tylenol and Robitussin that they pointed to on their bedside table not locked up.

In an interview on 12/09/2024 at 10:34 AM, Staff B, Medication Technician, stated R1 does not administer their own medications. Staff B stated all of R1's medications were locked up in the medication cart by the facility. Staff B stated R1 was not allowed to keep medications in their room.

In an interview on 12/09/2024 at 10:59 AM, Staff A, Executive Director, stated the resident care manager was responsible to complete the resident unit audits for unsecured medications. Staff A stated the resident care manager was expected to audit every residents room monthly to ensure that there were no medications unlocked. If a resident was assessed to be independent with self-administering medications, the resident care manager would ensure that resident had their medications locked up in

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their locking drawer.

In an interview on 12/09/2024 at 11:31 AM, Staff A stated they were unaware if the monthly medication audits had been started as the resident care manager was recently hired.

In an interview on 12/09/2024 at 12:21 PM, Staff A, stated the facility staff provided R1 their medications. Staff A stated R1 had been having multiple falls recently related to their balance being off. Staff A acknowledged R1 should not have had medications in their room on their bedside table and could have possibly been a contributor to R1's falls. Staff A acknowledged that multiple staff go into R1's room throughout the day and that staff should have removed the medication from R1's room when it was observed. Staff A stated R1 was not cleared to have medication in their room and self-administer.

This is an uncorrected and recurring deficiency previously cited on 09/25/2024 and 06/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on
(Date) 01/23/2025

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

Bryce A. Bann
Administrator (or Representative)

12.26.2024
Date



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

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

The department completed data collection for an unannounced on-site follow-up on 09/04/2024 and 09/04/2024 of:

Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

This document references the following SOD dated: 09/25/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 46 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Emily Boniface, Community Program Nurse Licensors

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

10/07/2024

Date

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

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

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Administrator (or Representative)

Bryan Bower

Date 10/18/2024

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;
- (4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;
- (5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70, 70.122, 11.88, 11.92, and 11.94 RCW;
- (6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

Bryan Bower ^{SB}
11/8/24

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to address and resolve 1 of 4 resident (Resident 2 [R2]) grievance. This failure resulted in R2 having unresolved concerns and placed R2 at risk for decreased quality of life.

Findings included...

RCW 70.129.140 "Quality of life—Rights. (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. (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."

RCW 70.129.060 "Grievances. A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Record review of the facility's policy titled, "Complaint and grievance policy", undated, showed residents and their responsible party would have an opportunity to submit complaints and grievances without discrimination or reprisal, to be addressed by the appropriate Department with the goal of resolution and to comply with state regulations. Anyone with a complaint may fill out a complaint form and turn it into the staff member in charge. The administrator would receive the complaint form, assess the complaint and forward to the appropriate Department Director to address, investigate, and respond to the complaint and return to the administrator within five business days.

The administrator or the Department Director would contact the person that submitted the complaint with a resolution. The resolution would be documented on the complaint form for review.

Review of R2's Service Agreement, dated 04/24/2024, showed R2 had a diagnosis of [REDACTED]

[REDACTED] as a part of the service plan effective 11/28/2023.

Review of R2's document titled, "Medication Administration Record [MAR]," dated 08/01/2024 through 08/31/2024, showed R2's Humulin N insulin (prescribed medication injection insulin that helps lower blood sugars for a longer period of time) administration times were changed on 08/14/2024. The scheduled Humalog insulin (prescribed medication insulin injection that helps lower blood sugar levels quickly) and Humulin N were changed from "AM" to 8 AM and "PM" was changed to 8 PM.

Review of R2's document titled "MAR," dated August 2024, showed R2's AM's blood sugars reading 08/22/2024 was 76 and on 08/31/2024 R2's blood sugar reading was 83.

Review of R2's document titled "progress notes", dated 08/15/2024 at 5:27 PM, showed R2 refused their Humulin N insulin. Staff A, Executive Director, documented, "It was reported to this ED by a Med Tech [Medication Technician] that [R2] was treating her poorly and yelling at [Staff H, Medication Technician] because [R2] insulin orders and dosage times have changed."

Review of R2 document titled "progress notes", dated 08/15/2024 at 9:16 PM, showed "Resident was frustrated with [R2] insulin dose being changed on. [R2] stated 'I've been a diabetic for 30 years and I know some people do that because its how THEIR sugars work but not mine I've been a diabetic for 30 years' med tech recruited help from [Staff A] to talk with resident due to [R2] being so upset. When med tech tried to give resident his 2000 [8 PM] dose of slow acting insulin resident denied it. Med tech let resident know they would be back to check and resident stated 'Don't bother just write up the note and tell everyone i refused because i don't want to worry about my sugars dropping to low' Med tech noted it in the chart after trying three times."

Record review of R2's progress note, dated 08/16/2024 at 9:56 PM, showed R2 refused their Humulin N insulin.

Record review of R2's progress note, dated 08/18/2024 at 10:10 PM, showed R2 refused their Humulin N insulin.

Record review of R2's progress note, dated 08/19/2024 at 10:04 PM, showed R2 refused their Humulin N insulin.

In an interview on 09/04/2024 at 11:17 AM, R2 stated last month, approximately three weeks ago, their scheduled diabetic medication times changed without their knowledge nor involvement with that decision. R2 said they used to receive their PM insulin (both long-acting and short-acting insulin) before dinner. R2 stated with the recent changes they were not allowed to receive the evening long-acting until after dinner beginning at 8PM. R2 said they reported to staff the change in time did not work for them and requested to have it changed back because the time change was causing very low blood sugars during the night and in the mornings. R2 said they have requested to

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Speak with their doctor to discuss these changes and has not yet met with them.

In an interview on 09/04/2024 at 11:48 AM, Staff C, Medication Technician, said R2 complained to them numerous times about the medication being late.

In an interview on 09/04/2024 at 3:24 PM, Staff A said the insulin administration times were changed and was aware R2 did not want the medication time changes. Staff A said the times were changed to narrow the window of administration time allowed.

In an interview on 09/04/2024 at 4:10 PM, Staff D, Resident Care Manager, said medication times were changed due to how heavy the before dinner medication pass had been for the medication technicians. Staff D stated the time changes were to help space out the workload for medication technicians. Staff D stated R2 knows their body very well and there have been some complaints about the time changes.

In an interview on 09/04/2024 at 4:16 PM, Staff D, stated that R2 had a voice in everything related to their insulin time changes. Staff D stated R2 knows their body and had been a diabetic for a long time.

In an interview on 09/17/2024 at 3:47 PM, Staff F, Registered Nurse (RN) Delegator, said that R2's physician had written a twice daily order for insulin on 02/10/2024. From 02/10/2024, until 08/14/2024, insulin administration times were in the AM and at 5PM. Staff F said that on 08/14/2024, Staff G, RN Corporate, did chart audits and changed the AM medication times for all residents to a set 8AM, and changed the PM scheduled medication times to 8PM. Staff F said Staff G did not inform nor make these changes with the consent of the residents.

As of 09/25/2024 the facility did not provide any documentation to show they addressed and responded the grievance voiced by R2.

This is an uncorrected deficiency previously cited on 06/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 11.8.24.

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

Brycen Brown
Administrator (or Representative)

10.18.24
Date

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

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.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure fit testing (testing for respirator mask fitting and use) was completed per Washington state regulations for 1 of 4 staff members (Staff C). This failure placed 46 of 46 residents, staff, and visitors' life and safety at risk of spread of infectious disease during an outbreak.

Findings included...

WAC 296-842-14005 "Provide medical evaluations.

Medical Evaluation Process

Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:

(a) Are required to use respirators; or

Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:

(a) Whether or not the employee is medically able to use the respirator;

(b) Any limitations of respirator use for the employee;

(c) What future medical evaluations, if any, are needed;

(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005

"Conduct fit testing.

(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:

(a) Before employees are assigned duties that may require the use of respirators;

(b) At least every twelve months after initial testing;"

Record review of the facility's Respiratory Protection Program (RPP), dated 01/15/2021, showed the Executive Director was responsible to maintain RPP records and conduct program evaluations annually. Facility supervisors were listed as responsible to ensure associates received initial and annual respirator mask fit tests and medical clearances before authorization to wear a respirator. Records were to be kept based on Occupational Safety and Health Administration guidelines, which would be an associate's period of employment, plus 30 years. All staff were required to be fit tested for an N95 respirator for COVID-19 (Corona Virus Disease 2019- an infectious communicable 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).

Review of the document titled "L&I [Labor and Industries] and Department of Health

(DOH) Respirator and 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. 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 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 the dear provider letter number 2023-014, dated 03/30/2023, showed that the Secretary of Health announced the order that required wearing a face covering in long term care facilities had ended on 04/03/2023. Despite that the order had ended the individuals in long-term care facilities, including residents, staff, and visitors, were required to continue to follow the Department of Health (DOH) and Centers of Disease Control and Prevention (CDC) guidance. Respiratory Protection Program (RPP) requirements were not changed by the ending of the Secretary of Health's order, nor would they change when the federal public health emergency ended on 05/11/2023. Staff would still be required to wear N95 respirators around individuals with suspected or confirmed COVID-19, and an RPP was required anytime a respirator was used in a long-term care facility. An RPP must include medical clearance, fit testing, training, written policies, and documentation.

Record review of the facility's document titled, "Respiratory Protection Program", undated, showed every employee of the facility who must wear a respirator would be provided with a medical evaluation before they were allowed to use a respirator. All employees who wore a tight-fitting respirator would be fit-tested before using their respirator or given a new one. Fit-testing would be repeated annually, when a different respirator facepiece was chosen, or if there was a physical change in an employee's face that would affect the fit. The fit testing procedure were followed by the Washington Industrial Safety and Health Act (WISHA). The document showed that the facility evaluated and found respirators must be used by all staff when there was COVID-19 in the facility.

Record review of the facility's Plan of Correction, undated, showed Staff F, Registered Nurse, was responsible to fit test new hires as part of the new hire process and to ensure other employee's fit tests were completed.

Record review of the Department database showed on 08/16/2024 at 6:52 PM, the facility reported Resident 3 and Resident 7 both tested positive for an infectious disease (requiring use of fit tested respirator equipment).

Record review of the facility provided document titled, "schedule for week of 08/11/2024 – 08/17/2024", showed Staff C, Medication Technician, worked 08/12/2024 through 08/16/2024 from 6 AM until 2 PM as the assisted living medication technician. There were no other scheduled assisted living medication technician that worked those

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days.

Record review of the facility provided document, untitled and undated, showed Staff C, Medication Technician, was hired at the facility on 08/01/2024.

In an interview on 09/04/2024 at 2:08 PM, Staff B, Licensed Practical Nurse/Operations Support Specialist, stated Staff C was not fit tested for an N95 respirator and did not have a medical clearance for review.

In an interview on 09/04/2024 at 4:36 PM, Staff E, Director of Operations, stated the facility's expectation for new employees were to have them fit tested the first week they were employed.

As of 09/04/2024 at 5:00 PM, the facility was unable to provide Staff C's medical clearance and fit testing record for review.

This is a uncorrected and recurring deficiency previously cited on 06/26/2024 and 04/28/2023.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on
(Date) 11-8-2024.

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

Bryan W. Brown
Administrator (or Representative)

10-18-2024
Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records for 1 of 2 units reviewed (Assisted Living Units). These failures placed 33 of 33 residents at risk for exposure of confidential records.

Findings included...

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Record review of the facility's policy titled, "Confidentiality of Resident Information", undated, showed all resident information would be held in the strictest confidence and was accessible only to authorized staff, the resident, authorized authorities, and individuals with resident's approval in accordance with applicable state and federal law. All resident records were secured. The facility would maintain the resident records in the confidential files. The facility would not disclose the residents' records to others unless the resident directed to that was documented in writing or unless the law authorized or compelled the facility to do so.

Record review of the facility's document titled, "plan of correction", undated, showed medications technicians were retrained for protection of resident records.

In an observation on 09/04/2024 at 9:56 AM, on the second floor by the maintenance office door, the medication cart was unattended with a laptop computer that sat on top with the laptop screen that was closed halfway and was illuminated with light. The laptop computer screen was lifted up, the screen had an electronic record that displayed Resident 6's (R6) name and medical information. The electronic record showed what room R6 resided in, R6 ate a regular diet, texture of mechanical soft and thin liquids, and listed R6's medications furosemide. The electronic record listed multiple medical diagnoses for R6. As of 10:18 AM, the computer screen on top of the medication cart remained unsecured with R6's personal information accessible for review.

In an interview on 09/04/2024 at 10:38 AM, Staff C, Medication Technician, stated they were to either shut the computer or lock the electronic record on the computer screen to ensure residents personal information was secured.

In an interview on 09/04/2024 at 4:16 PM, Staff D, Resident Care Manager, stated all resident personal health records and information were to always be kept secured and unavailable to other residents and visitors when the medication cart or the computer were left unattended.

This is an uncorrected deficiency previously cited on 06/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 11.8.2024.

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

Brynn Boulton
Administrator (or Representative)

10.18.2024
Date

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

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications were stored and locked in a secure manner in 1 of 5 residents (Resident 5 [R5]) rooms. This failure placed 34 of 34 assisted living residents at risk of potential ingestion of harmful substances and risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility provided document titled, "assisted living resident characteristic roster and sample selection", undated, showed there were 34 residents that resided in the assisted living side of the facility. The facility documented that there were four residents residing on the assisted living side of the facility that had a diagnosis of [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] listed.

R5

Record review of R5's Service Agreement, dated 07/23/2024, showed R5 had diagnoses to include [REDACTED]

[REDACTED] and [REDACTED]
[REDACTED] The services agreement showed R5 received medication services from the facility medication technicians.

In an observation on 09/04/2024 at 10:56AM, in R5's unlocked room accessible to other residents, showed in R5's bathroom was two bottles of nighttime sleep aid liquid medicine bottles on the right side of the bottom shelf inside the medicine cabinet: one bottle a third full and the other bottle two thirds full. Additionally, two medicine cups and sore throat relief spray were viewed inside the unlocked cabinet. Inside the resident closet was a bottle of Tylenol, arnica bruise gel (medicated topical gel to help treat pain), ketoconazole shampoo gel (medication shampoo to help treat fungal infections), and an inhaler labeled albuterol sulfate inhalation powder (prescribed inhalant medication to help open the lungs to breath easier). To the right of the bedside on the table was a bottle of Tums (medication that helps heart burn or upset stomach). Inside the kitchenette, in an unlocked cabinet, were glucose tabs (sugar tablets), and two glucometers (a machine that checks a persons blood sugar level), test strips, and lancets (fine tip needle to pierce finger for blood). On top of the entertainment center was a travel glucometer set.

In interview on 09/17/2024 at 3:47 PM, Staff F, Registered Nurse, said medication technicians were responsible for ensuring resident medications were locked up and

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inaccessible to other memory care residents. Staff F said staff had been trained to observe for unlocked medications and other hazardous items and to remove and secure these items if they came across them in a resident accessible area.

This is an uncorrected deficiency previously cited on 06/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 11-8-2024.

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

Brynn Boun
Administrator (or Representative)

10-18-2024
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 5 sampled residents (Resident 2 [R2]) refused their medication. This failure placed R2 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's policy titled, "missed medication policy", undated, showed all residents would receive medications according to physician's orders. Any medication that was not provided due to non-delivery of the medication results in notification of the resident care coordinator (RCC). The medication technician or the

RCC would call the pharmacy to determine the delivery date. If the delivery date of the medication would be longer than 48 hours, the facility nurse, administrator, physician, and family/power of attorney would be notified. Notification would be documented in the resident's record. Further action would then be determined. Any medication not provided for 48 hours (including refusals) would result in notification of the RCC, facility nurse, administrator on the 24-hour report. Further action would be taken that included notification of the physician according to their preference. Notifications would be documented in the resident record and further action would then be determined and could include faxing the physician for alternative medications order, faxing the pharmacy for help with pre-authorization, and obtaining from a satellite pharmacy if needed as an immediate order.

Record review of the undated facility policy titled "Medication Refusal by a Resident", showed all residents would receive medications according to physician's orders, including assistance as prescribed by facility staff. The facility policy said the facility would take appropriate action, including notifying the prescriber or health care practitioner when there was a pattern of the resident not taking their medications. The policy said facility staff would contact a licensed nurse to evaluate the significance of the resident not receiving his or her medication and that if a nurse was not available the prescriber or health care prescriber would be notified. The facility staff were to document in the resident record the refusal, including date and time, the staff person's response to the refusal, and any prescriber directions following the notification.

Record review of R2's Service Agreement (facility's version of the Negotiated Services Agreement [NSA]), dated 04/24/2024, showed R2 had multiple medical diagnoses that included [REDACTED]. The service agreement showed R2 was Registered Nurse (RN) Delegated for blood sugar checks and insulin administration.

Record review of fax messaging between the facility staff and R2's physician, dated 06/11/2024, showed R2's physician reply on 06/12/2024 with instruction to "please notify if med refused 3 times in one week."

Record review of R2's Medication Administration Record (MAR), dated 08/01/2024 through 08/31/2024, showed R2 refused their Humalog insulin (prescribed injectable medication that helps lower high blood sugars quickly) on 08/15/2024 through 08/17/2024 and on 08/19/2024. R2's Humulin N insulin (prescribed injectable medication that helps maintain and keep high blood sugars levels at a more normal range for long period of times) was documented as held on 08/18/2024.

Record review of R2's progress note, dated 08/15/2024 at 5:27 PM, showed R2 refused their Humulin N insulin.

Record review of R2's progress note, dated 08/16/2024 at 9:56 PM, showed R2 refused their Humulin N insulin.

Record review of R2's progress note, dated 08/18/2024 at 10:10 PM, showed R2 refused their Humulin N insulin.

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Record review of R2's progress note, dated 08/19/2024 at 10:04 PM, showed R2 refused their Humulin N insulin.

Record review of R2's progress notes, dated 08/14/2024 through 08/22/2024, showed there was no documentation that showed R2's physician was notified that R2 had refused their insulin four times that week.

In an interview on 09/17/2024 at 3:47 PM, Staff F, RN Delegator, said all medication technicians have been trained to notify the resident physician if medications were refused three or more times in a one-week period, including late and held medications.

In an interview on 09/17/2024 at 3:47 PM, Staff F said they learned of R2's repeated refusals upon return to the office on 09/03/2024 and viewing a report that showed R2's medication refusal incidences.

This is an uncorrected deficiency previously cited on 06/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 11.8.2024.

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

Brynn Baum
Administrator (or Representative)

10.18.2024
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 that 3 of 5 residents (Resident 1 [R1], Resident 2 [R2], and Resident 5 [R5]), had their medications available for administration per physician orders. This failure placed R1, R2, and R5 at risk for medical complications from not receiving medications as prescribed, and a decreased quality of life.

Finding included...

Record review of the facility's policy titled, "missed medication policy", undated, showed all residents would receive medications according to physician's orders. Any

medication that was not provided due to non-delivery of the medication results in notification of the resident care coordinator (RCC). The medication technician or the RCC would call the pharmacy to determine the delivery date. If the delivery date of the medication would be longer than 48 hours, the facility nurse, administrator, physician, and family/power of attorney would be notified. Notification would be documented in the resident's record. Further action would then be determined. Any medication not provided for 48 hours (including refusals) would result in notification of the RCC, facility nurse, administrator on the 24-hour report. Further action would be taken that included notification of the physician according to their preference. Notifications would be documented in the resident record and further action would then be determined and could include faxing physician for alternative medications order, faxing pharmacy for help with pre-authorization, and obtaining from a satellite pharmacy if needed as an immediate order.

Record review of the facility's Plan of Correction, undated, showed the facility would notify the residents physician when a medication was not available for administration. The facility reviews for missed or held medications in the electronic medical records during their clinical meetings.

Record review of the Mayo Clinic's website article titled, "symptoms low potassium", dated 06/23/2022, showed a very low potassium level in a person blood could be life-threatening and required urgent medical attention. The most common cause of low potassium was excessive potassium loss in the urine due to a prescribed medication that increase urination. This was also known as water pills or diuretics. These types of medications were often prescribed for people who had high blood pressure or heart disease. Low potassium symptoms may include weakness, fatigue, muscle cramps, and abnormal heart rhythms particularly for people with underlying heart disease.

Record review of the Mayo Clinic's website article titled, "furosemide [prescribed medication that helps rid excessive water with in the body also known as water pill or diuretic] (Oral route) precautions", dated 09/01/2024, showed the medication could cause you to lose more potassium from the body than normal.

R1

Record review of R1's face sheet, dated 09/04/2024, showed R1 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED]

[REDACTED], and [REDACTED].

Record review of R1's Master Assessment, dated 08/08/2024, showed R1 did not self-administer their medications. R1 required the facility to assist with their medication up to three times daily. R1 used an outside pharmacy to get their medications filled.

Record review of R1's Medication Administration Record, dated 08/01/2024 through 08/31/2024, showed R1 had an order for potassium chloride to be take every day, furosemide (prescribed diuretic medication that eliminates excessive fluid retention in the body through urine), and metolazone daily (prescribed medication diuretic that help eliminate excessive fluid in the body through the urine). Review of the administrations showed R1 did not receive their potassium chloride medication on 08/15/2024 through 08/16/2024 and 08/19/2024 through 08/28/2024 that was a total of 12 doses of the potassium chloride. Under medications notes showed the medication was not available,

awaiting delivery from pharmacy, and held.

Record review of R1's document titled, "renewal response", dated 08/02/2024 at 4:03 PM, showed R1 physician denied the refill request for R1's potassium chloride as R1 needed to make a physician appointment. This physician notification was made 13 days prior to R1 being out of potassium chloride and would be out of the medication if it was not refilled.

Record review of R1's document titled, "renewal response", dated 08/02/2024, showed the document was sent to the facility on 08/14/2024 at 1:02 PM, that showed R1's physician continued to refuse to fill the medication as R1 needed to make an appointment with the physician. There was no documentation on the document to show that the resident was out of the medication.

Record review of an email sent to the Department on 09/10/2024 at 5:40 PM, showed there were no provided documentation that the facility faxed or notified the physician that R1 was out of their potassium and was not receiving the medication on 08/15/2024 through 08/28/2024 for review. Review of R1's progress note, dated 08/16/2024 at 10:07 PM, showed the pharmacy was notified to get a refill on R1's potassium. The pharmacy did not have any further refills and were only able to send the facility an emergency supply.

Record review of R1's progress note, dated 08/23/2024 at 2:17 PM, showed R1 had not been able to take their potassium for the last few weeks. R1's physician required R1 to be seen for an appointment and refused to refill the medication.

Record review of R1's progress note, dated 08/23/2024 at 2:48 PM, showed Staff D, Resident Care Manager, documented that R1's physician office was called and notified that R1 was out of their medications. There were no other documented progress notes for dated 08/16/2024 through 08/23/2024, that showed R1's physician was called and notified that R1 was out of their medication and not receiving the dose.

R2

Review of R2's record, titled, "medication notes", dated 08/20/2024, R2 missed a dose of Lisinopril (medication that treats high blood pressure and other heart conditions), with a note of "med not available."

Record review of a Progress note for R2, dated 08/20/2024, showed, "Called pharmacy to request refill for Lisinopril 5mg [Milligram]. [the facility preferred pharmacy] informed me that the medication would go out tonight. [Staff D's name]."

R5

Record review of Resident 5 (R5) medication notes, dated 08/21/2024 at 5:00 PM, showed Lanzoprazole ODT (prescribed medication to reduce stomach acid) tablet was not available. There was no note documented by the medication technician regarding what was done to obtain the medication.

Record review of R5 medication notes, dated 08/01/2024 through 08/31/2024, showed on 08/22/2024 and 08/26/2024 R5 did not receive Lantanoprost (prescribed medicated

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eye drops to help increase the outflow of the fluid from the eye) . Medication notes showed the medication was not available but there was no further documentation of the circumstance or plan to obtain the medication.

In an interview on 09/17/2024 at 1:49 PM, Staff D, Resident Care Manager, stated they first called the physician for R1 on 08/23/2024 to get their potassium medication refilled. Staff D stated the medication technicians were to notify the resident care manager immediately when a resident was out of medication to fax the physician, call the physician, and notify family to get the medication at the facility to administer.

In an interview on 09/17/2024 at 3:47 PM, Staff F, Registered Nurse, stated medication technicians were responsible for reordering resident medications when medications were out. Staff F stated that medication technicians were trained to place residents on alert charting until the medication had been restocked and available for the resident.

This is an uncorrected deficiency previously cited on 06/26/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 11-8-2024.

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

Bryan W. Baur
Administrator (or Representative)

10-18-2024
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

- (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
- (d) The plan to provide necessary health support services, if provided by the assisted living facility;
- (e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
- (a) Exclusively for the individual resident; or
- (b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.
- (3) The times services will be delivered, including frequency and approximate time of day, as appropriate;
- (4) The resident's preferences for activities and how those preferences will be supported;
- (5) Appropriate behavioral interventions, if needed;
- (6) A communication plan, if special communication needs are present;
- (7) The resident's ability to leave the assisted living facility premises unsupervised; and
- (8) The assisted living facility must not require or ask the resident or the resident's representative to sign any negotiated service or risk agreement, that purports to waive any rights of the resident or that purports to place responsibility or liability for losses of personal property or injury on the resident.

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to have the residents service plan agreement (facility's version of the negotiated service agreement [NSA]) updated with the most accurate information for 1 of 5 residents (Resident 3 [R3]). This failure placed R3 at risk of unmet care needs and care staff being uneducated and unable to provide the care and services that the resident required.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements [NSA]", undated, showed the service agreements were based on the assessed needs of the resident. The NSA would be updated to be consistent with the residents needs and when there had been an observed change in resident's physical, mental, or emotional

function. The NSA would be updated when it no longer addressed the residents needs and/or preferences. The NSA would be implemented to meet the residents needs and preferences.

Record review of the facility's policy titled, "Alert Charting Policy", undated, showed the team member that started the resident on alert charting would enter that information on the 24 hour shift to shift report in the electronic medical records, initiate a temporary service plan (TSP), and place the TSP in the TSP binder behind the resident's care plan off set so that it signals that it a new TSP had been created and needed to be reviewed. The resident care coordinator, licensed practical nurse (LPN), or registered nurse (RN) was responsible to check the roster in each building each day. They were to review any TSP's for completeness.

Record review of R3's face sheet, dated 09/04/2024, showed R3 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED]

Record review of R3's Master Assessment, dated [REDACTED]/2024, under the section titled, "cognitive capabilities", showed R3 had a diagnosis of [REDACTED] and [REDACTED] that indicated condition that would affect the resident's orientation in the last six months. R3 did not wander, or exit seek and was oriented to person, place, time, and situation.

Record review of R3's Master Assessment, dated 08/16/2024, under the section titled, "cognitive capabilities", showed R3 was oriented to person, place, time, and situation. R3 did not have any indication conditions list that would affect the resident's orientation within the last six months. R3 did not display any behaviors, wandered, exit seek, or was an elopement risk.

Record review of R3's progress note, dated 04/03/2024 at 5:59 AM, showed R3 was found wandering around the second floor of the facility around 12:15 AM. R3 told the medication technician they were trying to find a way to go upstairs. The medication technician had to help him back to their room and into bed. At 12:40 AM, R3 was found downstairs with another resident that was trying to help R3 find their way back upstairs. The medication technician helped R3 back upstairs to their room. R3 was unable to tell the medication technician as to why he was downstairs. At 4:00 AM R3 was found again wandering around on the second floor. R3 told the medication technician they did not know what they were doing or where they were going. The medication technician assisted R3 to their room.

Record review of R3's progress note, dated 07/17/2024 at 5:28 AM, showed R3 was found wandering around on the second floor around 5:15 AM. R3 told the medication technician they did not know where they were or where they were going. Medication technician assisted R3 to their room. R3 told the medication technician that they were glad that they knew where to go as they did not know where to go.

Record review of R3's progress note, dated 07/31/2024 at 12:31 AM, showed R3 was coming in and out of their room and seemed confused. The caregivers had to redirect R3 into their room.

Record review of R3's progress note, dated 08/09/2024 at 2:35 PM, showed that R3

seemed confused and fatigued (extremely tired).

Record review of R3's progress note, dated 08/14/2024 at 5:56 AM, showed R3 was confused as to why they were not feeling well. R3 had tested positive for COVID-19 (Corona Virus Disease 2019-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).

Record review of R3's progress note, dated 08/16/2024 at 9:48 PM, showed R3 was found on the second floor with their bed side table. R3 told the medication technician they were trying to find their room. The medication technician redirected R3 back to their room.

Record review of R3's progress note, dated 08/20/2024 at 2:22 PM, showed R3 was taken off alert related to recent COVID-19 infection.

Record review of R3's progress note, dated 08/22/2024 at 5:57 AM, showed R3 was found wandering the hall at 1:45 AM. R3 was looking for their bathroom and was found with their pants and brief down. The medication technician assisted R3 to their room when R3 told them they were not aware that they had a bathroom in their room.

Record review of R3's progress note, dated 09/01/2024 at 6:48 AM, showed R3 was found lying outside in some bushes on the ground. R3 was wet, muddy, and shaking. R3 denied any pain, but expressed they were cold.

Record review of R3's Service Agreement, dated 05/17/2024, under the section title, "cognition", showed R3 had age-related issues with long-term and short-term memory. R3 was able to make their own medication decisions. R3 was able to make their needs known without difficulty and was able to understand without assistance. There was nothing documented that R3 had a history of wandering or confusion.

Record review of R3's Temporary Service Plan Isolation, dated 08/13/2024, showed R3 was COVID-19 positive. There was no documentation or instructions about R3's confusion and wandering.

Record review of R3's Temporary Service Plan Isolation, dated 08/28/2024, showed R3 had recent medications discontinued. Staff were to chart on the resident's mood and if any change in behavior.

In an interview on 09/04/2024 at 4:36 PM, Staff E, Director of Operations, stated when there were changes to be made on the service agreement, the section that needed to be updated would have the updated date and information added.

As of 09/13/2024 at 5 PM, the facility had not provided a temporary service plan or an updated service plan that reflected R3's increase in confusion and wandering that has been documented since April 2024 with interventions and guidance for the caregivers and the facility staff to follow to protect R3.

This is an uncorrected deficiency previously cited on 06/26/2024.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 11.8.2024.

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

Bryce W Bower
Administrator (or Representative)

10.18.2024
Date



Residential Care Services Investigation Summary Report

Provider/Facility: Centralia Point Assisted
Living and Memory Care

License/Cert.#: 2609

Compliance Determination #: 41791

Investigator: Celeste Vashey

Investigation Date(s): 05/30/2024 through 06/26/2024

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 136139

Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1) Facility is non compliant with state fire marshall regulations.

Investigation Methods:

Sample: Total residents: 50
Resident sample size: 7
Closed records sample size: 0

Observations: Dining
Activities
Kitchen

Interviews: Maintenance staff
Administrative Staff

Record Reviews: Maintenance logs

Investigation Summary:

1) Based on observation, record review, and interview the facility was not in compliance with the life and safety fire marshall inspection for the fourth time. Failed practice identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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

07/09/2024

Licensee: Centralia Point Operating Company LLC
Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

RE: Centralia Point Assisted Living and Memory Care License # 2609

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 06/26/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Centralia Point Operating Company LLC
Centralia Point Assisted Living and Memory Care #2609
06/26/2024
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Cory Cisneros, Field Manager
Residential Care Services
Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

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

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

If You Have Any Questions:

- Please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

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

Enclosure



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 #: 2609	Compliance Determination # 41791
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 05/30/2024, 05/31/2024, 06/03/2024, 06/04/2024 and 06/26/2024 of:

Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

This document references the following complaint numbers: 136139.

The following sample was selected for review during the unannounced on-site visit: 7 of 50 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

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

07/09/2024

Date

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

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

Brynn Baum
Administrator (or Representative)

07/18/2024
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
 - (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

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 7 of 7 areas reviewed within the building (Courtyard, Kitchen, Second floor Balcony, 2nd floor Public Bathroom, Resident 3's Room, Resident 5's Room, and Resident 6's Room). The facility also failed to keep exterior grounds in good repair, equipment, and furnishings clean for 1 of 1 facility reviewed. These failures placed 50 of 50 residents at risk for to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's policy titled, "Disclosure of Services Required by RCW 18.20.300", revised 03/2017, showed "all assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean and comfortable condition."

Record review of the facility's policy titled "Maintenance-Building", undated, showed the maintenance director was responsible to assure that the building was properly maintained at all times. The buildings exterior should not have any missing screens. The resident apartments needed to be clean, safe, and comfortable. Resident's carpets should be clean and in good condition, window coverings needed to be clean and in good condition.

Record review of the facility's policy titled, "Kitchen-Cleaning", undated, showed the food service department would post a monthly cleaning schedule, broken down into weekly and daily cleaning routines, which included an employee list of cleaning responsibilities. Staff were to use a sanitizer cleaning mixture on cloths to keep equipment clean. The cleaning schedule section showed they floors were to be mopped daily, the vents were to be cleaned monthly, and food storage bins were to be cleaned monthly.

Courtyard

In an observation and interview on 05/30/2024 at 11:35 AM, the common courtyard next

to the reception area showed there were multiple windows without screens. Resident 8 had been observed to open their screenless window and stuck their hand outside the window to greet Department Licensors and Staff A, Executive Director. Staff A stated that facility windows were supposed to have screens.

In an observation on 05/31/2024 at 8:52 AM, the common courtyard next to the reception area showed the south side wall had 4 of 8 windows that were missing screens.

Kitchen

In an observation on 05/30/2024 at 1:24 PM, the hand washing sink inside the kitchen showed there were yellow and brown substances embedded into the faucet crevices. The white wall behind the hand washing sink showed a variety of yellow and brown splatters and stains.

In an observation on 05/30/2024 at 1:52 PM, the pantry inside the kitchen showed a ventilation system air duct that had red and orange discoloration on it. There were multiple black specks on the air duct that surrounded opened to air and closed containers of food. The pantry shelving unit was observed to have four missing vertical support beams that helped hold up the structure. The top shelf was observed to be slanted downwards from the weight of the food items. The pantry floor had a sticky substance on it. As the Department Licensors lifted their shoe off the ground a noise was heard. On the shelves were two white Rubbermaid containers with white granulated and powdered substances inside. The outside of the white containers had brown residue and smudges covering them.

In an observation on 05/31/2024 at 9:22 AM, inside the refrigerator on the door there was a square glass window had dirt caked on to the surface.

In an observation and interview on 06/03/2024 at 9:10 AM, Staff K, Dietary Aide, said they were not aware inside the pantry that the shelving unit had been missing support beams. Staff K acknowledged the top shelf had been slanted downward due to food items on top of it and was unstable. Staff K said the kitchen did not have a formal cleaning schedule of what they were supposed to clean and when. Staff K said they cleaned the dishes and were responsible to serve residents their meals. Staff K said if they were supposed to do additional tasks they had not been informed since they were hired 05/06/2024. Staff K looked at the ventilation system inside the pantry and said they were unsure if the orange and red substance and black dots were rust (formed on iron or steel in the presence of moisture) or black mold (a fungus that can may cause a person's immune system to react). Staff K said they were unwilling to touch the substance.

In an observation on 05/30/2024 at 2:05 PM, inside the kitchen showed an overflowing bucket of what appeared to be wet and soiled rags that were next to the low boy sandwich station and were touching the shelving unit that contained clean kitchen utensils. The shelving unit had been observed to have 7 single bins, 5 2-container bins, and 1-tri container bin. All the bins on the shelving unit had a layer of brown film on the outside that had a variety of smudges. The containers that held clean utensils showed there were various amounts of dirt and unknown particles inside of them.

In an observation on 05/31/2024 at 9:23 AM, inside the kitchen showed the once silver 2-step ladder in the corner of the room was coated in a brown substance.

In an observation on 05/31/2024 at 9:26 AM, inside the kitchen pantry showed the floor remained sticky.

In an interview and observation on 06/04/2024 at 10:50 AM, Staff J, Cook said the hot plate warmer in the kitchen did not work. Staff J said because the plate warmer had been broken, they kept plates on the food line. Staff J said food was supposed to go on the food line, but they needed to put resident plates there to try and keep food warm. Observation of the food line showed stacked plates in the compartment on the food line. Staff J said the hot plate warmer had been broken since they were hired on 05/01/2024. Staff J said the door to the freezer had been broken. Observation of the freezer door showed the door handle was loose. Staff J said the refrigerator door handle had been broken. Observation of the refrigerator door showed it was loose. Staff J said the blender inside the kitchen did not have a lid. Staff J said anytime they needed to use the blender they had to use saran wrap and tin foil as a lid. Staff J said the bucket next to the low boy sandwich station that was touching the shelving unit that contained clean kitchen utensils was for dirty rags. Staff J acknowledged the dirty rags were touching clean items. Staff J acknowledged all the shelving unit bins that contained clean utensils were dirty. Staff J said they tried to clean as they went but they did not have a cleaning schedule to follow. Staff J said administration staff preach to clean, but they did not have enough time to clean and complete all kitchen tasks.

2nd Floor Balcony

In an observation and interview on 05/30/2024 at 12:25 PM, on the second floor in the activity room were two doors that lead to an outside balcony sitting area. The door to the right to go out to the balcony was noted to be difficult to open. The door handle was observed to be missing the key and locking mechanism. Staff A, Executive Director, stated maintenance was working on the repair of the door handle. Staff A was unaware of when the door handle would be repaired. The door handle to the left of the activity room that went out to the balcony area was able to be opened. Once outside on the balcony, with the left side door shut, the door was unable to be opened. The door handle was noted to be missing the keyhole and locking mechanism. Licensors was unable to open the door and Staff A had to open the door for the Licensors to re-enter the facility. Staff A stated the door should not have been locked.

2nd Floor Public Bathroom

In an observation on 06/04/2024 at 3:44 PM, on the second floor inside the public bathroom next to the elevator, the toilet was noted to rock when any pressure was applied or sat down on and was unstable.

Resident 3 (R3)'s Room

Record review of R3's Service Agreement, dated 04/24/2024, showed R3 would receive routine housekeeping as part of their basic housekeeping package.

In an interview on 06/03/2024 at 10:00 AM, R3 said they locked their door at night. R3 said they regularly got up early enough to open their door for the medication technician. R3 said on 06/03/2024 they did not get up early enough and the medication technician struggled to enter their door. R3 said facility staff had a key but did not know how to unlock R3's door. R3 said they knew how to move the key in a manner that unlocked their door. R3 said the lock had been difficult to open since they moved into the room after the

facility's remodel.

In an interview on 06/04/2024 at 8:37 AM, Staff D, Medication Technician, said they had a conversation with Staff L, Medication Technician, who reported to Staff D they had a hard time opening R3's door. Staff D said they had not experienced a difficult time opening R3's door due to it normally being left unlocked.

In an observation on 06/04/2024 at 1:10 PM, R3's bedroom floor showed there were multiple brown and black stains on various parts of the carpet. R3's bathroom showed the bottom of their white shower curtain turned yellow and brown.

Resident 5 (R5's Room)

Record review of R5's "Service Agreement", dated 04/10/2024, showed R5 had a diagnosis of [REDACTED]

In an observation on 06/04/2024 at 3:39 PM, inside of R5's bathroom showed above the mirror that was halfway up the wall and reachable was a screw that was partially sticking out of the wall.

Resident 6 (R6's Room)

In an observation and interview on 06/03/2024 at 12:50 PM, inside R6's apartment the carpet had large areas that were dark brown rings and stained areas that were near the sink of the counter, around R6's dining table, and throughout the high walking areas of their carpet. R6 stated that at times they have spilt things causing the carpet to be stained.

In an interview on 06/04/2024 at 4:48 PM, Staff N, Resident Care Manager, stated the facility was aware of R6's carpets being soiled with dirty and stains. Staff N stated maintenance was responsible to complete carpet cleaning, but there was no routine schedule to have R6's carpets cleaned.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryan W. Bauer
Administrator (or Representative)

07/18/2024
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:
- (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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 6 of 6 areas (Dining Room, Memory Care unit, Laundry room sink, Resident 6's (R6) apartment, Resident 4's (R4) bathroom sink, Resident 7's (R7), Resident 3's (R3), and Resident 5's (R5) bathroom sink) of the facility. The facility failed to implement infection control practices by staff not performing hand hygiene in 2 of 2 areas (memory care unit and assisted living unit) when care and services were provided. These failures placed all 50 residents, staff, and visitors at risk for cross contamination and infection when care and services were provided by the facility staff.

Findings included...

Record review of the Centers of Disease Control document titled, "about handwashing", dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other person's hands or common objects. Hands were to be washed often.

Record review of the CDC's document titled, "clinical safety: hand hygiene for healthcare workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare personnel from being infected from germs received from the patient. Healthcare workers were to clean their hands before touching a patient, before moving from work from soiled to clean, after touching a patient or patient's surrounding, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare workers were to wash their hands with soap and water when their hands were visibly soiled.

Record review of the facility's policy titled, "Handwashing", undated, showed the purpose of good handwashing was to be the front- line protection of spread of infections. Handwashing was the single most important measure for preventing the spread of infection and disease. All staff would be responsible to carry out the hand washing policy. Staff would wash their hands after handling soiled laundry or items with body fluids and housekeeping tasks, after helping a resident with personal care tasks of daily living, before handling any food, whenever you change from doing a "dirty" task to a "clean" task, dietary employee's hands must be washed at the kitchen sink upon reentry in the kitchen, when ever hands were obviously soiled and the use of gloves do not replace hand washing. Under the section of handwashing with soap and water procedure showed staff were to completely wet hands with water, apply soap and bring hands together to create a heavy lather for one full minute, then rinse hands well under running water, dry hands well with the use of paper towels, and turn the water off with the paper towel and discard. Under the section that was titled "handwashing with waterless cleaner", showed to apply a dime size amount of sanitizer into the palm of the hand, vigorously apply the sanitizer over all of the hand and finger surfaces using the same technique for scrubbing and applying the hand sanitizer as you would for soap. Allow the skin to dry in the air briefly.

Hand Washing Supplies

In an observation on 05/30/2024 at 11:43 AM, inside the dining room showed the hand washing sink did not have any soap or paper towels available to use.

In an observation on 05/30/2024 at 11:53 AM, the hand sanitizer device outside of the dining room showed it was empty. When the device was pumped multiple times no hand sanitizing solution came out.

In an observation and interview on 06/04/2024 at 12:35 PM, the hand sanitizer device outside of the dining room showed it was empty. Staff A confirmed it was empty and needed to be refilled.

In an observation on 05/30/2024 at 12:10 PM, in the memory care unit's laundry room, there was one sink accessible in the area. On the wall behind the sink to the left was a soap dispensing machine. Upon dispensing the solution from the machine showed it was hand sanitizer as there was a smell of alcohol and the foam was thin. There was no soap supply available for use at the sink or anywhere in the laundry room area for use.

In an observation on 06/03/2024 at 12:08 PM, inside R7's bathroom, the sink was observed to not have any supply of soap or paper towels for the staff or resident to use. At 1:51 PM the sink that was in the common area of the apartment outside of R7's bathroom and near R7's television did not have any supply of soap or paper towels for use.

In an observation on 06/03/2024 at 12:50 PM, inside R6's bathroom, the sink was observed to not have any supply of soap or paper towels for the staff or resident to use.

In an observation on 06/03/2024 at 1:55 PM, inside R4's bathroom, the sink was observed to not have any supply of soap or paper towels for the staff or resident to use.

In an observation and interview on 06/04/2024 at 1:10 PM, inside of R3's bathroom did not have paper towels available to use. R3 said the facility did not provide paper towels for them to use.

In an interview and observation on 06/04/2024 at 3:39 PM, R5 said the facility did not provide them with soap or paper towels. R5 said they were responsible for supplying the items themselves.

Hand Washing

In an observation on 05/30/2024 at 12:05 PM, Staff N, Resident Care Manager, came out of the memory care resident laundry room wearing blue disposable gloves on both of their hands. Staff N then scratched their face with their gloved hand. Staff N placed one of the gloved hands in their pocket, removed some keys and unlocked the laundry room. Staff N entered the memory care laundry room and immediately walked out. Staff N continued to wear the blue disposable gloves. Staff N replaced the keys back in their pocket. Staff N remained out in the hallways talking to Staff A, Executive Director and Staff F, Human Resources/Payroll. Staff N removed the disposable gloves from their hands. Staff N held the disposable gloves in one hand walked down the hallway and entered a resident's room. Staff N was not observed to wash their hands or use hand sanitizer after removing their gloves and prior to entering the resident's room.

In an observation on 05/31/2024 at 9:39 AM, in the memory care unit, Staff O, Caregiver, removed a pair of disposable gloves from the pocket of their shirt and put them on each hand. Staff O entered Resident 20's (R20) room. Staff O propped R20's door open with R20's laundry basket. Staff O collected multiple used drinking cups that had red liquid inside and plates with eaten food on them. Staff O grabbed their keys from their shirt pocket, unlocked the door to the room with a plaque labeled "servery" door, discarded the used dishes on a cart. Staff O exited back into the memory care dining room with the same disposable gloves. Staff O walked down the hallway removed their keys from their shirt pocket. Staff O unlocked the door to the laundry room. Staff O grabbed a laundry basket that had clean clothes folded inside. Staff O took the clean clothes to Resident 21's (R21) room and left them. Staff O continued to wear the same disposable gloves when they left R21's room. Staff O entered R22's room and removed a laundry basket with soiled clothes inside. Staff O unlocked the laundry room door and dropped of R21's clothes. Staff O continued to wear the same gloves and entered Resident 22's (R22) room at 9:46 AM. Staff O was not observed to wash their hands with soap and water or hand sanitizer during the entire uninterrupted observation.

In an interview on 06/03/2024 at 12:20 PM, Staff N stated the expectation was for staff to wash their hands all the time. Staff N stated staff were to use hand sanitizer or soap and water to wash their hands. Staff N stated staff were to wash their hands after the use of the bathroom, after touching any food, after removing their disposable gloves, and if their hands were visibly soiled. Staff N stated all staff had hand sanitizer in their pockets for use.

In an observation on 06/03/2024 at 12:22 PM, in the memory care unit dining room, there was no hand sanitizer dispensers available for use. Staff O was observed to grab clear disposable gloves and put them on both their hands. Staff O removed used soiled dishes from a table the residents that had just eaten lunch at and put them in a food cart. Staff O removed their disposable gloves at 12:25 PM. Staff O put on a new pair of disposable gloves right after. Staff O had not washed their hands or used hand sanitizer after they removed their gloves and before the new gloves were put on. Staff O asked an unknown named female resident if they wanted some more juice. Staff O poured a glass of juice and handed it to the resident with the disposable gloves on. At 12:27 PM, Staff O reached into their scrub shirt pocket and pulled out a meal ordering ticket pad, reviewed it, and then put it back into their shirt pocket. Staff O picked up more dirty dishes and put them on the cart. At 12:29 PM, Staff O left the dining room down the hallway with the same disposable gloves on that were applied at 12:25 PM. Staff O did not wash their hands with soap and water or use hand sanitizer on their hands during the entire observation.

In an interview on 06/04/2024 at 1:05 PM, Staff O stated they were to wash their hands all the time. Staff O stated they would wash their hands after the use of the bathroom, after they took off their disposable gloves, and if they had a change in task.

In an interview on 06/04/2024 at 2:28 PM, Staff P, Director of Operations, stated the facility does not provide soap and paper towels to the assisted living residents bathrooms and public sink areas. Staff P stated staff were to rinse their hands exit the resident's room and wash their hands in the closest public bathroom that would have soap and paper towels.

In an observation and interview on 06/04/2024 at 3:57 PM, Staff O entered the memory care laundry room from the door in the hallway that is closest to the dining room. Staff O stated they washed their hands in the sink that was in the same area as the washer and drying machines. Staff O stated they would rinse their hands with water, use hand sanitizer, and then rinse again and dry with paper towels. Staff O stated they would have to enter a door to the soiled utility room to wash their hands with soap and water as the sink in the laundry room area did not have soap. Staff O stated they used the sink in the laundry room area and not the soiled utility room when they needed to wash their hands after handling soiled resident linens and clothes.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on
(Date) 08/09/2024

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

Brycen Baum
Administrator (or Representative)

07/18/2024
Date

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

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;
- (4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies for assisted living resident for 5 of 5 locations reviewed (servery room, laundry room, maintenance room, kitchen, and housekeeping closet). This failure placed 50 of 50 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's policy titled, "Housekeeping-Cleaning Resident Rooms", undated, showed all housekeeping supplies would be kept in line of sight of the housekeeper or locked in the secured housekeeping cart. All staff members would be trained on use, labeling, and storage of chemicals.

Servery Room

In an observation on 05/30/2024 at 11:37 AM, the unlocked door to the room on the first floor that had a plaque with the name "servery room", showed inside the unlocked cabinet under the sink was a container of 73 disinfecting acid bathroom cleaner (removes water build up and soap scum), two bottles of Clorox wipes (cleaning chemical), one container of odoban eliminates odors (chemical to stop offensive smells), one bottle of Lysol disinfecting spray (cleaning chemical), two bottles of Lysol all-purpose cleaners (cleaning chemical), and without a lid there was a h2 orange 2 concentrate 117 sanitizer/virucide cleaner (chemical that cleans, deodorizes, and sanitizes) that had a napkin on top over the top.

In an observation on 05/31/2024 at 8:49 AM, the door to the servery room was unlocked. The cabinet under the sink remained unlocked that had the same chemicals observed on 05/30/2024.

In an observation on 06/03/2024 at 9:14 AM, the door to the servery room was unlocked. The cabinet under the sink remained unlocked that had the same chemicals observed on 05/30/2024.

Laundry Room

In an observation on 05/30/2024 at 12:06 PM, the unlocked laundry room in the memory care unit showed on the shelf in the corner was a container of chocolate flavored covered pretzels that had handwritten purple writing that read "detergent". Inside the container was a white and blue powder substance.

In an observation on 06/03/2024 at 12:40 PM, inside the unlocked second floor laundry room was a small spray bottle that had a label that showed, "rapid multi surface disinfectant cleaner", that was sitting on the counter. On the ground under the sink unlocked in the laundry room were two large bottles were stored, had a label home style laundry detergent. In the corner of the laundry room across from the sink there were two 40-pound white buckets stacked on each other with blue lids. The top bucket's blue lid was not secured and inside was white powder substance. The buckets were both labeled heavy duty laundry powder.

Maintenance Room

In an observation on 05/30/2024 at 12:28 PM, the door to the maintenance room was unlocked and able to be opened. Inside the maintenance room contained a variety of chemicals which included comet (powdered cleaning chemical), bleach (cleaning chemical), trim enamel (oil-based paint), pro mar 400 deep base (paint), peroxide (cleaning chemical), and goo gone (cleaning chemical). On a shelf was a clear, unlabeled bottle that had an unknown pink substance inside.

Kitchen

In an observation on 05/30/2024 at 1:52 PM, outside the pantry door showed a bucket of concentrated pot and pan detergent that expired "03/27".

In an observation on 05/30/2024 at 2:30 PM, an unlocked partition door next to the kitchen's out door showed multiple chemicals which included Reliase heavy duty degreaser (cleans grease), grease express high temperature grill cleaner (cleans grease), kool klene thaw freezer cleaner (cleaning chemical), scale remover for ice machines (cleaning chemical), and raid killing insect (chemical that kills insects).

Housekeeping Closets

In an observation on 06/03/2024 at 9:30 AM, the second-floor housekeeping closet was unlocked. There were multiple chemicals on the shelves that included oasis 100 (floor cleaner), 73 disinfecting acid bathroom cleaner (cleaning chemical), 2 bottles of odoban eliminates odors disinfectant (chemicals to stop offensive smells), Febreze (chemical to stop offensive smells), bio enzymatic odor eliminator (chemical to stop offensive smells), acid disinfectant bathroom cleaner (cleaning chemical), and 7 comet deodorizing cleanser (chemical to stop offensive smells).

In an interview on 05/30/2024 at 11:39 AM, Staff A, Executive Director, said all chemicals were supposed to be stored behind locked doors. Staff A said the server room was attached to the memory care unit and were to remain locked as well as the housekeeping closets.

Statement of Deficiencies	License #: 2609	Compliance Determination # 41791
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
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In an interview on 06/03/2024 at 8:31 AM, Staff I, Housekeeping, said chemicals were supposed to be kept locked up. There were two housekeeping closets at the facility, one for each floor. Staff I said the housekeeping closets were to remain locked. Staff I said they had a housekeeping cart that contained chemicals remained locked if they were not present.

In an interview on 06/04/2023 at 10:50 AM, Staff J, Cook, said chemicals were supposed to be labeled to identify what was inside the container and stored in the closet in the kitchen. Staff J said the partition door to the closet did not lock.

In an observation on 06/04/2024 at 11:06 AM, on the second floor the housekeeping closet door was unlocked. Inside the housekeeping closet were two bottles of odoban eliminates odors disinfectant, one bottle of Febreze spray, two 2.5-gallon jugs of pink solution with a label that showed disinfectant acid bathroom cleaner, and one 2.4-gallon jug with blue liquid that had a label that showed glass cleaner.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryana Boun
Administrator (or Representative)

07/18/2024
Date

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

- (1) Comply with chapter 70.129 RCW, Long-term care resident rights;
- (2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;
- (4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;
- (5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 , 70.122, 11.88, 11.92, and 11.94 RCW;
- (6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to address and resolve 1 of 1 resident (Resident 3 [R3]) grievances and resident council meeting grievances. These failures resulted in residents having unresolved concerns and placed 50 of 50 residents at risk for decreased quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights. (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. (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

RCW 70.129.060 Grievances. A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

R3

Record review of R3's "Service Agreement", dated 04/24/2024, showed R3 had diagnosis that included [REDACTED]. Under the dining section showed R3 was independent. R3 was able to make their own choices and requests regarding their food and fluid preferences. R3 preferred to go into the dining room thirty minutes after the meal start time and take it back to their room to eat.

In an interview on 06/03/2024 at 10:00 AM, R3 said they preferred to use their own kitchen utensils such as silverware, bowls, and jars with lids to use as cups. R3 said due to their vision impairments they preferred using jars with lids to prevent spills in case they knocked it over. R3 said they would wash and rinse their dishes after use. R3 said in the past facility staff had found mold (fungus that can cause side effects to health) growing inside of their drinking containers. R3 said Staff A, Executive Director and the former food service director said the state law prohibited them from using their own dishes. R3 said they had been able to use their own dishes and silverware for over a year before being informed they no longer were allowed to. R3 said now they use the facility dishes and continue to use their own silverware. R3 reported that themselves and another resident in the facility had a verbal resident to resident altercation. R3 reported that the resident called them a racial slur (insulting or disparaging remark). R3 said the verbal altercation escalated to where they thought they were going to get into a physical altercation. R3 said they thought the resident followed them after their argument. R3 recalled getting on the bus to go into the community and R3 reported they heard the resident on the bus. R3 said due to the resident-to-resident altercation they do not eat in the dining room. R3 said they come to the dining room a half hour after mealtimes, pick up their meal, and return to their room to eat. R3 said they do not participate in facility activities due to not wanting to be around other residents. R3 would not disclose the name of the resident or the time of when the resident to resident occurred. R3 said the other resident still lived at the facility. R3 said they would not report their concerns to Staff A. R3 said they used to go to resident council meetings but stopped. R3 said if they had a complaint, they felt that it would be explained away. R3 said they were not in the "in crowd" and would not be taken seriously.

In an interview on 06/04/2024 at 12:00 PM, Staff A, said at stand up it had been reported

that mold was found in the dishware that R3 used. Staff A said the former food service director and themselves thought it was unsanitary for R3 to bring their own dishes into the dining room. Staff A said they had a meeting with R3 and strongly encouraged them to use the facility dishes. Staff A said they offered to serve R3 with facility dishes and facility staff could transfer the food into R3's dishware if R3 demanded it that way. Staff A said R3's dishes would need to be washed daily. Staff A was unaware if R3's preference to use their own dishes and how facility staff could support R3 request was in R3's service agreement. Staff A was unaware R3 had a verbal resident to resident altercation. Staff A acknowledged that now they were aware of the resident to resident they would start an incident investigation to follow up.

Record review of an email, dated 06/10/2024, showed Staff B, Operations Support Specialist/LPN, said the facility did not have any documentation to provide regarding the conversation Staff A and former food service director had with R3 about the use of their own dishes at the facility.

Resident Council Meetings

In an observation on 05/31/2024 at 8:25 AM, the table located in the reception area showed there were a stack of "compliments/complaints/grievances" forms. The "compliments/complaints/grievances" forms were not observed the previous day on 05/30/2024.

In a group interview on 05/31/2024 at 10:00 AM, fourteen residents at the facility collectively reported they do not know where in the facility they could go to pick up and fill out a grievance form. Residents reported that when they do express concerns they are not always followed up on. Resident 15 said they would not report their concerns to Staff A, due to feeling uncomfortable. Resident 8 said they had no idea how to make a grievance and asked who Staff A was. R16 said the facility used to provide grievance forms at the front desk but noticed they were not available. All residents had concerns regarding the food that was served at the facility. R19 reported that the food temperature fluctuated, and hot foods were not always served hot and cold foods were not always served cold. R17 said food that was supposed to be served cold was warm. R5 said hot food were rarely served hot. R18 reported at mealtimes they did not get food items on the menu that they preferred such as peppers and ham. R15 said the facility served a lot of chicken. R15 said sometimes they were served chicken twice daily. R15 said they used to get a menu delivered to them. All residents in the group meeting agreed that menus used to be delivered but now were set on the tables on Wednesday's. All Residents agreed that what was on the menu was not always what was served. R16 said they kept monthly minutes from resident council meetings and provided them to Staff A. R16 said some of the issues that were reported had not been followed up on.

Record review of an email, "Resident Council Meeting", dated 04/03/2024, showed Resident 16 (R16) sent the meeting notes to Staff A, Executive Director. The notes showed 14 residents were present and discussed that the facility still did not have a maintenance person and they were encouraged to make a list of any maintenance needs. Residents expressed concern that there was only one housekeeping staff member to service all residents. Residents thought another worker should be hired to share the workload. Residents expressed concern that the laundry machines accessible to them were not commercial units and requested the machines be changed. One resident reported they had ants in their bathroom. Residents expressed that they do not feel like their service

agreements were being followed due to the facility being understaffed. Residents reported they do not bring up current concerns they had due to feeling as if staff were too busy to address their needs. Residents expressed frustration that the community bus had been broken. The bus being broken had caused them to not be able to attend activities in the community. Residents expressed concerns that the kitchen did not have working appliances. Residents noted they worked with the food service director to improve their concerns of larger portions, more variety in the menu, less chicken served, and to have foods that accommodated residents with dental and chewing issues. Residents expressed concern that they need someone who can help them with their telephones, televisions, and other electrical equipment. A resident brought up concern they were uneducated in what to do if there was a fire.

Record review of an email, "Resident Council Meeting", dated 05/09/2024, showed R16 sent the meeting notes to Staff A. The notes showed 15 residents were present and discussed concern that one former employee was told they could not visit the residents. It was discussed that Staff A would be asked to ensure grievance forms were accessible in the lobby for resident use. Residents expressed concern that there was one housekeeper for the building to complete all cleaning and laundry. Residents requested another housekeeper be hired to share the workload. One resident expressed concerns they lived next to the laundry room, and it appeared the units were hitting the wall repeatedly. Residents expressed concern that it was difficult for them to shower due to staff not being available. Residents expressed once a new food service director was hired, they want the food council to return. Residents expressed concern that all residents are not provided with a pendant alert button.

As of 06/14/2024 the Department had not received any documentation to review regarding how April and May resident council meeting notes were addressed by the facility.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryce Brown
Administrator (or Representative)

07/18/2024
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.
- (2) The assisted living facility must have its building approved by the Washington state fire

marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain fire safety per the state fire marshal regulations and failed to ensure fit testing was completed per Washington state regulations for 1 of 1 facility reviewed. These failures placed 50 of 50 residents, staff, and visitors' life and safety at risk in the event of a fire and spread of infectious disease.

Findings included...

WAC 296-842-14005 "Provide medical evaluations.

Medical Evaluation Process

Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:

(a) Are required to use respirators; or

Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:

(a) Whether or not the employee is medically able to use the respirator;

(b) Any limitations of respirator use for the employee;

(c) What future medical evaluations, if any, are needed;

(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005

"Conduct fit testing.

(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:

(a) Before employees are assigned duties that may require the use of respirators;

(b) At least every twelve months after initial testing;"

Record review of the facility's Respiratory Protection Program (RPP) dated 01/15/2021 showed the Executive Director was responsible to maintain RPP records and conduct program evaluations annually. Facility supervisors were listed as responsible to ensure associates received initial and annual respirator mask fit tests and medical clearances before authorization to wear a respirator. Records were to be kept based on Occupational Safety and Health Administration guidelines, which would be an associate's period of employment, plus 30 years.

Review of the document titled "L&I (Labor and Industries) and Department of Health (DOH) Respirator and 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- an infectious communicable 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] and other airborne hazards. 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 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 the dear provider letter number 2023-014, dated 03/30/2023, showed that the Secretary of Health announced the order that required wearing a face covering in long term care facilities had ended on 04/03/2023. Despite that the order had ended the individuals in long-term care facilities, including residents, staff, and visitors, were required to continue to follow the Department of Health (DOH) and Centers of Disease Control and Prevention (CDC) guidance. Respiratory Protection Program (RPP) requirements were not changed by the ending of the Secretary of Health's order, nor would they change when the federal public health emergency ended on 05/11/2023. Staff would still be required to wear N95 respirators around individuals with suspected or confirmed COVID-19, and an RPP was required anytime a respirator was used in a long-term care facility. An RPP must include medical clearance, fit testing, training, written policies, and documentation.

Record review of the facility's document titled, Respiratory Protection Program, undated, showed every employee of the facility who must wear a respirator would be provided with a medical evaluation before they were allowed to use a respirator. All employees who wore a tight-fitting respirator would be fit-tested before using their respirator or given a new one. Fit-testing would be repeated annually, when a different respirator facepiece was chosen, or if there was a physical change in an employee's face that would affect the fit. The fit testing procedure were followed by the Washington Industrial Safety and Health Act (WISHA). The document showed that the facility evaluated and found respirators must be used by all staff when there was COVID-19 in the facility.

"Code 906.2 General Requirements. 906.2 General requirements.

Portable fire extinguishers shall be selected, installed and maintained in accordance with this section and NFPA 10. Exceptions:

1. The distance of travel to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2. Thirty-day inspections shall not be required and maintenance shall be allowed to be once every 3 years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
 - 2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
 - 2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a

trouble signal.

2.3.The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.

2.4.Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.

2.5.A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA 10.

3.In Group I-3, portable fire extinguishers shall be permitted to be located at staff locations.”

"Code IFC 5303.5.3 2018: compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. Securing of compressed gas containers, cylinders and tanks shall be by one of the following methods: 1. Securing containers, cylinders and tanks to a fixed object with one or more restraints. 2. Securing containers, cylinders and tanks on a cart or other mobile device designed for the movement of compressed gas containers, cylinders or tanks. 3. Nesting of compressed gas containers, cylinders and tanks at container filling or servicing facilities or in sellers' warehouses not open to the public. Nesting shall be allowed provided that the nested containers, cylinders or tanks, if dislodged, do not obstruct the required means of egress. 4. Securing of compressed gas containers, cylinders and tanks to or within a rack, framework, cabinet or similar assembly designed for such use. Exception: Compressed gas containers, cylinders and tanks in the process of examination, filling, transport or servicing."

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."

Record review of the facility's document titled, "Oxygen Policy", undated, showed the facility recognizes oxygen presents at a potential risk for fire, explosion, and injury from unsafe handling. The facility would work closely with the Office of the State Fire Marshall and local fire officials to promote safe use and storage of oxygen in the facility. The facility would assist residents to store oxygen in a safe manner.

Respiratory Protection Program

Record review of the facility provided untitled, and undated document with a list of employees, showed Staff A, Executive Director, was hired at the facility on 03/01/2023 and first day of employment was on 03/13/2023.

Record review of the facility's provided undated and untitled document with a list of employees, showed Staff C, Caregiver, was hired and started employment at the facility on 06/05/2023.

Record review of the facility's provided undated and untitled document with a list of employees, showed Staff D, Medication Technician, was hired at the facility on 02/19/2024 and started employment at the facility on 02/20/2024.

Record review of the facility provided untitled, and undated document with a list of employees, showed Staff E, Cook, was hired at the facility on 12/29/2023 and first day of employment was on 12/30/2023.

Record review of the facility provided untitled, and undated document with a list of employees, showed Staff F, Human Resources/Payroll, was hired at the facility on 12/13/2022 and first day of employment was on 12/14/2022.

Record review of the facility provided untitled, and undated document with a list of employees, showed Staff G, Dietary Aide, was hired at the facility on 03/04/2010 and first day of employment was 04/01/2022.

In an interview on 06/03/2024 at 3:45 PM, Staff B, Licensed Practical Nurse/Operations Support Specialist, stated there was no fit testing binder for the facility staff for review. Staff B stated the facility's staff were not fit tested for N95 respirators or had medical clearances completed. Staff B stated the facility did not have a fit testing hood to conduct fit tests for the facility staff.

As of 06/05/2024 at 5 PM, the Department was not provided any medical clearances or fit testing records for Staff A, Staff C, Staff D, Staff E, Staff F, and Staff G for review.

Fire Marshal

"Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NFPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

Record review of the Washington State Patrol Fire Protection Bureau report, dated 05/29/2024, showed the fire marshal conducted a re-inspection at the facility and found that the following violation had not been corrected... "Code IFC 705.2 2018 Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NFPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft

control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified.” The facility failed to provide the State Fire Marshal the fire door inspection report by a qualified staff.

On 06/25/2024 at 11:51 AM, the Department received an email that was sent from the State Fire Marshall office that reported the facility failed their fourth fire and life safety inspection on 05/29/2024. The facility had recent failed fire and life safety inspections on 01/03/2024, 02/08/2024, 04/23/2024, and 05/29/2024.

In an interview on 06/26/2024 at 11:30 AM, Staff A, Executive Director, stated Staff Q, Maintenance Director had been responsible to follow up and correct the state fire marshal violations.

Smoking area

In an observation and interview on 05/30/2024 at 1:24 PM, inside of the kitchen there was a door to the outside located to the left of the hand washing sink. There was a typed message attached to the door that read “this door must remain shut if you are going out to take a break and smoke, to cut down on smells entering the dining room. You will have to go around and use the other door to come back in please. – management”. Staff E, Cook, said the facility staff were supposed to smoke outside and pointed in the general direction of the covered breezeway, tables, and coffee tin.

In an observation on 05/30/2024 at 2:27 PM, inside the kitchen looking out the kitchen door window, Staff Q, Maintenance Director, was observed sitting in a chair that was up against the facility’s wall and a small round table. Staff Q was observed to take an electronic cigarette out of their pocket and vape (inhale mist from an electronic cigarette) underneath the no smoking sign that was posted on the wall under the small table.

In an observation on 05/31/2024 at 9:04 AM, outside the back door of the kitchen there was a small round table and chairs that were sitting under the covered walkway and against the wall of the facility. On the wall above the small table and chairs there was a bright green sign that said no smoking within 25 feet from the building. Next to the pillar of the covered walkway was a metal coffee tin that had water inside and discarded and smoked cigarette butts. The metal tin can, and the table and chairs were 22 feet and 2 inches away from the door to the kitchen.

In an observation on 05/31/2024 at 9:15 AM, inside the kitchen looking out the kitchen door window, Staff Q, Maintenance Director, was observed sitting in a chair that was up against the facility’s wall and a small round table. Staff Q was observed to be smoking a cigarette underneath the no smoking sign that was posted on the wall under the small table.

In an interview on 05/31/2024 at 2:36 PM, Staff A, Executive Director, stated the smoking area was required to be 25 feet away from the facility entrance. Staff A stated there was a

tin can with water inside that the staff and residents used to dispose their smoking materials. Staff A stated the designated area was by the little shack building beside the dumpster.

Fire Extinguishers

In an observation on 05/30/2024 at 11:53 AM, the fire extinguisher on the first floor by the mailboxes showed it was last serviced January 2024. There were no monthly checks for February and March 2024 for review.

In an observation on 05/30/2024 at 12:11 PM, the fire extinguisher by the door to the outside courtyard was last serviced January 2024. There were no monthly checks for February and March 2024 for review.

In an observation on 05/30/2024 at 12:17 PM, on the second floor one of the fire extinguisher was last serviced January 2024. There were no monthly checks for February and March 2024 for review.

In an observation on 05/30/2024 at 12:20 PM, the fire extinguisher that was on the wall by Resident 2's apartment door, was last serviced January 2024. There were no monthly checks dated or documented for February and March 2024 for review.

In an interview on 06/04/2024 at 2:28 PM, Staff P, Director of Operations, stated in a nearby town they had a sister facility. Staff P stated the maintenance staff at the sister facility would be responsible to complete the monthly fire extinguisher checks if the facility did not have a maintenance director or staff available.

Door Propped Open

In an observation on 05/30/2024 at 12:28 PM, the door to the maintenance office was propped open with a wooden door wedge that kept the door from closing.

In an interview on 06/03/2024 at 9:14 AM, Staff Q stated the maintenance office door was not to be propped open.

Oxygen and propane Cylinders

In an observation on 05/31/2024 at 9:31 AM, in the kitchen's storage area across from the cleaning closet, in the far-right corner on the ground between two large metal shelving units was a 20-pound propane tank that was unsecured to the wall and not stored in a secured base or stand.

In an observation on 06/03/2024 at 12:08 PM, on the door frame of Resident 7's (R7) apartment showed there were signs posted that oxygen was in use. Inside of R7's apartment at 1:49 PM, beside R7's brown cushioned chair was a small green cylinder oxygen tank that was free standing on the carpet. Inside of R7's closet on the ground were

cardboard holder that had 31 small green oxygen cylinders that were unsecured.

In an observation on 06/04/2024 at 11:07 AM, in R7's apartment beside their brown cushioned chair was a small green cylinder oxygen tank that was free standing on the carpet.

Fire Sprinkler

In an observation on 05/31/2024 at 9:26 AM, inside of the kitchen's pantry showed on the shelving unit was a hollandaise container that was 13 inches directly under the fire sprinkler system.

Fire Panel

In an observation on 05/31/2024 at 9:31 AM, inside of the kitchen's pantry showed the fire panel was located on the left side of the room. Directly in front of the fire panel was a silver rolling rack that had multiple items on it.

This is a recurring citation previously cited on 04/28/2023.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryan Bower
Administrator (or Representative)

07/18/2024
Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records for 2 of 2 units reviewed (Memory Care and Assisted Living Units). These failures placed 50 of 50 residents at risk for exposure of confidential records.

Findings included...

Record review of the facility's policy titled, "Confidentiality of Resident Information", undated, showed all resident information would be held in the strictest confidence and was accessible only to authorized staff, the resident, authorized authorities, and individuals with resident's approval in accordance with applicable state and federal law. All resident records were secured. The facility would maintain the resident records in the confidential files. The facility would not disclose the residents' records to others unless the resident directed to that was documented in writing or unless the law authorizes or compels the facility to do so.

In an observation and record review on 05/31/2024 at 8:54 AM, on top of the medication cart of the assisted living unit there were multiple pharmacy dispensed medication bubble packages that did not have medications in them. Review of one of the medication bubble packages showed there was a prescription label that showed it was for the medication escitalopram oxalate 5 milligram (mg) for Resident 10 (R10). There were two other empty medication bubble packages that had prescription label for Resident 11 (R11).

In an interview on 05/31/2024 at 8:57 AM, Staff M, Medication Technician, stated the medication bubble packages were kept on the top of the medication cart as they were needed to be refilled.

In an observation on 06/03/2024 at 11:57 AM, in the memory care unit on top of the medication cart, there were multiple prescription labels. Review of one of the prescription labels showed Resident 12 and was for the medication vitamin B-12 (a supplement vitamin). Review of another prescription label showed it was for Resident 13 (R13) and listed R13's medication quetiapine (antipsychotic medication to help treat mental disorders or behaviors). Review of a prescription label showed it was for Resident 14 (R14) that was for the medication hydrocodone/Tylenol (prescribed pain mediation). All the medication prescription labels were available for anyone to review on the medication cart.

In an interview and observation on 06/03/2024 at 12:15 PM, Staff N, Resident Care Manager, when asked if the medication prescription labels with resident's name and medication were to be left out on the medication carts, Staff N grabbed all of the prescription labels, removed them from the medication cart and put them in their scrub top pocket. Staff N stated that when a residents medication ran out, the staff would remove the prescription label and would dispose the prescription label in the shredder. Staff N stated they were not to be stored on top or on the medication cart accessible to residents and public.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Byron W. Brown
Administrator (or Representative)

07/18/2024
Date

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

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications were stored and locked in a secure manner in 2 of 2 residents (Resident 3 [R3] and Resident 5 [R5]) rooms. This failure placed 50 of 50 assisted living residents at risk to potential ingestion of harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

R5

Record review of R5's "Service Agreement", dated 04/10/2024, showed R5 had a diagnosis of [REDACTED] and [REDACTED]. R5 required assistance with set up of their oral medications to ensure safe and effective medication administration practices.

Record review of R5's "90 Day Assessment", dated 04/08/2024, showed R5 had not been evaluated and approved for self-medication administration by the nurse. R5 received oral medication assistance five times daily.

Record review of R5's "Medication Administration Record (MAR)", dated, 04/01/2024 – 04/30/2024, showed "Gvoke Hypopen" (medication to treat low blood sugar) inject subcutaneously (beneath the skin) as needed for low blood sugar less than 60.

Record review of R5's "MAR", dated, 05/01/2024 – 05/31/2024, showed "Gvoke Hypopen" inject subcutaneously as needed for low blood sugar less than 60.

In an observation and interview on 06/04/2024 at 3:39 PM, inside R5's bathroom medicine cabinet had a bottle of equate antacid (non-prescribed medication that alleviates heart burn and indigestion), a bottle of equate Nite time cold and flu (temporarily relieves common cold and flu symptoms), a bottle of nighttime multi system relief acetaminophen

(temporarily relieves common cold and flu symptoms), and a bottle of instant action sore throat relief (relieves sore throat). R5 retrieved their inhaler (medical device that helps a person breath) and said they had 194 puffs left. R5's living room showed on their dresser they had a glucagon emergency kit for low blood sugar. R5 said historically they were informed they could not keep the medication in their room. R5 reported their physician said the kit needed to stay in R5's possession in case they passed out and needed to be injected. R5's kitchen countertop showed R5 had a glucose meter (medical device to determine how much glucose is in the blood), 310 twist Lancets (used to obtain blood), and a box of Curad alcohol prep pads (protects the skin from germs when an injection is administered). R5 said they poked themselves when they checked their blood sugar.

In an interview on 06/17/2024 at 3:09 PM, Staff B, LPN/Operations Support Specialist, said during a care conference with R5 it had been discovered that R5 had a blood glucose machine and an emergency kit in their room. Staff B said it was agreed upon that the facility would manage R5's medications and that the items needed to be turned into Staff N, Resident Care Manager. Staff B said R5's items were not turned in and the facility needed to follow up.

R3

Record review of R3's "Service Agreement", dated 04/24/2024, showed R3 had multiple medical diagnosis that included [REDACTED] and [REDACTED]. R3 received assistance with their medication three times daily. R3 required nurse delegation with RN (Registered Nurse) oversight for R3's diabetes management of blood sugar checks and insulin injections. The facility provided medication set-up services to support safe and effective medication administration practices.

Record review of R3's "90 Day Assessment", dated, 04/23/2024, showed R3 had not been evaluated and approved for self-medication administration by the nurse. R3 received oral medication assistance up to three times daily. Facility staff gave R3 their insulin for their diabetes.

In an interview on 06/03/2024 at 10:00 AM, R3 said some of the facility medication technicians left their medications in a cup on the dresser next to their bed side for R3 to take at their leisure. R3 said some of the facility medication technicians had informed them they cannot leave R3's medication and must watch them take the medication before leaving.

In an observation on 06/03/2024 at 10:00 AM, inside of R3's bathroom showed a bottle of D3 vitamins (helps absorb calcium and phosphorus) on the counter.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryan Baur
Administrator (or Representative)

07/18/2024
Date

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.

(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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to administer medications as they were ordered by the prescribed physician for 1 of 7 residents (Resident 3 [R3]). This failure placed R3 at risk for medical complications and unmet care needs.

Findings included...

Record review of the facility's policy titled, "Policy Incidents/Events/Medication Errors", undated, showed if a medication error was found or witnessed the medication aide would fill out a medication incident form. The resident would be placed on alert charting and a temporary service plan would be created for intervention and to monitor the residents needs.

Record review of the facility's policy titled, "missed medication policy", undated, showed all residents would receive medications according to physician's orders.

R3

Record review of R3's "Service Agreement", dated 04/24/2024, showed R3 had multiple medical diagnosis that included [REDACTED] and [REDACTED]. R3 received assistance with their medication three times daily. The facility provided medication set-up services to support safe and effective medication administration practices.

Record review of R3's "90 Day Assessment", dated, 04/23/2024, showed R3 received oral medication assistance up to three times daily.

Record review of R3's "Medication Administration Record (MAR)", dated 03/01/2024 through 03/31/2024, showed R3 had an order for "metoprolol succ er(long acting medication to help lower high blood pressure) 25 mg (milligram) TAB (tablet) (TOPROL XL) 0.5 TAB (12.5 MG) by mouth every day for blood pressure. Hold if DBP (diastolic blood pressure) [lower number of the blood pressure reading] below 60..." On 03/06/2024 the MAR showed R3's DBP was 117 over 59 but the medication was still given. On 03/12/2024 R3's DBP showed R3's DBP was 116 over 51 but the medication was still given. On 03/31/2024 R3's DBP showed it was 110 over 56 and the medication was still given.

In an observation and interview on 06/04/2024 at 1:29 PM, Staff D, Medication Technician, reviewed R3's March 2024 MAR and acknowledged that they were the staff member who provided R3 their Metoprolol Succ er 25 mg tab medication on 03/06/2024, 03/12/2024, and 03/31/2024 outside of the doctors prescribed parameters due to R3's DBP being under 60.

Refer to 388-78A-2240 Non availability of Medications, 388-78A-2230 Medication Refusal, and 388-78-2260 Storing, securing, and accounting for medications.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Brynn W. Bower
Administrator (or Representative)

07/18/2024
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 4 of 7 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 5 [R5], and Resident 4 [R4]) 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's policy titled, "missed medication policy", undated, showed all residents would receive medications according to physician's orders. Any medication that was not provided due to non-delivery of the medication results in notification of the resident care coordinator (RCC). The medication technician or the RCC would call the pharmacy to determine the delivery date. If the delivery date of the medication would be longer than 48 hours, the facility nurse, administrator, physician, and family/power of attorney would be notified. Notification would be documented in the resident's record. Further action would then be determined. Any medication not provided for 48 hours (including refusals) would result in notification of the RCC, facility nurse, administrator on the 24-hour report. Further action would be taken that included notification of the physician according to their preference. Notifications would be documented in the resident record and further action would then be determined and could include faxing the physician for alternative medications order, faxing the pharmacy for help with pre-authorization, and obtaining from a satellite pharmacy if needed as an immediate order.

R1

Record review of R1's "Service Agreement", dated 04/03/2024, showed R1 had a diagnosis of [REDACTED]. R1's service agreement did not indicate who provided R1 their medications.

Record review of R1's "Initial/Pre-Admission Assessment", dated 03/04/2024, showed the facility would assist R1 with all medication management.

Record review of R1's "Admission Physician's Report and Orders", dated 12/14/2023, showed the facility were to notify R1's physician if R1 refused their medication 3 times in one week.

Record review of R1's MARs, dated 03/01/2024 through 04/30/2024, showed R3 had an order for Biofreeze 4% gel to be applied topically (on the skin) to R1's knees two times daily for pain. R1 refused one of the administrations of the biofreeze on 03/29/2024, 03/30/2024, and 04/03/2024.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not have documentation to provide that showed R1's physician was notified

when R1 refused their medication.

R2

Record review of R2's Service Agreement, dated 05/17/2024, showed R2 had multiple medical diagnoses that included [REDACTED]

[REDACTED] The facility assisted R2 to take their medication as ordered. R2's insulin injections were delegated and administered to R2 by the medication technician. The facility provided supportive assistance with R2's management of diabetes.

Record review of R2's document titled, "Admission Physician's Report & Orders", dated 11/02/2023, showed R2's physician wanted to be notified of all medication refusals. The physician orders were signed and dated by R2's physician.

Record review of R2's Medication Notes, dated 03/01/2024 through 03/31/2023, showed R2 refused their humalin N insulin (prescribed injectable long acting insulin to help lowers blood sugar level in a more normal range) on 03/10/2024 at 7pm and on 03/18/2024 at 11 am. R2 refused their diclofenac sodium 1 % gel (prescribed gel that is applied to the skin to help with pain relief) on 03/10/2024 at 11 AM, 03/29/2024 at 11 AM, and 03/30/2024 at 11 AM. R2 refused their aspirin on 03/31/2024 at 7 AM.

Record review of R2's Medication Notes, dated 04/01/2024 through 04/30/2024, showed R2 refused their aspirin 21 of 30 days. R2 refused their diclofenac sodium 1 % gel at 7 AM on 04/19/2024, 04/20/2024, and 04/26/2024.

Record review of R2's Medication Notes, dated 06/01/2024 through 06/05/2024, showed R2 refused their aspirin on 06/02/2024, 06/03/2024, and 06/04/2024. R2 refused their diclofenac sodium 1% gel on 06/01/2024.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not report to R2's physician when R2 refused humalin insulin on 03/10/2024 and 03/18/2024. The facility did not report or notify the physician when R2 refused their diclofenac sodium 1% topical gel on 03/13/24, 03/18/2024, 03/29/2024, 03/30/2024, 04/19/2024, 04/20/2024, and on 04/26/2024. The facility did not notify R2's physician when R2 refused their Aspirin 21 days in the month of April 2024.

R5

Record review of R5's "Service Agreement", dated 04/10/2024, showed R5 had a diagnosis of [REDACTED]

[REDACTED] and [REDACTED]. R5 required assistance with set up of their oral medications to ensure safe and effective medication administration practices.

Record review of R5's "90 Day Assessment", dated 04/08/2024, showed R5 had not been evaluated and approved for self-medication administration by the nurse. R5 received oral medication assistance five times daily.

Record review of R5's "Medication and Treatment Orders", dated 05/17/2023, showed R5's physician were to be notified the first time R5 refused their medication. The physician orders were signed and dated by R5's physician.

Record review of R5's MAR, dated 03/01/2024 – 03/31/2024, showed R5 had an order for Inzo barrier cream to protect the skin. R5 refused their medication twelve out of thirty-one days for the month of March.

Record review of R5's MAR, dated 04/01/2024 through 04/30/2024, showed R5 had an order for Inzo barrier cream to protect the skin. R5 refused their medication twenty out of thirty days in the month of April.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not have documentation to provide that showed R5's physician was notified when R5 refused their medication.

R4

Record review of R4's Service Agreement, dated 04/15/2024, showed R4's medications were administered by the medication technician as ordered by R4's physician. The facility staff assist R4 to take their medications as ordered.

Record review of R4's "Admission Physician's Report and Orders", dated 03/20/2024, showed R4's physician wanted to be notified the first time R4 refused their medications. The physician orders were signed and dated by R4's physician.

Record review of R4's medication notes, dated April 2024, showed R4 refused their ketoconazole 2% cream on 04/19/2024. The facility was unable to provide documentation that showed R4's physician was notified that R4 refused their medication.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on
(Date) 08/09/2024.

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

Byron W. Bann
Administrator (or Representative)

07/18/2024
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 that 4 of 7 residents (Resident 6 [R6], Resident 2 [R2]), Resident 1 [R1], and Resident 3 [R3]) had their

medications available for administration per physician orders. This failure placed all residents 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, placed residents at risk for medical complications from not receiving medications as prescribed, and a decreased quality of life.

Finding included...

Record review of the facility's policy titled, "missed medication policy", undated, showed all residents would receive medications according to physician's orders. Any medication that was not provided due to non-delivery of the medication results in notification of the resident care coordinator (RCC). The medication technician or the RCC would call the pharmacy to determine the delivery date. If the delivery date of the medication would be longer than 48 hours, the facility nurse, administrator, physician, and family/power of attorney would be notified. Notification would be documented in the resident's record. Further action would then be determined. Any medication not provided for 48 hours (including refusals) would result in notification of the RCC, facility nurse, administrator on the 24-hour report. Further action would be taken that included notification of the physician according to their preference. Notifications would be documented in the resident record and further action would then be determined and could include faxing physician for alternative medications order, faxing pharmacy for help with pre-authorization, and obtaining from a satellite pharmacy if needed as an immediate order.

R6

Record review of R6's Service Agreement, dated 03/26/2024, showed R6 had multiple medical diagnoses that included [REDACTED]

Record review of R6's medication notes, dated March 2024, showed R6 did not received their Levothyroxine (prescribed medication to help treat low thyroid hormone levels not produce by the thyroid) on 03/09/2024 and 03/10/2024 as the facility was waiting for the medication to be delivered.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not report to R6's physician when R6 did not receive their Levothyroxine on 03/09/2024 and on 03/10/2024 when the medication was not available, and the facility was waiting for the medication to be delivered.

R2

Record review of R2's Service Agreement, dated 05/17/2024, showed R2 had multiple medical diagnoses that included [REDACTED] and [REDACTED]

[REDACTED] The facility assisted R2 to take their medication as ordered. R2's insulin injections were delegated and administered to R2 by the medication technician. The facility provided supportive assistance with R2's management of diabetes.

Record review of R2's medication notes, dated March 2024, showed R2 did not receive their senna laxative (medication to help soften and move bowel movements) on

03/01/20204 through 03/04/2024 as the medication was not available and the facility was waiting for the medication to be delivered. R2 had to take their as needed medication polyeth glycol (a medication to help soften and move bowel movements) every day R2 did not receive their medication senna for constipation. R2 did not receive their repaglinide (prescribed medication to treat high blood sugar levels for people with diabetes type 2) on 03/22/2024 and 03/23/2024 as the facility was waiting for the medication to be delivered.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not report to R2's physician when R2 missed their prescribed medication repaglinide on 03/22/2024 and on 03/23/2024. There was no physician notification completed to inform the physician when R2 did not receive their senna on 03/01/24 through 03/04/2024.

R3

Record review of R3's "Service Agreement", dated 04/24/2024, showed R3 had multiple medical diagnosis that included [REDACTED] and [REDACTED]. R3 received assistance with their medication three times daily. The facility provided medication set-up services to support safe and effective medication administration practices.

Record review of R3's "90 Day Assessment", dated, 04/23/2024, showed R3 received oral medication assistance up to three times daily.

Record review of R3's Medication Administration Record (MAR), dated 03/01/2024 – 03/31/2024, showed R3 had an order for "Humalog [medication to manage blood sugars] three times daily before meals for diabetes." R3 missed 2 dosages on 03/27/2024, and 3 dosages on 03/28/2024 – 03/31/2024 due to the medication not being available.

Record review of R3's "MAR", dated 04/01/2024 – 04/30/2024, showed R3 had an order for "Humalog 3 times daily before meals for diabetes." R3 missed 3 dosages on 04/01/2024 – 04/02/2024, and 1 dosage on 04/03/2024 due to the medication not being available.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not report to R3's physician when R3 missed their prescribed medications due to them not being available.

R1

Record review of R1's "Service Agreement", dated 04/03/2024, showed R1 had a diagnosis of [REDACTED]. R1's service agreement did not indicate who provided R1 their medications.

Record review of R1's "Initial/Pre-Admission Assessment", dated 03/04/2024, showed the facility would assist R1 with all medication management.

In an interview on 06/03/2024 at 10:46 AM, R1 said that the facility staff provided them their medications when needed.

Record review of R1's MAR, dated 03/04/2024 – 03/31/2024, showed R1 had an order for "Secura Dimethicone [cream to treat or prevent incontinence associated skin issues] Apply to buttocks topically 3 times daily for skin issues." R1 missed three dosages on 03/05/2024, one dose on 03/06/2024, two dosages on 03/07/2024, one dose on 03/08/2024, one dose on 03/09/2024, two dosages on 03/10/2024 due to the medication not being available.

Record review of an email sent to the Department on 06/10/2024 at 4:08 AM, showed the facility did not report to R1's physician when R1 missed their prescribed medications due to them not being available.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on
(Date) 08/09/2024.

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

Bryce W. Brown
Administrator (or Representative)

07/18/2024
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 the resident's well-being after admission to the facility and when a new medication was prescribed for 3 of 7 sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 4 [R4]). This failure placed R1, R2, and R4 at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy titled, "Alert Charting Policy", undated, showed a resident would be placed on alert charting for any reason consistent with alert charting guidelines. The residents name and reason why they are placed on alert charting would be filled out. The medication technician would alert chart each shift on the status of the resident. If a resident was on alert for more than 7 to 10 days they would be evaluated for a change of condition if it is anticipated they would not return to baseline.

Record review of the facility's policy titled, "Alert Charting Schedule", undated, showed a newly admitted resident would be on alert charting for up to 3 days or at the administrations discretion. If a resident had a new medication, they would be alert charted on for a minimum of 3 days. If a resident started an antibiotic the staff would chart on the resident until 24 hours after the antibiotic was completed.

Record review of the facility's policy titled, "Policy Incidents/Events/Medication Errors", undated, showed the medication technician would place the resident on alert charting roster and indicate why the resident was placed on alert charting. The medication technician would chart on the resident each shift and reference the state of the issue they are monitoring in the progress notes under alert charting note. The resident care manager (RCM) would review the alert charting to assure that staff were charting appropriately per shift or interval instructed by the nurse. If the situation with the resident was resolved within 10 to 14 days and the resident has returned to baseline the alert charting was discontinued by the RCM or the nurse.

R1

Record review of R1's "Face Sheet", undated, showed R1 moved into the facility on 03/04/2024. R1 had diagnoses which included [REDACTED] and [REDACTED].

Record review of "Progress Notes for [R1]", dated 03/08/2024 at 5:30 AM, showed R1 had been placed on alert for new admission into the facility.

Record review of R1's progress notes, dated 03/10/2024 through 03/11/2024, showed there were no other alert charting notes for R1 since they were admitted to the facility for review.

Record review of "Progress Notes for [R1]", dated 03/11/2024 at 11:27 AM, showed R1 was being removed from alert monitoring due to R1 being settled into the facility.

In an interview on 06/04/2024 at 8:55 AM, Staff N, Resident Care Manager, said new residents who admitted into the facility were supposed to be on alert charting for three consecutive days.

R2

Record review of R2's face sheet, dated 06/10/2024, showed R2 moved into the facility on [REDACTED] 2023, with multiple medical diagnoses that included [REDACTED]

[REDACTED] and [REDACTED]

Record review of R2's Medication Administration Record (MAR), dated 05/01/2024 through 05/31/2024, showed R2 started the medication doxycycline mono [an antibiotic] take one tablet two times a day for five days. The medication was first administered on 05/30/2024 in the AM. The order said that medication was for ABO (antibiotic) with no other details provided.

Record review of the progress notes, dated 05/01/2024 through 06/03/2024, showed on 05/31/2024 at 2:08 PM, R2 was on alert for new antibiotic. There were no issues to report and R2 had not experienced any side effects. There were no other progress notes about R2 being on the antibiotic for review.

In an interview on 06/04/2024 at 11:11 AM, Staff D, Medication Technician, stated if a resident started an antibiotic, the medication technicians would chart on the resident the entire time they were on the antibiotic to ensure they were getting better and were not having any side effects.

R4

Record review of R4's face sheet, dated 06/03/2024, showed R4 moved into the facility on [REDACTED] 2024 with multiple medical diagnoses that included [REDACTED]

Record review of R4's progress note, dated 04/30/2024 at 3:17 AM, showed at 2:30 AM, R4 was heard yelling and had rolled out of bed. As the staff entered R4's room, R4 was wrapped up in their blankets on the ground.

Record review of R4's progress notes dated 05/01/2024 through 05/05/2024, showed R4 was on alert for "RTF [return to facility]". There was no documentation on those days that showed how R4 was doing, if any injuries, or changes in R4's activity level from being found on the ground on 04/30/2024 for review.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Duane W. Brown
Administrator (or Representative)

07/18/2024
Date

WAC 386-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the residents Service Agreement (facility's version of the negotiated service agreement) were followed and implemented for 4 of 7 sampled residents (Resident 4 [R4], Resident 6 [R6], Resident 1 [R1], and Resident 5 [R5]). These failures contributed to R4 experiencing an increase of fluid retention to both of their feet and lower legs and placed all other residents at risk for unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements [NSA]", undated, showed the service agreements were based on assessed needs of the resident. The NSA would be implemented to meet the residents needs and preferences.

R6

Record review of R6's face sheet, dated 06/03/2024, showed R6 moved into the facility on [REDACTED] /2023, with multiple medical diagnoses that included [REDACTED]

and [REDACTED]

Record review of R6's Master Assessment, dated 03/25/2024, showed R6 was on a regular diet with finger food textures.

Record review of R6's Service Agreement, dated 03/26/2024, showed R6 had a history of a stroke with left side weakness. R4 was on a regular diet that was cut up.

In an observation on 06/03/2024 at 9:24 AM, outside of R6's room door, there were two plates that were wrapped in plastic wrap that had two-whole pancakes, scramble eggs, and two-whole sausage links. None of the food had been cut up.

In an observation and interview on 06/03/2024 at 12:50 PM, on the dining room table in R6's apartment room there was a plate with whole pieces of breaded chicken with an orange sauce with rice. None of the food on the plate was cut up or finger foods. R6 stated that he does not get their food cut up or required finger foods. R6 was observed to

not use their left arm and their left hand was contracted (condition when the muscles become stiff and rigid and unable to use) closed.

R4

Record review of R4's face sheet, dated 06/03/2024, showed R4 moved into the facility on [REDACTED] /2024, with multiple medical diagnoses that included [REDACTED].

Record review of R4's Master Assessment, dated 04/29/2024, showed R4 took heart medications, high blood pressure medications, and diuretics (prescribed medication to help reduce the amount of excessive fluid the body retains). R4 required one-person physical assist with putting on and removing R4's ted hose (tight compression socks to help with blood flow and fluid retention in lower legs or within the body).

Record review of R4's Service Agreement, dated 04/15/2024, showed R4 required staff physical assistance to put on their ted hose every day. Staff were to put them on in the morning and then remove the ted hose at bedtime. If R4 refused to wear the ted hose, the caregivers were to report to the resident care coordinator and/or licensed nurse. The facility would provide support with the ted hose.

In an observation on 06/03/2024 at 12:01 PM, R4 was sitting up in a chair in the dining room eating lunch. R4 was wearing gray socks and sandals that had two straps. In between the two straps of R4's sandals, R4 had their gray sock and protruding out. R4 was not observed to be wearing any ted hose.

In an interview on 06/04/2024 at 9:44 AM, Staff B stated if a resident refused care or services, the caregiver was to report the refusal to the medication technician. Staff B stated the caregivers and medication technicians only charted by exception when a resident refused care and services. Staff B stated the charting would be completed by the medication technician in the facility's resident electronic progress notes.

In an observation on 06/04/2024 at 9:14 AM, R4 was in their room lying on the bed. R4 was not wearing their ted hose. R4 was wearing their sandals and gray socks. R4's skin was noted to have large amounts of edema (swelling that builds up in the body tissue/skin) that protrude up between the straps of their sandals. R4 stated they were the first person to be in the dining room for breakfast that morning.

In an interview on 06/04/2024 at 9:24 PM, Staff M, Medication Technician, stated the caregivers were responsible to put R4's ted hose on every morning and then take them off daily at bedtime. Staff M stated the caregivers put R4's ted hose on when they assisted R4 with getting dressed for breakfast around 8 AM. Staff M stated they were not aware of R4 refusing to wear their ted hose recently.

In an observation on 06/04/2024 at 1:01 PM, R4 was in bed and was not wearing their ted hose.

In an interview on 06/04/2024 at 1:07 PM, Staff O, Caregiver, stated R4 did not have their ted hose put on that day (06/04/2024). Staff O stated they were unable to find R4 ted hose to put them on. Staff O stated R4's ted hose were missing since Sunday 06/02/2024. Staff O stated R4 was compliant with allowing the caregivers to put the ted hose on their legs.

Staff O stated they had not told the medication technician that R4 did not have their ted hose on yesterday 06/03/2024 and today 06/04/2024.

R1

Record review of R1's "Service Agreement", dated 04/03/2024, showed R1 had diagnoses of [REDACTED] and [REDACTED]. R5 had loose fitting dentures and required chewy food to be cut into bite sized pieces.

Record review of R1's "Initial/Pre-Admission Assessment", dated 03/04/2024, showed R1 needed finger foods.

In an observation on 06/03/2024 at 12:24 PM, in the dining room R1 was served the sweet and sour chicken with rice. R1 had been observed trying to cut their chicken with their spoon. R1 missed the chicken with their spoon a few times before being successful at cutting and eating it.

In an interview on 06/03/2024 at 12:36 PM, Staff K, Dietary Aide, said sometimes they cut up R1's food. Staff K said they would ask R1 if they wanted their food cut up and do so at their request.

R5

Record review of R5's "Service Agreement", dated 04/10/2024, showed R5 had a diagnosis of [REDACTED]. R5 was intolerant to lactose (the body is unable to digest sugar in dairy products).

In an observation on 06/03/2024 at 12:17 PM, inside the dining room, Staff K, Dietary Aide, asked R5 if they wanted milk with their lunch. R5 said they were allergic to milk. Staff K said I hope you are not allergic, we put milk in your cereal today.

In an interview on 06/04/2024 at 9:06 AM, R5 stated when they consumed dairy, they got diarrhea (loose watery stool).

In an interview on 06/04/2024 at 10:43 AM, Staff J, Cook, stated they referenced the document "Resident Orders", undated, to see what residents needed their food cut up for them and what resident had food allergy. Staff J stated they were unsure if the document was current because it had not been updated since they started working at the facility as of 05/01/2024.

Record review of the facility's "Resident Orders", undated, inside the kitchen on the wall by the lo boy (sandwich station), showed a total of ten assisted living and memory care resident orders. The document included if the resident needed their food cut up into bite sized pieces and allergy information. R1 was not included in the document that stated they needed their food cut up and R5 was not included as having a food allergy.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryce Bowman
Administrator (or Representative)

07/18/2024
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

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

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

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

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

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

- (3) The times services will be delivered, including frequency and approximate time of day, as appropriate;
- (4) The resident's preferences for activities and how those preferences will be supported;
- (5) Appropriate behavioral interventions, if needed;
- (6) A communication plan, if special communication needs are present;
- (7) The resident's ability to leave the assisted living facility premises unsupervised; and
- (8) The assisted living facility must not require or ask the resident or the resident's representative to sign any negotiated service or risk agreement, that purports to waive any rights of the resident or that purports to place responsibility or liability for losses of personal property or injury on the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have the residents service plan agreement (facility's version of the negotiated service plan) updated with the most accurate information for 4 of 7 residents (Resident 6 [R6], Resident 4 [R4], Resident 7 [R7], and Resident 1 [R1]. This failure placed 50 of 50 residents at risk of unmet care needs and care staff uneducated and unable to provide the care and services that the residents required.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements [NSA]", undated, showed the service agreements were based on assessed needs of the resident. The NSA would be updated to be consistent with the residents needs and when there has been an observed change in resident's physical, mental, or emotional function. The NSA would be updated when it no longer addressed the residents needs and/or preferences. The NSA would be implemented to meet the residents needs and preferences.

R6

Record review of R6's Master Assessment, dated 03/25/2024, showed R6 had a history of stroke (a condition when part of the brain loses blood flow and damages the brain tissue that can cause changes in the bodies ability to move, talk, or function) with left side weakness. R6 used assistive devices that included a reclining wheelchair and left foot brace. R6 required finger foods for diet texture. R6 was independent with their call system operations. R6 was currently on hospice services. The assessment showed R6 received their medication from the facility's house pharmacy Consonus. The assessment showed hospice provided bathing for R6 three times weekly.

In an observation and interview on 06/03/2024 at 12:50 PM, R6 was sitting in a manual wheelchair with footrests. R6 left arm was bent at the elbow and hand was folded in as a fist. R6 stated they were unable to use their left hand. When R6 smiled, the left side of their face remained drooped down. R6's bed was a hospital bed that had an air mattress on top of the regular mattress. The assessment showed R6 required one-person physical assistance with bathing. R6 was on hospice services and the facility would coordinate R6's care with hospice services as needed.

Record review of R6's Service Agreement, dated 03/26/2024, showed R6 had a history of stroke with left side weakness. There was nothing in the documentation that showed R6 had limited use of their left arm, their left hand was contracted closed and unable to use, and that R6's left side of their face had a droop. R6 was independent with their call light system. There was nothing in the service agreement that showed R6 wore a call light pendent and to ensure that R6 had the pendent on for use. The service agreement showed R6 received their medications from Pharmerica pharmacy. The pharmacy was not the same as indicated on the master assessment. R6 ate a regular diet with chopped meats. The service plan did not say anything about R6 requiring finger foods. R6 used a wheelchair that they could propel self independently. The service agreement did not say anything about R6 using a reclining wheelchair. R6's service agreement did not show that R6 used a hospital bed with an air mattress. There was no documentation that R6 refused to have the air mattress inflated. The service agreement showed R6 required one-person physical assistance for bathing.

In an interview on 06/04/2024 at 9:44 PM, Staff B, Licensed Practical Nurse/Operations Support Specialist, stated the residents service agreement and assessment, should indicate that the resident was provided showers by hospice staff.

In an interview on 06/04/2024 at 2:28 PM, Staff B stated that R6 only used a manual wheelchair and was not aware that R6 used a hospital bed with an overlay air mattress.

R4

Record review of R4's Master Assessment, dated 04/29/2024, showed R4 had a recent hospitalization. Upon return to the facility, R4 required one-person physical assistance with all mobility tasks and would refuse to assist with transfers and ambulation that made it difficult for one staff person to assist related to R4's size. Staff were to provide R4 specific directions during transfers and care services. R4 received home health services for physical and occupational therapy. R4 had skin impairments that was a rash to the groin area that was being treated with topical medications. R4 had dentures and required one-person physical assistance for care of R6's dentures. R4 used a bed cane on their bed to assist with bed mobility.

In an observation on 06/03/2024 at 1:55 PM, in R4's room, there was a side rail on the left side of R4's bed. Inside the bathroom on the counter was a denture cup that had an upper and lower denture inside soaking in water.

Record review of R4's Service Agreement, dated 04/15/2024, showed R4 required cues and stand-by assistance with dressing and undressing in the morning and bedtime. R4 had natural teeth and could brush them without staff assistance. R4 was able to enter and exit their bed independently but would occasionally need assistance. R4 was able to turn and reposition self in bed without assistance. R4 could stand independently most of the time but need staff to stand by and cue. At times R4 could stand independently most of the time and required staff to stand by and cue. R4 at times would require assistance with standing. R4 used a bed can on their bed to help aide them to get in and out of bed. The service agreement did not indicate that R4 was receiving home health that included physical and occupational therapy services. The service agreement did not indicate that R4 required more assistance with mobility and care services as indicated on the assessment. There was no documentation that R6 had any skin impairment. The service agreement did not reflect that R4 used a breakaway bed rail for bed mobility.

In an interview on 06/04/2024 at 9:24 PM, Staff M, Medication Technician, stated R4 required two staff members to assist R4 during transfers. Staff M stated R4 required one person assist with grooming and care needs.

In an interview on 06/04/2024 at 9:59 AM, Staff B, stated R4 did not have a bed cane on their bed, but a break away bed rail that R4 used to help with bed mobility.

R7

In an observation on 06/03/2024 at 12:08 PM, inside R7's apartment, R7's right side of the bed was up against the wall and the head of the bed was up against the wall in the corner of the room. R7 had a four-wheeled walker that was parked beside the left side of their bed. R7 stated they used the four-wheeled walker when they walked.

Record review of R7's Master Assessment, dated 04/08/2024, showed R7 walked with a four-wheel walker independently. The only assistive device R7 used was a four-wheeled walker. R7 was a high fall risk. There was nothing documented about one side of R7's bed being up against the wall per their choice.

Record review of R7's Service Agreement, dated 04/18/2024, under the section titled, "device assessment", showed R7 ambulated independently with their front wheeled walker. Under the section titled, "mobility", showed R7 was independent with mobility using their four-wheel walker. The service agreement did not indicate that R7's bed was up against the wall and was residents' preference rather than risk of restraint. R7 was indicated as a low risk for falling.

R1

Record review of R1's "Service Agreement", dated 04/03/2024, showed R1 had multiple medical diagnoses of [REDACTED] and [REDACTED].

Record review of R1's "Master Assessment", dated 02/12/2024, showed the facility would assist R1 with medication management 3 times daily.

In an interview and observation on 06/03/2024 at 10:46 AM, R1 said that the facility staff provided them their medications. R1 said when they showered, they used a shower bench to sit on. In R1's bathroom was a shower bench. R1 said they had a pendant they wore around their neck and if they pushed the button facility staff would come help them. R1 wore the pendant around their neck. R1's room showed that their bed was against the wall. R1 had a transfer pole on the side of the bed that was not against the wall.

In an interview on 06/04/2024 at 8:55 AM, Staff N, Resident Care Manager, said R1 used a shower bench when they showered because home health recommended it. Staff N said that when R1 admitted into the facility their family positioned R1's bed to be against the wall.

In an interview on 06/04/2024 at 9:57 AM, Staff B, License Practical Nurse/Operations Support Specialist, said upon R1's admission into the facility their family put R1's bed up against the wall. Staff B said that a bed being against the wall could be considered a restraint and the information should be in R1's service agreement to indicate it was R1's and their family's preference. Staff B acknowledged that R1 used a shower bench and a

transfer pole.

In an interview on 06/04/2024 at 9:57 AM, Staff B stated if residents opted into having their bed against the wall it would need to be in their service agreements because it would be considered a restraint.

Record review of R1's Service Agreement, dated 04/03/2024, showed R1's service agreement did not indicate who provided R1 their medications. There was nothing in the service agreement that showed R1 used a shower bench when showering. There was nothing in the service agreement that showed R1 wore a call light pendent and to ensure that R1 had the pendent on for use. R1 had loose fitting dentures and required chewy food to be cut into bite sized pieces. There was nothing in the service agreement that R1 needed finger foods. There was nothing in the service agreement that indicated R1's bed was against the wall and that they used a transfer pole.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Brycen Bann
Administrator (or Representative)

07/18/2024
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 resident's service agreements (facility's version of the negotiated service agreement) was signed annually for 1 of 7 sampled residents (Resident 6 [R6]). This failure placed the R6 at risk for unmet care and services.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements", undated,

showed the facility would develop a negotiated service agreement (NSA) for each resident upon admission, annually, and as necessitated by a change of condition. The NSA would be agreed upon, documented and the plan would be implemented to meet the residents needs and preferences. All parties involved with the NSA agreement should be reviewed and agreed up on with the resident and/or resident representative, case manager if appropriate, and a community staff.

Record review of R6's face sheet, dated 06/03/2024, showed R6 moved into the facility on [REDACTED]/2023 with multiple medical diagnoses.

Record review of R6's Service Agreement, dated 03/26/2024, showed it was signed, dated, and agreed upon on 03/27/2024.

On 06/04/2024 at 9:06 AM, the Department requested the prior signed service agreement for R6 for review.

In an interview on 06/04/2024 at 12:15 PM, Staff B, Licensed Practical Nurse/Operations Support Specialists, stated the facility did not have a prior signed service agreement to provide to the Department for R6 for review.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Byron W Bauer
Administrator (or Representative)

07/18/2024
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 reviews, the facility failed to perform a preadmission assessment for 1 of 3 sampled residents (Resident 4 [R4]) prior to the resident's admission to the facility. This failure placed Resident 4 at risk for not having an assessment to identify and meet the resident's healthcare needs.

Findings included...

Record review of the facility's policy titled, "Assessments", undated, showed the preadmission assessment would be completed prior to the prospective resident moving into the community.

Record review of R4's Face Sheet, dated 06/03/2024, showed R4 was admitted to the facility on [REDACTED] /2024 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R4's records as of 06/03/2024 showed there was no preadmission assessment to review.

In an interview on 06/04/2024 at 9:58 AM, Staff B, Licensed Practical Nurse/ Operations Support Specialist, stated the resident's pre-admission assessments were dated and completed prior to the date that the resident admitted to the facility.

In an interview on 06/04/2024 at 12:13 PM, Staff B stated the facility did not have a pre-admission assessment for R4 that was completed prior to R4's move into the facility on 03/26/2024 for the Department to review.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Byrdell Brown
Administrator (or Representative)

07/18/2024
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(iii) Include all food and snacks served that contribute to nutritional requirements;

(iv) Are kept at least six months;

(v) Provide a variety of foods; and

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure menus were written at least one week in advance, document substitution of foods of equal nutrition when changes were made and accommodate preferences for 1 of 1 kitchen reviewed. These failures placed 50 of 50 residents at risk of not having their nutritional needs and preferences met.

Findings included...

Menus

Record review of the facility's, "[facility's name] Weekly Menu", dated "05/30 – 06/05", showed Thursday "05/30" lunch would be chicken, mashed potatoes, corn, and a breadstick. For dinner there would be tuna casserole, green salad, and sliced cake. On "05/31" for lunch would be Swedish meatballs over noodles, mixed veggies, and ice cream. For dinner there would be baked ham, cheesy hashbrowns, beans, and assorted pie. On "06/01" for lunch would be smothered chicken, biscuits, green beans, and cookies. For dinner there would be club sandwiches, a bag of chips, fruit, and pudding. On "06/02" for lunch there would be pork and vegetables fajitas, black beans, corn, and Jello. For dinner there would be meatloaf, roasted potatoes, broccoli medley, and a slice of cake. On "06/03", for lunch there would be sweet and sour chicken, seasoned rice, coleslaw, and assorted desserts. For dinner there would be cheeseburgers, sweet potato fries, and ice cream sundaes. On "06/04" for lunch there would be beef stew, side salad, baked roll, and assorted pie. For dinner there would be baked macaroni and cheese, peas, carrots, grapes, and cookies. On "06/05" for lunch would be chili dogs, tater tots, apple slices, and pudding. For dinner there would be hot turkey sandwich, scalloped potatoes, green beans, and Jello.

Record review of the facility's, untitled document, dated "05/30 – 06/05", showed in handwritten letters under Thursday "05/30" lunch would be chicken, mashed potatoes topped with corn, gravy, cheese, and a breadstick. For dinner there would be tuna casserole and salad. Compared to the "[facility's name] Weekly Menu", dated "05/30 – 06/05", for lunch the handwritten menu added gravy and cheese. For dinner the handwritten menu omitted that they were to have green salad and sliced cake. On "05/31" for lunch would be Swedish meatballs over noodles and mixed veggies. The handwritten menu omitted the ice cream that was supposed to be served. For dinner there would be brown sugar ham, cheesy hashbrowns was crossed out and cheesy potato casserole had been written in. The handwritten menu omitted the beans and assorted pie that was supposed to be served. On "06/01" for lunch would be smothered chicken, biscuits, and green beans. The handwritten menu omitted the cookies that were supposed to be served.

For dinner there would be club sandwiches and a bag of chips. The handwritten menu omitted the fruit and pudding that was supposed to be served. On "06/02" for lunch there would be pork and vegetables fajitas, black beans, and corn. The handwritten menu omitted the Jello that was supposed to be served. For dinner there would be meatloaf and roasted potatoes. The handwritten menu omitted the broccoli medley and sliced cake that was supposed to be served. On "06/03", for lunch there would be sweet and sour chicken, seasoned rice, and coleslaw. The handwritten menu omitted the assorted desserts that were supposed to be served. For dinner there would be cheeseburgers and sweet potato fries. The handwritten menu omitted the ice cream sundaes that were supposed to be served. On "06/04" for lunch there would be beef stew, salad, and a roll. The handwritten menu omitted the assorted pie that was supposed to be served. For dinner there would be baked macaroni and cheese, peas, and carrots. The handwritten menu omitted the grapes and cookies that were supposed to be served. On "06/05" for lunch would be chili dogs with tater tots. The handwritten menu omitted the apple slices and pudding that was supposed to be served. For dinner there would be hot turkey sandwich with green beans. The handwritten menu omitted the scalloped potatoes and Jello that was supposed to be served.

In a group interview on 05/31/2024 at 10:00 AM, fourteen residents at the facility collectively reported they had concerns regarding the food that was served at the facility. Resident 15 (R15) said the facility served a lot of chicken. R15 said sometimes they were served chicken twice daily. R15 said they used to get a menu delivered to them. All residents in the group meeting agreed that menus used to be delivered but now were set on the tables on Wednesday's. All Residents agreed that what was on the menu was not always what was served to them.

In an interview and observation on 06/04/2024 at 10:43 AM, Staff J, Cook, said they followed the menu unless they did not have a food item that they were supposed to serve. Staff J said if they made a substitution to the menu, they would not mark it down and create a record of what had been changed. Staff J said they needed to follow up with Staff A, Executive Director to obtain a menu for the following week. Staff J said they needed to start prepping food for the following week but did not know what was supposed to be served. Staff J said menus used to be delivered to the residents' rooms. Staff J said the menus are now left out on the dining room tables for the residents to view. Staff J said the menus that were provided to the residents this week were wrong. Staff J said there was a miscommunication about the menus between Staff E, Cook and Staff A. Staff J said Staff E created a menu and shopped for everything on the menu. Staff J said Staff A printed menus for the residents but what was on the menus were not accurate to what Staff J had shopped for and served to the residents. Staff J pointed to the food line and said the menu they used for the week was on the handwritten piece of paper.

In an interview on 05/31/2024 at 2:20 PM, Staff A, Executive Director, said the facility did not keep documentation if the menu changed. The facility did not have a menu they could provide of what was served to the residents. Staff A said to their knowledge the menu did not change often.

In an interview on 06/04/2024 at 2:28 PM, Staff A, Executive Director, stated there were two menus that were made. One menu that Staff A had printed, and the other menu was completed by Staff E. Staff A stated the menu that Staff E made was not to be used or distributed to the residents. Staff A stated the one they printed was the corrected menu and should have been what was cooked and served to the residents.

Food preferences

In an observation on 05/30/2024 at 11:49 AM, inside the dining room, Staff K, Dietary Aide, had been taking residents lunch orders. Staff K informed an unknown resident what the main course was for the day. The unknown resident declined the main course. Staff K said the alternative item had been a sandwich and Staff K said the resident had to have white bread with the sandwich. After Staff K informed the resident, they had to have white bread Staff K asked the resident if that was okay.

In an observation on 05/30/2024 at 2:07 PM, inside of the kitchen showed at the lo boy (sandwich station) there were 5 loafs of white bread observed. There were no other kinds of bread observed.

In a group interview on 05/31/2024 at 10:00 AM, fourteen residents at the facility collectively reported they had concerns regarding the food that was served at the facility. Resident 18 (R18) reported at mealtimes they did not get food items on the menu that they preferred such as peppers and ham. Residents reported that for meals the facility provided white, wheat, and raisin bread. Residents reported towards the end of the week when the facility ran out of the popular breads such as wheat and raisin bread.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryce W. Boun
Administrator (or Representative)

07/18/2024
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have all staff trained on how to report abuse and neglect as a mandated reporter for 1 of 1 facilities reviewed. This failure placed all 50 of 50 residents at risk of staff not identifying and reporting potential abuse and neglect to help protect the residents.

Findings included...

Record review of the facility's "Reporting Abuse, Neglect and Exploitation", undated, all staff members would be trained on abuse, neglect, and exploitation and the mandatory reporting requirements during orientation and periodically throughout the year.

Record review of Attachment B, "Assisted Living Facility Request for Documentation", revised 04/2024, showed mandated reporting records for abuse and neglect were required to be provided by the end of the day on 05/30/2024.

Record review of an email sent to the Department on 06/10/2024, showed Staff B, Licensed Practical Nurse/Operations Support Specialist, provided a list of eight Relias trainings the facility had available regarding abuse and neglect. The document did not indicate what staff completed the training and when it had been completed.

In an interview on 05/30/2024 at 11:28 AM, Staff A, Executive Director, expressed understanding that they needed to provide staff training records on abuse and neglect training by the end of the day.

Record review on 05/31/2024 at 8:35 AM, showed a copy of the Complaint Resolution Unit notice poster had been provided. There were no other records provided to review regarding mandated reporting records for abuse and neglect.

In an interview on 06/03/2024 at 8:20 AM, Staff I, Housekeeping, said upon hire they did not complete facility orientation. Staff I said they had not been trained on what to do if they suspected a resident had been abused or neglected. Staff I said the training they had on the topic was from a past employer.

In an interview on 06/03/2024 at 8:57 AM, Staff K, Dietary Aide, said they never received any verbal training on being a mandated reporter and what to do if they suspected a resident was being abuse or neglected. Staff K said if they thought abuse and neglect happened, they would say something. Staff K did not indicate who they would report their concerns to.

In an interview on 06//2024 at 9:12 AM, Staff Q, Maintenance Director, stated they had not been trained on abuse and neglect since they started their employment at the facility on 04/16/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on
(Date) 08/09/2024

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

Bryce W. Bauer
Administrator (or Representative)

07/18/2024
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, document investigative actions and findings for incidents for 2 of 7 residents (Resident 4 [R4] and Resident 3 [R3]). This failure resulted in the facility being unable to determine the circumstances of the events, 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 titled, "Policy Incidents/Events/Medication Errors", undated, showed when an incident/accident or event occurred, either witness or unwitnessed directly the first staff person aware of the incident would begin the process. The caregiver that witnessed or found a resident that had an accident or incident would attend to the residents needs until stable. The medication technician would fill out the accident/incident report in the facility's electronic medical record. The resident care manager (RCM) would review the alert charting to assure that staff were charting appropriately per shift or interval instructed by the nurse. And begin the investigation of the incident. The RCM would put in place additional interventions that may be needed or considered as a result of the investigation. The administrator would review, sign, and lock all investigations within the appropriate time frames.

R4

Record review of the facility's document titled, "Resident Incident/Accident", dated 03/04/2024 through 05/27/2024, showed there was one incident documented for R4 dated 04/01/2024 at 11:30 PM that occurred.

Record review of R4's face sheet, dated 06/03/2024, showed R4 moved into the facility on [REDACTED] /2024 with multiple medical diagnoses that included [REDACTED]

and [REDACTED]

Record review of R4's progress note, dated 04/30/2024 at 3:17 AM, showed at 2:30 AM, R4 was heard yelling and had rolled out of bed. As the staff entered R4's room, R4 was wrapped up in their blankets on the ground.

In an interview on 06/04/2024 at 12:12 PM, Staff H, Regional Operations Support Specialists, stated there was no incident report or incident investigations completed for R4's fall that occurred on 04/30/2024 for review.

R3

Record review of R3's "Service Agreement", dated 04/24/2024, showed R3 had diagnosis that included [REDACTED]. R3 was able to understand and had the ability to be understood using verbal communication.

In an interview on 06/03/2024 at 10:00 AM, R3 reported that themselves and another resident in the facility had a verbal resident to resident altercation. R3 reported that the resident called them a racial slur (insulting or disparaging remark). R3 said the verbal altercation escalated to where they thought they were going to get into a physical altercation. R3 said they thought the resident followed them after their argument. R3 recalled getting on to the bus to go into the community and R3 reported they heard the resident on the bus. R3 said due to the resident-to-resident altercation they do not eat in the dining room. R3 said they come to the dining room a half hour after mealtimes, pick up their meal, and return to their room to eat. R3 said they do not participate in facility activities due to not wanting to be around other residents. R3 would not disclose the name of the resident or the time of when the resident to resident occurred. R3 did say the other resident were amongst the residents who moved into the facility due to their assisted living facility closing. R3 said the other resident still lived at the facility.

In an interview on 06/04/2024 at 12:00 PM, Staff A, had been unaware R3 had a verbal resident to resident altercation. Staff A acknowledged that now they were aware of the resident to resident they would start an incident investigation to follow up.

Plan/Attestation Statement

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

Bryce W. Bann
Administrator (or Representative)

07/18/2024
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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report to the Complaint Resolution Unit (CRU) for 1 of 7 sampled residents (Resident 3 [R3]). This failure to notify CRU placed R3 and all 50 of 50 Residents at risk of unreported abuse and prevented the department from evaluating facility systems in place to protect residents.

Findings included...

Record review of the Department of Social and Health Services book, "Assisted Living Guidebook", dated February 2018, showed facilities were required to report 24 hours a day, seven days a week to the Departments CRU hotline via phone or online for any reasonable cause to believe violations involving abuse or neglect.

Record review of the facility's "Reporting Abuse, Neglect and Exploitation", undated, showed the facility would not tolerate verbal and physical abuse. Any staff member who had reasonable cause to believe an incident of abuse or neglect occurred needed to notify the Department of Social and Health Services CRU hotline and report it to management so that immediate interventions could take place.

R3

Record review of R3's "Service Agreement", dated 04/24/2024, showed R3 had diagnosis that included [REDACTED]. R3 was able to understand and had the ability to be understood using verbal communication.

In an interview on 06/03/2024 at 10:00 AM, R3 reported that themselves and another resident in the facility had a verbal resident to resident altercation. R3 reported that the resident called them a racial slur (insulting or disparaging remark). R3 said the verbal altercation escalated to where they thought they were going to get into a physical altercation. R3 said they thought the resident followed them after their argument. R3 recalled getting on to the bus to go into the community and R3 reported they heard the resident on the bus. R3 would not disclose the name of the resident or the time of when the resident to resident occurred. R3 did say the other resident were amongst the residents who moved into the facility due to their assisted living facility closing. R3 said the other resident still lived at the facility.

In an interview on 06/04/2024 at 12:00 PM, Staff A, had been unaware R3 had a verbal resident to resident altercation. Staff A acknowledged that now they were aware of the resident to resident they would follow up.

In an interview on 06/14/2024 at 12:57 PM, Staff A said they did not complete a report to CRU on behalf of R3's resident to resident altercation because they did not know the time

frame of when the incident occurred.

Record review of the department database showed there were no incidents that had been reported to the department regarding R3.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/09/2024.

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

Bryce W Bauer
Administrator (or Representative)

07/18/2024
Date

WAC 388-78A-2470 Background check Employment-disqualifying information Disqualifying negative actions.

(1) The assisted living facility must not employ an administrator, caregiver, or staff person, to have unsupervised access to residents, as defined in RCW 43.43.830, if the individual has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, unless the individual is eligible for an exception under WAC 388-113-0040.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure they did not employ a staff member with a disqualifying crime for 1 of 2 staff (Staff R). This failure placed 50 of 50 residents at risk of receiving care and services from a disqualified staff member.

Findings included...

Record review on 06/03/2024 of Staff R's, Former Maintenance Director, employee file, showed Staff R was hired at the facility on 02/21/2024.

Record review of Staff R's "employee timesheet", dated 02/16/2024 through 02/29/2024, showed Staff R worked from 8:45 AM until 5 PM on 02/29/2024.

Record review of Staff R's "employee timesheet", dated 03/01/2024 through 03/15/2024, showed Staff R worked every day 03/04/2024 through 03/08/2024 and 03/11/2024 through 03/15/2024. Staff R had worked on 03/14/2024 for times 1:30 PM through 11:45 PM.

Record review of Staff R's "employee timesheet", dated 03/16/2024 through 03/31/2024, showed Staff R worked daily on 03/18/2024 through 03/21/2024 each day for eight

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hours.

Record review of Staff R's Washington State Name and Date of Birth background check, dated 02/16/2024, that showed there was no record or findings for Staff R.

Record review of Staff R's interim fingerprint background check, dated 02/29/2024, showed additional information was needed from the applicant. "based on your rules, the applicant may not be allowed to have unsupervised access to children or vulnerable individuals until the background check is complete and the results are reviewed by your office".

Record review of Staff R's final fingerprint background check dated 03/15/2024, showed "as of the date of the background data search, the applicant has: disqualifying information reported by one or more background check data sources. This means the applicant cannot have unsupervised access to children or vulnerable adults. If you allow the applicant to have unsupervised access to children or vulnerable adults, you may be violating federal or state regulations and your DSHS oversight program may take action against you license or contract."

Record review of the Staff R's employee file showed Staff R was terminated from employment at the facility on 03/21/2024.

In an interview on 06/14/2024 at 12:15 PM, Staff B, Licensed Practical Nurse/Operations Support Specialist, stated the facility did not have any policies about employee background checks. The facility follows all of the background check regulations for assisted living facilities.

In an interview on 06/04/2024 at 2:28 PM, Staff A, Executive Director, stated they received all the Washington State Name and Date of Birth and fingerprint background check results for all employees hired for the facility. Staff A stated they were aware that Staff R needed to send in more information as it was requested on the interim fingerprint background check dated 02/29/2024. Staff A stated that Staff R continued to work. Staff A stated Staff R's final fingerprint background check results were resulted on a Friday when Staff A was not working. Staff A stated on 03/21/2024 when they returned to work and reviewed the final fingerprint background check results for Staff R they terminated Staff R's employment. Staff A stated they were unaware that the interim fingerprint background check results stated Staff R was not allowed to work unsupervised around vulnerable adults until the final fingerprint background check results were completed.

Plan/Attestation Statement

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

Bryce W Bauer
Administrator (or Representative)

07/18/2024
Date

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a character, competence, and suitability for 2 of 4 staff members (Staff C and Staff D) before they were determined they were cleared to work with vulnerable adults. This placed 50 of 50 residents at risk for potentially being cared for by an unauthorized staff member.

Findings included...

"WAC 388-113-0060 How and when must a character, competence, and suitability [CCS] determination be conducted by the department or an authorized entity? (1) The department or an authorized entity must conduct a character, competence, and suitability determination of an employee, prospective employee, or other individual who is required to undergo a background check when the applicant has received a "review required" result as defined in WAC 388-113-0101(b). (3) If an applicant is required to have a character, competence, and suitability determination under this section, the applicant may not have unsupervised access to minors or vulnerable adults unless the character, competence, and suitability determination has: (a) Been completed and documented in writing. applicant may have unsupervised access to minors or vulnerable adults."

Record review of the facility's provided undated and untitled document with a list of employees showed Staff C, Caregiver, was hired and started employment at the facility on 06/05/2023.

Record review of Staff C's interim Washington state name and date of birth and fingerprint background check, dated 06/02/2023, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review. There was no CCS completed for Staff C's interim fingerprint background check results for review.

Record review of Staff C's final Washington state name and date of birth and fingerprint background check, dated 06/16/2023, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review. There was no CCS completed for Staff C's final fingerprint background check

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results for review.

Record review of the facility's provided undated and untitled document with a list of employees showed Staff D, Medication Technician, was hired at the facility on 02/19/2024 and started employment at the facility on 02/20/2024.

Record review of Staff D's interim Washington state name and date of birth and fingerprint background check, dated 02/15/2024, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review. There was no CCS compelled for Staff D's interim fingerprint background check results for review.

Record review of Staff D's final Washington state name and date of birth and fingerprint background check, dated 02/23/2024, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review. There was no CCS compelled for Staff D's final fingerprint background check results for review.

In an interview on 06/04/2024 at 12:15 PM, Staff B, Licensed Practical Nurse/ Operations Support Specialist, stated the facility did not have a policy for background checks and followed the assisted living facility regulations.

In an interview on 05/31/2024 at 1:17 PM, Staff A, Executive Director, stated they were unaware of needing to complete a CCS for Staff D and Staff C's background check results. Staff A stated they were aware that Staff C and Staff D had finding results on their background checks.

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Bryan W. Bann
Administrator (or Representative)

07/18/2024
Date

RCW 18.20.125 Inspections -- Enforcement remedies -- Screening -- Limitations on unsupervised access to vulnerable adults.

(3) (3) To the extent funding is available, the licensee, administrator, and their staff should be screened through background checks in a uniform and timely manner to ensure that they do not have a criminal history that would disqualify them from working with

vulnerable adults. Employees may be provisionally hired pending the results of the background check if they have been given three positive references.

(b) Long-term care workers, as defined in RCW 74.39A.009, who are hired after January 1, 2012, are subject to background checks under RCW 74.39A.055.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to obtain three positive references for 1 of 4 sampled staff (Staff E) before having unsupervised access to residents. This failure placed all 50 residents at risk of being cared for by an unqualified staff member.

Findings included...

Record review of the facility's untitled and undated document with a list of employees, showed Staff E, Cook, was hired at the facility on 12/29/2023 and first day of employment was on 12/30/2023.

Record review on 05/31/2024 at 1:00 PM, of Staff E, "Confidential Reference Check Form", dated 12/29/2023, showed there was 1 of 3 completed reference checks available to review.

In an interview on 06/04/2024 at 9:44 AM, Staff B, Licensed Practical Nurse/Operations Support Specialist, said Staff F, Human Resources/Payroll, had been responsible to obtain three references for facility staff members employee files.

In an interview on 06/04/2024 at 12:14 PM, Staff B, stated Staff E did not have any other reference checks available for review.

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Byrne W Bawn
Administrator (or Representative)

07/18/2024
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;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 5 sampled Staff (Staff A, Staff E and Staff I) had completed their facility orientation training. These failures placed 50 of 50 residents at risk for staff not being trained on life saving measures and staff being unaware of the facility's expectations.

Findings included...

WAC 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-

562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor.”

Record review of the facility provided untitled, and undated document with a list of employees, showed Staff A, Executive Director, was hired at the facility on 03/01/2023 and first day of employment was on 03/13/2023.

Record review of Staff A’s document titled “orientation and procedures, employee emergency and fire life safety checklists”, dated 03/13/2023, showed it only included water, power, sprinkler, and gas shut-off, fire alarm pull boxes, fire panels, maintenance logs, fire drills, fire extinguishers, floor plans, disaster location, elevator shut down, emergency water, disaster crates, eye wash stations, missing residents and other fire safety systems was completed for review.

Record review on 05/31/2024 of Staff A’s employee file showed there was no facility orientation training with all required content completed for review.

Record review of the facility provided untitled, and undated document with a list of employees, showed Staff E, Cook, was hired at the facility on 12/29/2023 and first day of employment was on 12/30/2023.

Record review on 05/31/2024 of Staff E’s employee file, showed Staff E completed the document titled “orientation and procedures, employee emergency and fire life safety checklists”. There was no facility orientation training for Staff E competed that included all the required content for review.

Record review of the facility provided untitled and undated document with a list of employees, showed Staff I, Housekeeping, was hired at the facility on 02/28/2023 and first day of employment was on 03/01/2024.

Record review of Staff I’s employee file on 06/03/2024, showed there was no facility orientation and training in the file for review.

In an interview on 06/03/2024 at 8:31 PM, Staff I stated that they did not participate in a

facility orientation upon first day of employment.

In an interview on 05/31/2024 at 1:17 PM, Staff A, said the "orientation and procedures, employee emergency and fire life safety checklists" that was located in Staff A, Staff E, and Staff I's employee files were not the completed facility orientation. Staff A said the facility orientation should be 5 pages long.

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Bryce W Bower
Administrator (or Representative)

07/18/2024
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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 4 sampled Staff (Staff E) received their Tuberculosis (infectious bacterial disease of the lungs) test within three days of employment. This failure placed 50 of 50 residents at risk for exposure to Tuberculosis (TB).

Findings included...

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 the facility's policy titled, "TB Testing", undated, showed "all staff must have a baseline two-step skin test initiated within three days of being hired..."

In an interview on 05/31/2024 at 12:46 PM, Staff A, Executive Director, said that facility staff members date of hire and first day worked were not always the same day.

Record review of the facility's, untitled and undated document, showed, Staff E's, Dietary Aide, date of hire was on 03/04/2010.

Record review of the facility's, untitled and undated document, showed, Staff E's first day of working was on 04/01/2022.

Record review of Staff E's employee file showed Staff E had their first step to their TB test initiated on 01/15/2024 which indicated it was not completed within three days of their employment.

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<u>Bryce W. Bauer</u> Administrator (or Representative)	<u>07/18/2024</u> 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:

(ii) Resident living rooms and resident sleeping rooms; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a communication system available for 3 of 3 sampled residents (Resident 7 [R7], Resident 3 [R3], and Resident 9 [R9]) in their living area of their apartment to call for staff if they required assistance. This failure resulted in all three residents not having a means to summon on-duty staff and placed the residents at risk for a delay of care and assistance, and unmet care needs.

Findings included...

R7

Record review of R7's Face Sheet, dated 06/04/2024, showed R7 moved into the facility on [REDACTED] 2021 with multiple medical diagnoses that included [REDACTED].

Record review of R7's Service Agreement, dated 04/18/2024, showed R7 was able to use the call system independently when R7 required assistance from staff. R7 used oxygen to help with breathing.

In an observation and interview on 06/03/2024 at 1:49 PM, inside the living room area of R7's apartment near the residents reclining chair noted there was no communication system available for R7 to use if they required assistance and was unable to walk. The only pull cord that was available for use was beside the resident's bed that was more than 20 ft away from the residents reclining chair that R7 was observed to be sitting in and watching their television. R7 stated they would yell for help if they needed assistance and unable to get to the pull cord by their bed. When R7 had raised their voice, R7 was observed to get out of breath.

R3

Record review of R3's Face Sheet, dated 06/03/2024, showed R3 moved into the facility on [REDACTED] /2021 with multiple medical diagnosis that included [REDACTED] and [REDACTED].

Record review of R3's Service Agreement, dated 04/24/2024, showed R3 was educated on and understood how to use the call light system.

In an observation on 06/04/2024 at 1:10 PM, inside R3's bedroom there was no communication system available for R3 to use next to their bed or desk. The pull cord that was accessible to use was located on the left side of the wall upon entering R3's apartment that was on the opposite wall away from R3's bed and desk.

R9

Record review of R9's Face Sheet, dated 06/10/2024, showed R9 moved into the facility on [REDACTED] /2020 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R9's Service Agreement, dated 03/26/2024, showed R9 had no difficulties with communicating. R9 was able to be understood and was able to use the call

light system if they required assistance. R9 had memory loss that impacted their cognition. R9 was at a high risk for falls with a history of falls.

In an observation on 06/04/2024 at 4:04 PM, inside R9's room, showed there was no call light or communication system available for R9 to use by their bed. On the opposite wall from R9's foot of the bed in between two dressers that was halfway up the wall, was a call light pull cord that was not accessible from the residents sleeping area.

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Bryan W. Boun
Administrator (or Representative)

07/18/2024
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:

(3) Resident's written acknowledgment of receipt of:

- (a) Required disclosure information prior to moving into the assisted living facility; and
- (b) Information required by long-term care resident rights per RCW 70.129.030 .

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure written acknowledgment of the facility disclosure of services was received and signed for 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7). This failure resulted in 50 of 50 residents and their resident representative's being uneducated about their rights and responsibilities while living at the facility.

Findings included...

"RCW 70.129.030 (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The

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notification must be made prior to or upon admission. Receipt of the information must be acknowledged in writing."

On 05/31/2024 at 12:00 PM, an on-site review of the facility's resident records showed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7 did not have a written acknowledgment of the facility's disclosure of services.

In an interview on 05/31/2024 at 12:46 PM, Staff A, Executive Director said they would follow up with what the facility's disclosure of services policy was.

In an interview on 06/04/2024 at 1:04 PM, Staff H, Regional Operations Support Specialist, said the facility provided residents a copy of the disclosure of services agreement but did not obtain a written acknowledgement for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7.

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Brynn W. Bann
Administrator (or Representative)

07/18/2024
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 ensure residents were provided a Medicaid Policy for 7 of 7 sampled Residents (Resident 1, Resident 2, Resident 3, Resident 4, 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...

WAC 388-78A-2665 "The assisted living facility must fully disclose the facility's policy on

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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 05/31/2024 at 12:00 PM, an on-site review of the facility's resident record showed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7 did not have a Medicaid policy in their records to review.

In an interview on 05/31/2024 at 12:46 PM, Staff A, Executive Director said they would follow up with what the facility's Medicaid policy was.

In an interview on 06/04/2024 at 1:04 PM, Staff H, Regional Operations Support Specialist, said the facility's Medicaid policy was included in a packet of information that residents and their representatives signed at the end of the document. Staff H said they did not have a separate Medicaid Policy Document on a free-standing page with 14-inch font that had been signed for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7 to review.

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Bryce Bowen
Administrator (or Representative)

07/18/2024
Date