



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

Greenlake Management Ocean Shores, LLC
Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

RE: Ocean Shores Assisted Living License # 2615

Dear Administrator:

This letter addresses Compliance Determination(s) 39957 (Completion Date 04/17/2024) and 36837 (Completion Date 03/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/17/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

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

WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-d, WAC 388-78A-2140-2, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-3, WAC 388-78A-2140-4, WAC 388-78A-2140-5, WAC 388-78A-2450-1-a, WAC 388-78A-2450-2-b, WAC 388-78A-2450-2-h-iv, WAC 388-78A-2450-2-h-vi, WAC 388-78A-2450-2-i-i, WAC 388-78A-2450-2-j, WAC 388-78A-2320-1-b, WAC 388-78A-2320-3-c

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

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



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 #: 2615	Compliance Determination #36837
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 11	Licensee: Greenlake Management Ocean Shores, LLC	03/05/2024

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 02/13/2024 and 03/05/2024 of:

Ocean Shores Assisted Living
 1020 Catala Avenue SE
 Ocean Shores, WA 98569

This document references the following SOD dated: 03/05/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 49 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
 Paul Aube, ALF NCI
 Melissa Brunton, Regulatory QA Program Manager - Community Programs

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

03/18/2024

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.

Statement of Deficiencies	License # 2615	Compliance Determination # 36837
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 2 of 11	Licensed: Greenlake Management Ocean Shores, LLC	03/05/2024

Debbie Smathers
Administrator (or Representative)

3/21/24
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:

- (i) 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 full assessments;
 - (ii) On-going assessments of the resident;
 - (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;
- (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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure necessary information was documented in residents needs and services plans (facility's version of the negotiated services agreement) for 2 of 3 sampled residents (Resident 2 [R2] and Resident 3 [R3]). This failure resulted in staff not having information to meet resident needs and

Administrator (or Representative)

Date

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- (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:
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
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- (5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure necessary information was documented in residents needs and services plans (facility's version of the negotiated services agreement) for 2 of 3 sampled residents (Resident 2 [R2] and Resident 3 [R3]). This failure resulted in staff not having information to meet resident needs and

placed the residents at risk for unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed "Negotiated Service Agreement will be updated as frequently as necessary to ensure they reflect current residents care needs and preferences. Individualized Negotiated Service Agreements are used to plan for and meet residents needs using an interdisciplinary approach." Under the section titled, "Service Agreement Planning", showed the assisted living must integrate the assessment information provided by the Departments case manager for each resident whose care was partially or wholly funded by the department or the health care authority, identified the residents, and provide direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

R2

Record review of R2's, Face Sheet, showed R2 moved into the facility on [REDACTED]/2024, with multiple medical diagnoses that included [REDACTED]

[REDACTED], and [REDACTED]

Record review of R2's, Washington Resident Assessment, dated 01/30/2024, showed staff were to assist R2 with their medication administration as R2 could not follow frequency or dosage. R2 had confusion at times related to their depression and anxiety. R2 often forgot names and numbers. R2 had an ulcer (an open wound or sore that does not heal or continued to return) on their left big toe. R2 wore glasses for reading. R2 liked to sleep late. R2 ate a diabetic diet and was able to leave the facility unassisted.

Record review of R2's, Needs and Service Plan, dated 01/29/2024, showed R2 required total assistance for the medication administration by the medication technician. It did not indicate that R2 required nurse delegation for what specific medication or injections that R2 took. R2 had COPD (chronic obstructive pulmonary disease [a lung disease that blocks the airflow that makes it difficult to breathe). There was nothing documented under goals, interventions, expected outcome, or any other information that could assist the caregivers. R2 had a wound. The section about the wound did not indicate where it was as or what kind of wound. There were no interventions or directions documented for the caregivers to review and implement. There was no documentation that R2 had neuropathy and could contribute to their ulcer from progressing as R2 had decreased feeling in their foot and toe. There was nothing on R2's service plan that showed R2 wore glasses or had confusion at times related to their anxiety and depression. R2's needs and service plan did not have any information that R2 had depression. There was no documentation that R2 required a diabetic diet and R2 liked to sleep in late.

R3

Record review of R3's Face Sheet, showed R3 moved into the facility on [REDACTED]/2020 with multiple medical diagnoses that included [REDACTED].

Record review of R3's Washington Resident Assessment, dated 01/07/2024, showed R3

had [REDACTED]

[REDACTED], and [REDACTED]

R3 required the nurse at the facility to assist in monitoring R3 for any shortness of breath. R3 required use of oxygen, 3 liters per minute, per nasal canula. R3's was to be monitored for any decrease in their oxygen saturations. R3 had a pacemaker (a small device used to treat fast or slow heart rate). R3 had some difficulty with remembering recent events.

Record review of R3's Needs and Services Plan, dated 10/06/2023, showed R3 was not complaint with wearing their oxygen. There was nothing else documented in the service plan that showed how much oxygen R3 required, how often R3 was required to wear the oxygen, and what things the caregivers were to watch for related to R3's breathing. There was nothing documented about R3 having sleep apnea or guidance to the caregivers about R3's sleep apnea. There was nothing in the service plan that indicated R3 used a BIPAP (a bilevel positive airway pressure [a machine that helps you breath when you have sleep apnea]) or required nebulizer treatments (a small machine that creates a mist out of liquid medications, for quicker absorption of medication into the lungs). There was nothing in his service plan about R3 requiring home health services or that he had an implanted pacemaker for R3's heart as R3 had a rapid heart rate. R3 understood others and could communicate desires. There was nothing documented that R3 had some difficulty with remembering current events and required redirection.

In an interview and observation on 02/13/2024 at 10:18 AM, R3 was sitting in their reclining chair with their four wheeled walker beside the reclining chair and their oxygen tubing lying on the seat of their walker. Beside R3's bed was a black BIPAP machine and a nebulizer machine. R3 stated they wore their BIPAP machine at night. R3 stated the medication technicians bring R3's medications to them. R3 stated they did not have any therapy services or home health services.

In an interview and observation on 02/13/2024 at 10:45 AM, Staff B, Registered Nurse/Health Services Director, was talking to a visitor. Staff B stated the visitor was a home health nurse there at the facility to see R3. Staff B stated R3 was currently on home health services for nursing and therapy services related to a recent hospitalization. R3 had gotten weaker and required additional home health services to get their strength back. Staff B told the home health nurse about R3 not wearing their oxygen and needed frequent reminders from all staff interactions for R3 to put their oxygen back on. Staff B stated R3 did forget and needed to be reminded that they received home health services.

In an interview on 02/13/2024 at 11:43 AM, Staff D, Medication Technician, stated they reorder all of R3's medication and administer them. Staff D stated R3 has used a walker and oxygen for a few years now.

In an interview on 02/13/2024 at 12:09 PM, Staff B stated R3's assessment was completed on 01/07/2024. Staff B stated the needs and services plan was to be updated after an assessment was completed for a resident. Staff B stated all the information on the assessment would be documented on the needs and services plan for the caregivers to review.

This is an uncorrected and recurring deficiency previously cited on 11/13/2023, 08/22/2023 and 04/26/2023.

Statement of Deficiencies	License # 2615	Compliance Determination # 36837
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 5 of 11	Licenses: Greenlake Management Ocean Shores, LLC	03/05/2024

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/29/24.

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

Debbie Smathers
Administrator (or Representative)

3/21/24
Date

WAC 388-78A-2450 Staff.

- (1) Each assisted living facility must provide sufficient, trained staff persons to:
 - (a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;
- (2) The assisted living facility must:
 - (b) Verify staff persons' work references prior to hiring;
 - (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;
 - (vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and
 - (i) Develop and implement a process to ensure caregivers:
 - (i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;
 - (j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all employees had updated records on how to provide the care and services for 5 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], and Resident 5 [R5]) based on their Needs and Services Plans (facility's version of the Negotiated Service Agreements). This failure resulted in staff not having current and accurate directions for providing care and services, and placed all 5 residents at risk of unmet care needs and decreased quality of life.

Plan/Attestation Statement

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Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed "Negotiated Service Agreement will be updated as frequently as necessary to ensure they reflect current residents care needs and preferences. Individualized Negotiated Service Agreements are used to plan for and meet residents needs using an interdisciplinary approach... A copy of the Negotiated Service Agreement is kept in the residents' records. A copy of each resident's Negotiated Service Agreement should also be kept in a Negotiated Service Agreement binder that is readily available to care staff."

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R1 moved into the facility on [REDACTED]/2024, R2 moved into the facility on [REDACTED]/2024, R4 moved into the facility on [REDACTED]/2024, and R5 moved into the facility on [REDACTED]/2024.

In an interview on 02/13/2024 at 10:03 AM, R4 stated they had lived at the facility for the last three weeks.

In an interview on 02/13/2024 at 10:29 AM, R5 stated they had lived at the facility for the last three weeks with their spouse R2. R5 stated R2 required assistance from staff with their wound on R2's big toe and their diabetic (bodies inability to lower high blood sugar levels and maintain in normal range) medications. R5 stated they smoked and checked their own blood sugar levels. R5 stated R4 completed their laundry independently on the weekends.

In an interview on 02/13/2024 at 11:32 AM, Staff D, Medication Technician, stated they administered insulin injections to R1 and R2. Staff D stated they also checked R2's blood sugar daily.

In an observation and interview on 02/13/2024 at 12 PM, Staff C, Business Office Manager, entered the employee break room and grabbed the resident care binders. Staff C stated the resident care binders had all the residents needs and services plans filed for caregivers to review what care and services each resident required.

Record review on 02/13/2024 at 12:05 PM, of the resident care binder showed there were no needs and services plan for R1, R2, R4, and R5 for review. The needs and services plan for R3 in the binder was dated 10/01/2023 that was not the most updated version for caregivers to review.

In an interview and observation on 02/13/2024 at 12:09 PM, Staff B, Registered Nurse/Health Services Director, stated R3's needs and services plan would have been updated on 01/07/2024 when R3's assessment was completed. Staff B was observed to look through the resident care binder for R1, R2, R3, R4, and R5's needs and services plans. Staff B stated R1, R2, R4, and R5's needs and services plans were not in the binder for review. Staff B stated R3's updated needs and services plan was not in the binder for review. Staff B stated all residents updated needs and services plans were to be in the binder for the caregivers to review and know what care and services were needed to be provided by the caregivers.

This is an uncorrected and recurring deficiency previously cited on 11/13/2023 and

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08/22/2023 for 368-78A-2450 (2)(h)(vi)(2i)(2j).

Plan/Attestation Statement

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

Debbie Smathers
Administrator (or Representative)

3/21/24
Date

WAC 368-78A-2320 Intermittent nursing services systems.

- (1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:
- (b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.
- (3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:
- (c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to have Registered Nurse (RN) delegation documentation in place for 2 of 3 sampled residents (Resident 1 [R1], and Resident 2 [R2]). This failure resulted in residents receiving medications from staff without required training, instructions, and oversight, and placed all residents receiving RN delegated services at risk for medication errors and unmet care needs due to receiving care and services by untrained staff.

Findings included...

Washington Administrative Code (WAC) 246-840-930- "Criteria for delegation- (1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE, ASSESS (3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition. (4) Determine the task to be delegated is within the delegating nurse's area of responsibility. (5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient. (6) Analyze the complexity of the nursing task and determine the required training or

08/22/2023 for 388-78A-2450 (2)(h)(vi)(2i)(2j).

Plan/Attestation Statement

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additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. (7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction. (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care. (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. PLAN (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent. (13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient. IMPLEMENT (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care. (17) The

registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Record review of the facility's policy, Nurse Delegation, dated 08/10/2021, showed RN transferred the performance of selected nursing tasks to competent unlicensed staff in selected situations, in accordance with state regulations. When delegation insulin injections, the RN delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections. If the RN determines that individual was competent to perform the injection properly and safely, supervision and evaluation shall occur at least every 90 days and thereafter. Before an RN delegated a nursing task the RN would decide what task needed to be delegated and the resident was stable and predictable and the task was within the delegating nurse's area of responsibility. Before delegation was started written consent must be obtained from the resident, or the authorized resident representative. Written consent was only necessary at the initial use of the nurse delegation process for each resident. The RN would document in the resident's records the rationale for delegating or not delegating nursing tasks. Specific written delegating tasks to the qualified medication technicians would be maintained in the residents record that included the rationale for delegating nursing task, nursing task specific to medication technician and one resident, nature of the condition requiring treatment and purpose of the delegated nursing task, clear description of the procedure or steps to follow to perform the tasks, predictable outcome of the nursing task, risks of the treatment, what side effects to observe and when to report and to who, what to do if the nursing task was altered or changed by the physician, how to document the nursing task, and documentation that teaching and return demonstration was done. RN shall supervise the medication technicians every 90 days with delegated insulin injections and at least weekly for the first four weeks. The RN was accountable and responsible for the delegated nursing task. The RN delegator monitors the performance of the tasks to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task.

Record review of the facility's Assisted Living Facility and Resident Characteristic Roster and Sample Selection, undated, showed R1 and R2 were documented to have RN delegation services.

Record review on 02/14/2024 at 11:50 AM, of the RN delegation binder showed there were no RN delegation consent form, nursing task form for insulin administration, and nursing visit forms for review for R1. There was no RN delegation consent form, nursing task form for blood sugar check or insulin administration, and nursing visit forms for review for R1.

R1

Record review of R1's, Face Sheet, showed R1 moved into the facility on [REDACTED]/2024, with multiple medical diagnoses that included [REDACTED].

Record review of R1's, Resident Care Plan, undated, under medication administration showed there was nothing documented if R1 required assistance or nurse delegation tasks.

Record review on 02/14/2024 at 1:35 PM, of R1's hard medical chart showed there were no nurse delegation consent form or delegation documents for review.

Record review of R1's, Medication Administration Record (MAR), dated 02/01/2024 through 02/14/2024, showed R1 had an order for Byetta injection (prescribed injected medication to help treat high blood sugar levels), to be injected two times daily. Review of the MAR showed every administration was completed by a medication technician.

R2

Record review of R2's, Face Sheet, showed R2 moved into the facility on [REDACTED]/2024, with multiple medical diagnoses that included [REDACTED].

Record review of R2's, Washington Resident Assessment, dated 01/30/2024, showed staff were to assist R2 with their medication administration as R2 could not follow frequency or dosage. R2 has confusion at times.

Record review of R2's, Needs and Service Plan, dated 01/29/2024, showed R2 required total assistance for the medication administration by the medication technician.

Record review of R2's, Physician Communication, dated 01/31/2024, showed R2 had an order for Basaglar (long-acting insulin that helps reduce high blood sugar levels and maintain) inject 30 units two times daily.

Record review of R2's, MAR, dated 01/01/2024 through 01/31/2024, showed R2 had an order for Basaglar inject 20 units two times daily. The MAR showed they were administered by medication technicians. There was no order for R2's blood sugar to be checked.

Record review of R2's, MAR, dated 02/01/2024 through 02/13/2024, showed R2's Basaglar 20 units injection was administered by all medication technicians. R2's prescribed medication Humalog insulin (short acting insulin injection that helps lower high blood sugar level quickly) inject 6 units three times daily before meals. Review of R2's Humalog insulin administrations showed all doses were administered by medication technicians. There was no order that showed R2's blood sugar needed to be checked.

In an interview on 02/13/2024 at 11:32 AM, Staff D, Medication Technician, stated they administered R1's insulin injection. Staff D stated they had administered R2's insulin injection and checked R1's blood sugar level.

In an interview on 02/13/2024 at 11:34 AM, Staff B, Registered Nurse/Health Services Director, stated R1 and R2 were nurse delegated for their insulin administration and blood sugar checks. Staff B stated their nurse delegation visit forms, task forms, and delegation

Statement of Deficiencies	License # 2615	Compliance Determination # 36837
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page of 11	Licenses: Greenlake Management Ocean Shores, LLC	03/05/2024

consents were filed in the RN delegation binder for review.

In an interview and observation on 02/13/2024 at 12:54 PM, Staff B, looked through the RN delegation binder for R1 and R2's delegation forms. Staff B stated R1 was new and that there were no nurse delegation forms filed in the nurse delegation binder. Staff B stated they did not have any nurse delegation forms or consents for R2 in the RN delegation binder for review. Staff B stated if the medication technicians were documented for administration for any of the resident's medication on the MAR, then that indicated the medication technician was the one that administered the medication. Staff B stated the facility started administering R1's insulin on 02/03/2024 as R1 was forgetting to administer their injection. Staff B stated all nurse delegation consents, delegation nursing tasks, and nurse visit were to be completed right after the resident moved into the facility and filed in the delegation binder for review.

In an interview on 02/13/2024 at 2:25 PM, Staff C, Business Office Manager, stated Staff B had not observed them administer R2's insulin.

This is an uncorrected and recurring deficiency previously cited on 11/13/2023 and 08/22/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/29/24.

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

Debbie Smethers
Administrator (or Representative)

3/21/24
Date

consents were filed in the RN delegation binder for review.

In an interview and observation on 02/13/2024 at 12:54 PM, Staff B, looked through the RN delegation binder for R1 and R2's delegation forms. Staff B stated R1 was new and that there were no nurse delegation forms filed in the nurse delegation binder. Staff B stated they did not have any nurse delegation forms or consents for R2 in the RN delegation binder for review. Staff B stated if the medication technicians were documented for administration for any of the resident's medication on the MAR, then that indicated the medication technician was the one that administered the medication. Staff B stated the facility started administering R1's insulin on 02/03/2024 as R1 was forgetting to administer their injection. Staff B stated all nurse delegation consents, delegation nursing tasks, and nurse visit were to be completed right after the resident moved into the facility and filed in the delegation binder for review.

In an interview on 02/13/2024 at 2:25 PM, Staff C, Business Office Manager, stated Staff B had not observed them administer R2's insulin.

This is an uncorrected and recurring deficiency previously cited on 11/13/2023 and 08/22/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date



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

Statement of Deficiencies	License #: 2615	Compliance Determination # 31235
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 24	Licensee: Greenlake Management Ocean Shores, LLC	11/13/2023

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

The department completed data collection for an unannounced on-site follow-up on 10/17/2023 and 10/20/2023 of:

Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

This document references the following SOD dated: 11/13/2023

The following sample was selected for review during the unannounced on-site visit: 6 of 49 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Melissa Brunton, Regulatory QA Program Manager - Community Programs
Paul Aube, ALF NCI

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.

Residential Care Services

Date

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

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

Administrator (or Representative)

Date

WAC 388-78A-2610 Infection control.

- (1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
- (2) The assisted living facility must:
- (a) Develop and implement a system to identify and manage infections;
 - (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;
 - (f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide necessary handwashing supplies for staff and residents for 1 of 1 areas (laundry room). This failure placed all 47 of 47 residents and 28 staff members, and all visitors at risk for the spread of infectious disease.

Findings included...

Record review of the Center of Disease Control and Prevention Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

Record review of the facility's policy, Hand hygiene, dated 12/15/2021, showed hand hygiene was a critical step in infection control. Hand hygiene would be used to aid in the prevention and spread/transmission of infections. Under the section, "Procedures", showed staff must wash their hands before and after putting on disposable gloves, before food preparation and after handling meat, before and after handling food or eating, after removal of any Personal Protective Equipment, and after contact with contaminated materials. The use of gloves did not replace handwashing or the use of alcohol-based hand sanitizer.

Record review of the facility's plan of correction, dated 08/22/2023, showed the laundry room sink would be installed to ensure it was available for staff and resident to use. The soiled laundry "in" door would be unlocked to allow staff and residents to enter the correct

door and leave the laundry room out the clean side of the room to maintain infection control. The changes were to be completed by 10/06/2023.

Record review of the facility's staff trainings, dated 07/26/2023, 07/27/2023, 07/28/2023, and 08/01/2023, showed staff were educated about handwashing techniques. Attached to the training was an untitled and undated document that showed the steps to wash your hands that included to rinse their hands, apply soap, scrub hands in different areas of the hand for a total of 20 seconds, rinse with water, and dry hands.

In an observation and interview on 10/17/2023 at 1:57 PM, inside the soiled "in" laundry room door to the left was a sink. There was no observed soap dispenser by the hand washing sink. There was a paper towel dispenser with paper towels inside with a dispenser next to it that was missing the top. The dispenser did not have any soap or hand sanitizer inside. The dispenser did not express any soap or hand sanitizer for use. Staff G, Concierge, stated they weren't sure where the soap was to use in the laundry room. Staff G stated there was no soap or hand sanitizer available for use in the laundry room.

In an interview on 10/17/2023 at 2:01 PM, when asked where the soap was in the laundry room to wash their hands, Staff H, Housekeeping, stated "you cannot wash your hands there is no soap".

In an observation and interview on 10/17/2023 at 2:02 PM, Staff K, Caregiver, walked into the soiled "in" laundry room door. Staff K wore blue disposable gloves on each hand and held a bag in each hand, that were tied up with unidentified articles inside, when they walked into the laundry room. At 2:03 PM, Staff K walked out of the soiled "in" laundry room door with bare hands. Staff K stated they carried one bag of dirty linen and one bag of trash to dispose inside the laundry room. Staff K stated they washed their hands after they removed their blue disposable gloves. Staff K showed the sink just inside the soiled "in" laundry room to the left. Staff K stated that was the sink that they used to wash their hands. Staff K was asked what soap they used to wash their hands with, Staff K stated, "there is no soap and needed to go get some". Staff K stated they did not have or use any hand sanitizer after they removed their blue disposable gloves and discarding the soiled trash and dirty linen bags. Staff K stated they were to exit out of the clean side of the laundry room.

In an interview on 10/25/2023 at 9:58 AM, Staff L, Business Office Manager, stated the new sink in the laundry room was purchased on 10/14/2023. Staff L stated the sink was installed the same day it was purchased.

This is an uncorrected deficiency previously cited on 08/22/2023 and recurring deficiency previously cited on 01/23/2023 and 11/22/2022 for 388-78A-2610 (1)(2)(a)(c)(d).

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

_____ Administrator (or Representative)	_____ Date
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WAC 388-78A-2590 Management agreements General.

- (1) If the proposed or current licensee uses a manager, the licensee must have a written management agreement that is consistent with this chapter.
- (2) The proposed or current licensee must notify the department of its use of a manager upon:
 - (a) Initial application for a license;
 - (b) Retention of a manager following initial application;
 - (c) Change of managers; and
 - (d) Modification of existing management agreement.
- (3) The proposed or current licensee must provide to the department a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations.
- (4) The written management agreement must be submitted:
 - (a) Sixty days before:
 - (i) The initial licensure date;
 - (ii) The proposed change of ownership date; or
 - (iii) The effective date of the management agreement; or
 - (b) Thirty days before the effective date of any amendment to an existing management agreement.
- (5) The proposed licensee or the current licensee must notify the resident and their representatives sixty days before entering into a new management agreement.
- (6) A proposed licensee must submit a management agreement attestation form, as required by the assisted living facility application.

This requirement was not met as evidenced by:

Based on interview and record review, the licensee failed to notify the Department of Social and Health Services of a change in Management company for 1 of 1 facility reviewed. This failure placed 47 of 47 residents and 28 staff members at risk of being uninformed of who was responsible for managing the facility.

Findings included...

Record review of the facility's plan of correction, dated 08/22/2023, showed the facility

would send in the change of management form to the department that was to be completed by 10/06/2023.

Record review on 10/17/2023 of the Department of Social and Health Services (DSHS) database showed the management company was last updated on 05/11/2022. The database showed Greenlake Senior Living, LLC had been the management company since 11/18/2021.

Record review of an email from the DSHS Business Operations and Analysis Unit (BOA), dated 10/02/2023 at 1:00 PM, showed the facility had submitted the forms, but there were still some documents that were pending to be submitted.

Record review of an email from the DSHS BOA department, dated 10/16/2023 at 10:08 AM, showed the department was waiting for the agreement packet to be sent to them from the facility's management paralegal.

Record review of an email from the DSHS BOA department, dated 10/19/2023 at 8:56 AM, showed the department had not received the agreement packet. The department had contacted another paralegal to get the document.

Record review on 10/25/2023 of the Department of Social and Health Services (DSHS) database showed the management company was last updated on 05/11/2022. The database showed Greenlake Senior Living, LLC was still the current management company.

In an interview on 10/19/2023 at 2:11 PM, Staff D, Senior Executive Director, stated they were not aware that all the required documentation were not sent into the BOA department.

This is an uncorrected deficiency previously cited on 08/22/2023 for 388-78A-2590 (6).

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-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

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

resident's health and safety that were identified in one or more of the following:

- (ii) The resident's full assessments;
- (iii) On-going assessments of the resident;
- (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;
- (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;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure necessary information was documented in residents needs and services plans (facility's version of the negotiated services agreement) for 3 of 4 sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure placed the residents at risk for unmet care needs.

Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed "The Negotiated Service Agreement is to include services as applicable for all areas addressed on the Resident Assessment and is to be individualized based on the resident's needs and preferences."

R1

Record review of R1's face sheet showed R1 moved into the facility on [REDACTED]/2025.

Record review of R1's Washington (WA) Resident Assessment, dated 10/17/2023, showed R1 had multiple medical diagnoses that included [REDACTED]

[REDACTED]. R1 had a history of holding their medications in their mouth and required staff assistance with R1's medication administration. R1 required the use of personal eyeglasses. R1 was non-verbal at times and "resident is rarely/never understood..." Staff were to interpret R1's body language and anticipate R1's needs. R1 had a history of eating sugar packs and would require staff to monitor R1 closely for redirection. R1 was unable to leave the community unassisted. R1 was known to exit seek and required staff to monitor R1 closely. R1 had a developmental disability (longer term mental and/or physical impairment). R1 required care staff to be monitor and implement interventions related to their behaviors.

Record review of R1's Needs and Service Plan (facilities version of negotiated service agreement), dated 10/04/2023, showed R1 required one person assistance with all grooming, toileting, bathing, and dressing needs. R1 was noted to be a high elopement (attempts to leave the facility) risk and had been found to leave the facility property. There were no interventions to direct the staff to help prevent or reduce the risk of R1 eloping or exit seeking. R1 required medication technician's total assistance with all their medication needs. There was no documentation that R1 required nurse delegated services for all their oral medications. R1 was identified to have had falls. There were no interventions to direct the care staff how to reduce or prevent R1's risk from having any further falls. The needs and service plan did not indicate R1 used eyeglasses, R1 could be non-verbal, and that care staff were to anticipate R1's needs by their body language. The needs and service plan did not have any interventions to direct the care staff for R1's history of falling and eating sugar packets.

R2

Record review of R2's face sheet showed R2 moved into the facility on [REDACTED]/2023.

Record review of R2's WA Resident Assessment, dated 10/01/2023, completed by Staff B, Resident Care Director/Registered Nurse, showed R2 had multiple medical diagnoses that included [REDACTED]

and [REDACTED]

R2 required medication technicians to administer their medications. R2 had some memory impairment. R2 required one-person total assistance with their bathing, dressing, toileting, and transfers. R2 was independent with walking, grooming, and their meals. The assessment did not show that R2 was at risk or had a history of any falls.

Record review of R2's Needs and Service Plan, dated 10/05/2023, showed R2 was able to independently groom, bathe, dress, toilet, and transfer themselves. R2 had a history of falls, but there were no interventions to direct care staff how to prevent or minimize R2's risk for reoccurring falls. R2 was to be monitored for signs of low or high blood sugars.

In an observation and interview on 10/18/2023 at 10 AM, R2 had walked to their apartment door to unlock the door. R2 was observed to walk with a four wheeled walker independently. R2 stated they were independent with all their dressing, grooming, bathing, transfers, and walking needs. R2 stated they only required assistance with their pneumatic compression device (an inflatable garment that improves the blood flow and movement of fluids in an arm or leg) for their legs. R2 stated they did not have diabetes type 2. R2 stated they had a fall in the last four months and required the staff to assist them up from the ground.

Record review on 10/19/2023 of R2's medical chart showed there was no documentation from R2's physician that showed they were diagnosed with diabetes type 2.

In an interview on 10/19/2023 at 1:01 PM, Staff C, Resident Care Coordinator, stated R2 did not have diabetes type 2.

R3

Record review of R3's face sheet showed R3 moved into the facility on [REDACTED]/2020.

Record review of R3's WA Resident Assessment, dated 10/01/2023, showed R3 had multiple medical diagnoses that included [REDACTED]

[REDACTED] and [REDACTED]. R3 required their food to be chopped. R3 required oxygen, had fall concerns, and required coordination with outside agency. R3 required staff's total assistance with ambulation with escorts in R3's wheelchair, one person assistance with grooming, bathing, toileting, and dressing.

In an observation and interview on 10/19/2023 at 2:39 PM, R3 stated they were on hospice services. R3's oxygen was lying on the bed. R3 was lying on an electric bed with an air-filled mattress. R3 didn't have any teeth in and would take multiple shallow breaths when they talked. R3 stated hospice provided them with their showers twice a week.

Record review of R3's Needs and Services Plan, dated 10/02/2023, showed R3 had a history of falls. There were no interventions to direct the care staff how to reduce or prevent R3's risk from having any further falls. R3 required a modified diet. There was no specific guidance or direction to the care staff for details of the modified diet. Under the section special care needs showed R3 had oxygen and outside agency. The needs and services plan showed R3 was on home health services and hospice services. There was no name of the home health or hospice provider for the care staff to contact regarding R3 if needed. There was no further details or direction for the care staff about R3's oxygen use.

In an interview on 10/19/2023 at 12:52 PM, Staff B, Resident Care Director/Registered Nurse, stated R3 was on hospice services for the last few months. Staff B stated the hospice provider was documented on R3's needs and services plan. Staff C stated there was a form with the hospice providers name, contact information, and details when to call by the medication carts.

In an observation and interview on 10/19/2023 at 1:04 PM, Staff E, Medication Technician, was observed to be opening cabinet doors near the medication carts. Staff E stated they were not aware that R3 was on hospice services. Staff E stated they did not know what hospice provider was or where the form that Staff C was referring to.

In an interview on 10/19/2023 at 11:50 AM, Staff B stated they completed the WA resident assessments and then updated the residents needs and services plan with the assistance from Staff C based upon the resident's assessment needs.

This is an uncorrected deficiency previously cited on 08/22/2023 and a recurring deficiency previously cited on 04/26/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

(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;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(i) Develop and implement a process to ensure caregivers:

(i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;

(j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all staff were trained on how to report allegations of abuse and neglect as a mandated reporter for 2 of 4 sampled Staff (Staff B, and Staff E). This failure placed all 47 of 47 residents at risk of staff not identifying and reporting potential abuse and neglect to protect the residents.

Findings included...

RCW 74.34.020 Definitions: "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare,

mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

Record review of the facility's policy, titled, "Elder Abuse, Neglect, and Exploitation", dated 12/15/2021, showed resident abuse, neglect, and exploitation were prohibited. Should any resident experience abuse by staff, residents, family, or others or when any form of abuse was suspected, staff and volunteers were required to immediately provide notification to persons/agencies as described in this policy. All resident care assistants would receive in-service training on elder abuse definitions and descriptions (term abuse as used in this policy also includes, but not is not limited to, neglect, abandonment, and financial exploitation), signs and symptoms of abuse, and reporting requirements during initial orientation. The training would be repeated annually.

Record review of the facility's document titled, "Mandatory Reporting", dated 07/2023, showed as an employee of the community, they were required to report concerns of possible resident abuse, neglect, or exploitation. There were different kinds of abuse that a staff member must be aware that included physical abuse, sexual abuse, mental abuse, neglect, financial exploitation and abandonment.

Record review of the facility's sign in sheet, dated 08/01/2023, showed the topic reviewed was neglect and abuse. Staff B, Resident Care Coordinator/Registered Nurse, presented the topic. The document showed the item's discussed included what neglect and abuse meant, definitions of all the different types of abuse and all types of abuse must be reported to the hotline number. The document showed there were 14 staff members that had attended the presentation.

Record review of the "Assisted Living Facility Guidebook, Partners in Protection", dated February 2018, under the section, "when to make a report", showed when an individual mandated reporter had reason to suspect sexual or physical assault had occurred, they must report immediately as soon as the resident victim was protected from further harm. An individual was to report when there was reasonable cause to believe abandonment, abuse, neglect, or financial exploitation had occurred, the report would be made immediately.

Record review of the facility's plan of correction, dated 08/22/2023, showed the facility in-serviced all staff on mandatory reporting to include allegations of abuse and neglect. Staff were trained how to report, who to report to, and when to report as a mandatory reporter. Staff were to be educated about mandatory reporting by 10/06/2023.

In an interview on 10/19/2023 at 11:28 AM, Staff E, Medication Technician, stated they did not know where the reporting hotline number was located. Staff E stated if a resident reported they had an item stolen they would look for the item and then report to Staff B. Staff E stated they were unsure if stolen items would be a reportable incident. Staff E stated the resident would need to report the incident themselves.

In an interview on 10/19/2023 at 12:20 PM, Staff B, Resident Care Coordinator/Registered Nurse, stated anyone can call and report to the hotline number for any abuse and neglect. Staff B stated the resident assistants (facility caregivers) were to report to the medication technician if they identified any abuse or neglect not to the hotline number.

In an interview on 10/19/2023 at 2:11 PM, Staff D, Senior Executive Director, stated all

staff were educated about abuse and neglect and all new employees were trained on their first day of employment.

This is an uncorrected deficiency previously cited on 08/22/2023 for 388-78A-2450 (1)(2)(iv).

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
_____ Administrator (or Representative)	_____ Date

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

- (1) Notify construction review services:
 - (a) In writing;
 - (b) Thirty days or more before the intended change in use;
 - (c) Describe the current and proposed use of the room; and
 - (d) Provide all additional documentation as requested by construction review services;
- (2) Obtain the written approval of construction review services for the new use of the room; and
- (3) Ensure the facility functional program and room list are updated to reflect the change.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to submit a request to Construction Review Services for a capacity increase for 2 of 2 residents (Resident 4 and Resident 5) request to reside with each other in a room approved for one capacity. This failure places these residents at risk of residing in a room not adequate per regulations for two people and a decreased quality of life.

Findings included...

Record review of the facility's plan of correction, dated 08/22/2023, showed the facility gave all residents their own room. The executive director would ensure all rooms had approved capacity completed by 10/06/2023.

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

Record review of the Washington State Construction Review Services website on 10/31/2023, showed there were no new submissions for a capacity increase for any rooms.

Review of the Departments of Social and Health Services database on 10/31/2023, showed the facility on 08/01/2023 request for capacity increase was placed on hold due to the facility being out of compliance. The database showed on 08/08/2023, the facility requested to cancel the bed increase.

Record review of R4's face sheet showed R4 moved into the facility on [REDACTED]/2017 with multiple medical diagnoses that included [REDACTED]

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R4 resided in room [REDACTED] with a move in date of [REDACTED]/2022.

Record review of R4's "Residence and Care Agreement", dated 08/16/2023, under section "living accommodations" showed R4 chose to live in apartment room [REDACTED] at the facility.

Record review of R4's charting notes, dated 08/19/2023 through 10/19/2023, showed there was no documentation that showed R4 had moved to a new room, refused to move to a new room, or anything about a new room for review.

In an observation and interview on 10/18/2023 at 3:01 PM, R5 and R4 resident in room [REDACTED] together. R5 stated they were never asked to move out of the room. R5 stated that they were told they needed to have a female resident or R4 move in and share R5's room with them about three months ago. R5 stated they were not married to R4, but partners. R5 stated R4 and R5 slept in the same bed.

In an observation on 10/18/2023 at 3:11 PM, R4's new apartment (Room [REDACTED]) showed there was Resident 6's name on the door plaque. Upon entering the room, the air was cold and the room was dark. There were no lights on. There was a television on the ground in the far wall left corner that sat on the ground with the cords and plugs sitting on top of the screen. There was a cloth reclining chair in front of the window of the apartment that had multiple black electrical cords sitting in the seat part preventing anyone to be able to sit in the chair. There was a bed that was set up in the middle of the far-right wall of the room. The mattress was yellow without any bedlinens, pillows, and unmade. There was a blue blanket that laid on top of the yellow mattress. There was no personal clothing or items in the clothing closet. The bathroom did not have any personal items or toiletry supplies inside for use.

In an interview and observation on 10/19/2023 at 1:21 PM, R5 and R4 remained in the same room together sitting in their reclining chairs watching television. R5 stated about three months ago, they were told they had to have a roommate. R5 decided to have R4 move in since R4 would stay the night at times in R5's room. R5 stated they didn't want to share a room with another female resident or R4 to share a room with a male resident. R5 stated they rushed to move R4 into R5's apartment. R4 stated they have never seen the new room that the facility showed R4 had chosen to live in. R4 stated they lived with R5. R4 stated they signed a bunch of paperwork but does not recall what the paperwork was about or why they had to sign the documents.

In an interview on 10/18/2023 at 3:09 PM, Staff C, Resident Care Coordinator, stated R4 and R5 preferred to reside in the same room together.

In an interview on 10/18/2023 at 4:22 PM, Staff A, Executive Director, stated R4 was provided their own room. Staff A stated R4 refused to move any of their personal items into the new room. R4 refused to leave the room that they resided with R5.

Record review of an email sent to the Department from Staff D, Senior Executive Director, on 10/20/2023 at 10:22 AM, showed the facility had not sent in a request a capacity increase for the room R4 and R5 resided in.

This is an uncorrected deficiency previously cited on 08/22/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2270 Resident controlled medications.

(1) The assisted living facility must ensure all medications are stored in a manner that prevents each resident from gaining access to another resident's medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure medications were stored properly and secured for 1 of 2 sampled resident's (Resident 3 [R3]) rooms. This failure placed 47 of 47 residents at risk to ingest non prescribed medications in error.

Findings included...

Record review of the facility's policy titled, "Resident Self-Management and Storage of Medications", dated 08/10/2021, showed the procedures and criteria contained in this policy must be met prior to allowing a resident to manage, administer, and store their own medications. A re-evaluation of the resident's ability to self-manage medications would be conducted per policy. Any resident that desired to self-manage medications must first successfully complete the assessment for medication self-management completed by the wellness director or designee. The assessment would be filed in the resident's record. Once the resident had satisfactorily passed the evaluation, the health and wellness director or designee would ensure there was a physician order that showed the resident was able to store and self-administer their medications. A re-evaluation of the resident's ability to

safely store and self-administer their medications would be conducted with each negotiated service agreement review or sooner if there was a change in status. The assisted living facility must ensure all medication were stored in a manner that prevents each resident from gaining access to another resident's medications. If a resident was allowed to keep their own medications, the wellness director was to ensure all medications were kept in a secure environment that was accessible only to the resident and the community staff. Medications were not to be left sitting out in a resident's room.

Record review of the facility's plan of correction, dated 08/22/2023, showed the facility would remove all medications from resident's rooms. The facility would educate the staff that medications were not to be in residents rooms except for residents that self-managed. All resident that self-managed their medications would have a locked drawer or cabinet to keep their medications stored in. The health services director and the executive director would ensure the changes had been implemented and completed by 10/06/2023.

Record review of R3's face sheet showed R3 moved into the facility on [REDACTED]/2020.

Record review of R3's WA (Washington) Resident Assessment, dated 10/01/2023, showed R3 had multiple medical diagnoses that included [REDACTED]

Record review of R3's Assessment for Medication Self-Management, dated 05/07/2023, showed R3 was unable to lock/unlock the secured medication storage area in their room. R3 was unable to open the medication container and properly demonstrate when, how often, and how much to administer of their medications. The assessment showed R3 did not meet the criteria to self-manage their medications.

Record review of R3's Needs and Services Plan, dated 10/02/2023, showed the medication technicians administered R3's eye drops per the physician order. R3 required the medication technicians to administer all their medications.

Record review of R3's Home and Community Services Current Annual assessment dated 07/12/2023, showed R3 required assistance with all their medications. R3 would forget to take their medications, didn't follow the frequency, and dosage of their medications. R3's ability to manage their medications fluctuated.

In an interview and observation on 10/18/2023 at 2:39 PM, R3 was lying in bed. There was a bedside table to the right of R3. On the bedside table was a time bottle with a label that showed R3's name and latanoprost (prescribed medicated eye drops to treat glaucoma) eye drops. R3 stated they keep the eye drops on their bedside table and administer them into their eyes. R3 stated they kept the eye drops on their bedside table so they could reach them.

In an interview on 10/19/2023 at 12:52 PM, Staff B, Resident Care Director/Registered Nurse, stated R3 didn't administer any of their medications independently or store them in their room. Staff B stated the current self-medication assessment was completed on 05/07/2023. Staff B stated they were unaware that R3's prescribed medicated eye drops were at R3's bedside.

This is an uncorrected deficiency previously cited on 08/22/2023.

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

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

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

- (1) The assisted living facility must:
- (g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:
 - (i) On-duty staff persons' responsibilities;
 - (ii) Provisions for summoning emergency assistance;
 - (iii) Coordination with first responders regarding plans for evacuating residents from area or building;
 - (iv) Alternative resident accommodations;
 - (v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and
 - (vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure the facility had developed and maintained a disaster preparedness manual for 1 of 1 facility reviewed. This failure placed all 47 residents and 28 staff not having the resources and direction to assist the residents if a natural or emergency disaster occurred.

Findings included...

Revised Code of Washington (RCW) 18.20.525 "Disaster preparedness plan - (1) Each assisted living facility shall develop and maintain a comprehensive disaster preparedness plan to be followed in the event of a disaster or emergency, including fires, earthquakes, floods, infectious disease outbreaks, loss of power or water, and other events that may require sheltering in place, evacuations, or other emergency measures to protect the health and safety of residents. The facility shall review the comprehensive disaster preparedness plan annually, update the plan as needed, and train all employees when they begin work in the facility on the comprehensive disaster preparedness plan and related staff procedures."

Record review of the Washington State (WA) Emergency Management division, dated 2023

(no date or month), showed natural and technological hazards threaten our citizens and community. The threats could potentially impact a company's bottom line. An analysis of potential hazards and planning for such event would allow you to mitigate the risks, enhance safety and reduce recovery time. Some threats and hazards but not entirely listed included severe storm, landslide, volcano, wildfire, hazardous material, and radiological.

Record review of the WA Department of Health website titled, Emergency Preparedness Fact sheets, undated, showed a list of disasters that included some but not all, 9-1-1 emergency calls, bomb threats, chemical agents, cold weather, carbon monoxide poisoning, cover your cough, fires in the home, hot weather, hypothermia, landslides and mud flows, pandemic flu, power outage, terrorism, windstorms, wildfires, and water.

Record review of the Federal Emergency Management Agency's hazard fact sheets, dated November 2020, showed following hazards were listed but not limited to the following active shooter, cyberattack, earthquake, extreme heat, landslide, novel pandemic, power outage, thunderstorm, lightning, volcano, wildfire.

Record review of the facility's plan of correction, dated 08/22/2023, showed the facility would have a completed disaster plan and that staff were trained on all aspects of the disaster plan by 10/06/2023.

Record review of the facility's disaster preparedness binder showed there were preparedness plans for flooding, earthquake, and tsunami. There were no other disaster preparedness plans for review.

In an interview on 10/17/2023 at 3:19 PM, Staff D, Senior Executive Director, stated the facility's emergency binder had the internal and external disaster preparedness plans for the facility for review.

In an interview on 10/18/2023 at 10:41 AM, Staff F, Maintenance, stated they developed the plans with Staff A, Executive Director. Staff F stated they coordinated with the State Fire Marshal for the best evacuation plan and meeting place for the facility. Staff F stated they were unaware of any other internal or external preparedness plans to have implemented for the facility. Staff F stated a fire would be considered an internal disaster for the facility.

This is an uncorrected deficiency previously cited on 08/22/2023.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

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

- (1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:
- (b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.
- (3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:
- (c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to have Registered Nurse (RN) delegation documentation in place for 3 of 6 sampled residents (Resident 1 [R1], Resident 7 [R7], and Resident 8 [R8]). The facility failed to ensure medication technicians only administered delegated injections for 1 of 1 residents (Resident 2 [R2]). These failures placed all residents receiving RN delegated services at risk for receiving care and services by untrained staff.

Findings included...

Washington Administrative Code (WAC) 246-840-930- "Criteria for delegation-...

- (3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
- (4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
- (5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient...
- (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.
- (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
- (13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The

registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.

(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.

(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).

(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.

(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

WAC 246-840-920 Definitions. The following definitions apply to WAC 246-840-910 through 246-840-970.

"(14) "Registered nurse delegation" means the registered nurse transfers the performance of selected nursing tasks to competent nursing assistants or home care aides in selected situations. The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the patient. (15) "Stable and predictable condition" means the registered nurse delegator determines the patient's clinical and behavioral status is nonfluctuating and consistent. Stable and predictable may include a terminally ill patient whose deteriorating condition is expected. Stable and predictable may include a patient with sliding scale insulin orders. The registered nurse delegator determines the patient does not require frequent nursing presence and evaluation. "

WAC 246-980-130 Provision for delegation of certain tasks to a home care aide.

"(3) A home care aide-certified who is performing nurse delegation tasks must comply with all applicable requirements of the nursing care quality assurance commission in WAC 246-840-910 through 246-840-970. (8) A home care aide-certified must not accept delegation of, or perform, the following nursing care tasks: (a) Administration of medication by injection, with the exception of insulin injections."

RCW 18.88B.070 Nurse delegated tasks.

"(3) The home care aide is accountable for his or her own individual actions in the delegation process. Home care aides accurately following written delegation instructions from a registered nurse are immune from liability regarding the performance of the delegated duties."

Record review of Department of Social and Health Services document, titled, "Community Nurse Delegation Orientation 2023", undated, showed the Registered Nurse delegator assessment was required to determine the residents clinical and behavioral status was not fluctuating and was consistent. The resident was stable and predictable. When the resident was not functionally able and/or not cognitively aware they received medications, the long-term care worker was authorized to so with delegation of the medication by the guidance of the RN delegator. The document showed under the Washington State Law, long-term care workers were delegated by an RN to perform specific nursing tasks that do not include administration of medications by injections except for insulin or non-insulin injections for diabetes and does not require nursing judgement.

Record review of the facility's plan of correction, dated 08/22/2023, showed the health services director would ensure that all nurse delegation was updated and correct. The Health Services Director would in-service all delegated staff on the delegation process and would be completed by 10/06/2023.

Record review of the Department of Social and Health Services (DSHS) form titled, instructions for completing nurse delegation: nursing visit, dated 07/2017, for section four showed to check the all the boxes that apply to show how the form was used. The instructions indicated if the box for "client assessment" was attached, the clients assessment must be completed and attached to the delegation form. The directions for section five showed the delegated task (s) needed to be listed and the reason why the client needed to have the tasks delegated. Review of the directions for section six showed review of systems: check the box for "no change" if client's condition is unchanged from your last client assessment. If client's condition was changed from the last assessment, check the appropriate category box. If a category box was checked, complete a note in section seven below. Section seven directions showed, notes: describe change in client's condition in this box. If a category box (other than "no change") was checked above, attach assessment documentation. section may also be utilized as a "progress note" section.

Record review of the facility's RN delegation binder on 10/18/2023 showed Collateral Contact 1 (CC1), RN, was the RN delegator for the facility. Review of all of the current nurse delegation task forms and nursing visit forms were signed and completed by CC1.

R1

Record review of R1's face sheet showed R1 moved into the facility on [REDACTED] /20215 with multiple medical diagnoses that included [REDACTED]

Record review of R1's Washington (WA) Resident Assessment, dated 10/17/2023, showed R1 had multiple medical diagnoses that included [REDACTED]

R1 was rarely and at times never understood by others. Caregivers were to anticipate R1's needs and interpret R1's body language. R1 had verbal-speech and at times was nonverbal. R1 was on the medication lithium (prescribed medication to help mental illness disorders) for bipolar disorder. R1 had developmental disability (a condition due to an impairment in physical, learning, language, or behavior area).

Record review of R1's medication administration record (MAR), dated 10/01/2023 through 10/31/2023, showed R1 had current orders for Flutic/Vilant (prescribed medicated inhalation powder to help decrease trouble breathing and wheezing within the lung) inhaler, folic acid (vitamin to treat low iron levels in the blood), Lithium, olanzapine (prescribed medication used to treat a mental illness disorders), pravastatin (prescribed medication to lower fat amounts in the blood), valproic acid syrup (prescribed medication used to psychiatric disorders or neurological [brain disorders] disorders), vitamin D (supplement medication to help increase vitamin d level in the blood), and Zyrtec (medication to help treat allergies). Review of R1's MAR showed there were no listed indications, condition, or side effects listed for each medication that R1 had listed for review.

Record review of R1's Nurse Delegation: Nursing Visit form, dated 08/27/2023, showed it was signed by CC1. Review of section five showed the boxes, R1's initial client assessment (see attached) and initial caregiver delegation were checked. R1 required nurse delegation tasks for "medication administration and oral inhalation therapy related to requiring assistance with medication administration". Under section seven showed R1 currently resided in Assisted Living Facility (ALF). R1 was able to make their needs known. RN at the community would notify the RN delegator (RND) for changes in condition.

Record review of R1's Nurse Delegation: Instruction for Nursing Task form dated 08/27/2023, under the section five: delegated task and expected outcome showed R1 required "oral medication administration". There was no expected outcome list for R1's delegated task. The delegated staff members were to report to the RND if the resident had a reaction to the medication or medication does not appear to be effectively treating the patient condition. There was no specific side effects listed for the delegated tasks to review. There were no specific conditions on the form for the delegated medication for the delegated staff to review to know if the resident medication used for and what condition to treat for R1. There was no listed health care provider name or contact phone number listed on the form for the delegated staff.

Record review of the facility's nurse delegation binder on 10/18/2023, showed there was no nurse delegation instructions for the nursing task for R1's inhalation therapy for review.

R2

Record review of R2's face sheet showed R2 moved into the facility on [REDACTED]/2023.

Record review of R2's MAR, dated 10/01/2023 through 10/31/2023, showed R2 had an order for Ozempic (prescribed medicated injection to help lower blood sugars and help in aiding weight loss) injected once a week. There was no listed indication as to why R2 was prescribed the injection. The administrations dated 10/02/2023 and 10/16/2023 were administered by Staff I, Medication Technician. The administration of the injection dated 10/09/2023, showed Staff J, Medication Technician, had administered the injection.

Record review of R2's WA Resident Assessment, dated 10/01/2023, showed R2 had multiple medical diagnoses that included [REDACTED]

Record review of R2's Needs and Service Plan, dated 10/05/2023, under section "medication administration", showed R2 took Ozempic for weight loss per the primary care

provider and not for diabetes.

In an interview on 10/18/2023 at 10:00 AM, R2 stated they received the Ozempic injections for weight loss. R2 stated they were not diabetic. R2 stated the medication technicians at the facility administer R2's Ozempic injections every week.

In an interview on 10/19/2023 at 9:30 AM, Staff B, RN Resident Care Director, stated R2 received the Ozempic injection for weight loss and was not diabetic. Staff B stated the delegated medication technicians and themselves administered R2's Ozempic injection for R2 weekly.

Record review on 10/19/2023 of the RN delegation binder showed there were no delegation forms for review for R2's Ozempic injection for the delegated staff to administer.

In an interview and observation on 10/19/2023 at 1:45 PM, Staff C, Resident Care Coordinator, stated R2's Ozempic injection was a delegated task. Staff C stated the forms were in the RN delegation binder under the "D" tab for review. Staff C observed to look through the "D" tab without finding the nurse delegation forms for review. Staff C was unable to find any delegation forms to review after they were observed to review through all the forms of the RN delegation binder. Staff C stated there were no nurse delegation forms for R2 Ozempic injection for review.

In an interview on 10/19/2023 at 1:38 PM, Staff B stated there was no documentation from R2's primary care physician that showed R2's Ozempic injection was administered for diabetes. Staff B stated R2 only had a medical diagnosis of [REDACTED]

R7

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R7 moved into the facility on [REDACTED]/2023.

Record review of R7's WA Resident Assessment dated 10/13/2023, showed R7's required staff to assist and administer R7's medications. Staff were to check R7's blood sugar as ordered by the healthcare provider. R7 was confused, disoriented most of the time, had a difficult time being understood and had a difficult time understanding others. Staff were required to cue R7 to ensure they understood a basic need as in mealtimes. R7 had a medical diagnosis of [REDACTED]

Record review of R7's Needs and Services Plan, dated 09/26/2023, showed R7 required significant total assistance for their medication by the medication technician. R7 required their blood sugar to be checked two times a day and took medication daily. R7 was confused and disoriented.

Record review of R7's MAR, dated 10/01/2023 through 10/31/2023, showed they had an order for Acetaminophen (medication to help reduce fever and pain.) R7 was to take one tablet by mouth every six to eight hours as needed for pain, Bengay (medicated patch to help relieve pain and aches to muscles and joints) ultra strength 5 percent patch to be applied to affected areas topically every day as needed for pain. R7 had a prescribed medication order for Loperamide (medication to help stop or reduce loose bowels) give two tablets by mouth initially. There were no listed condition, symptom, or reason documented

that would inform the medication technicians when and for what, they were to administer that medication for R7. There was no order for the nurse delegated medication technicians to check R7's blood sugar level for review.

Record review of R7's Nurse Delegation: nursing visit form, dated 09/23/2023, showed R7 resided in a adult family home rather than an assisted living facility. R7 required "medication administration topicals" related to requiring assistance with medication administration. There was no rationale or reason as to why they required nurse delegated task for the topical medication administrations. CC1 documented that R7 was able to make their needs known. There was nothing documented under review of systems that indicated that R7 had any changes from their last assessment.

Record review of R7's Nurse Delegation: Instructions for Nursing Task, dated 09/23/2023, showed R7's delegated task and expected outcome was "oral medication administration". There was no documented outcome for R7 with their oral medications being administered for review. Under the description what to report to the RND, showed "if patient appears to be having a reaction the medication, or the medication does not appear to be effectively treating the patient condition". There was no further explanation as to what the side effects for the medications R7 took that the delegated medication technicians were to watch for and there was no further information as to what to watch for to know if the medication was not effective on the form for review. There was no healthcare provider name or telephone number listed on the form.

Record review of R7's Nurse Delegation: Instructions for Nursing Task, dated 09/23/2023, showed R7's delegated task and expected outcome was "administering skin/topical medications". There was no documented outcome for the topical administration of medication for review. Under the section for healthcare provider name showed "on file". There was no healthcare provider name or phone number for review.

Record review of R7's Nurse Delegation: as needed (PRN) medication form, dated 09/23/2023, showed R7 had an order for acetaminophen. The medication dose and frequency showed one tablet was to be taken by mouth every six to eight hours as needed for pain. There were no further direction or guidance for the medication technician to determine at what hour frequency to give the medication. The medication technicians would have to nurse nursing judgement with the time frame.

Record review of R7's Nurse Delegation: PRN medication form, dated 09/23/2023, showed R7 had an order for Bengay ultra strength 5 percent patch. Under the section dose and directions showed medication technicians were to apply to affected areas topically (on the skin) PRN. The order was incomplete as to frequency and where on the skin for the medication technicians were to apply the patch.

R8

Record review of R8's Needs and Service Plan, dated 10/05/2023, showed R8 required significant total assistance with their medications by the medication technician. R8 had a medical diagnosis of [REDACTED] and [REDACTED]. R8 required assistance with checking and documenting their blood sugar readings and required their medications administered per R8's physician orders as noted on R8's MAR.

Record review of R8's MAR, dated 10/01/2023 through 10/31/2023, showed R8 had an order for insulin aspart 70-30 pen (long-acting insulin to help keep blood sugars

maintained at a lower level), inject 40 units under the skin two times daily. Review of the documented administrations of the aspart insulin showed there were numbers under the medication technicians documented initials. The order did not have directions for the medication technician to check R8's blood sugar level prior to administering the insulin and document. There was no parameters documented on the medication order for review. Review of the MAR showed there was no current order to check R8's blood sugar levels review.

Record review of R8's Nurse Delegation: Nursing Visit, dated 08/27/2023, showed R8 resided at an adult family home setting rather than the assisted living facility. R8 required nurse delegation for tasks, medication administration for insulin administration related to required assistance with medication administration. There was no documented justification why R8 required their insulin to be a nurse delegated task for review on the form. Under the notes section showed the RN delegator documented R8 was able to make their needs known and the RN at the community would notify the RND of any change in conditions.

Record review of R8's Nurse Delegation: Instructions for Nursing Task, dated 09/01/2026 (date as shown), showed the delegated task and expected outcome for R8 was "insulin pen administration; delegated staff will administer insulin with pen rotating injections sites." The health care provider name on the form showed "on file". There was no name of the healthcare provider or the healthcare provider's phone number for review on the task form.

Record review of R8's Nurse Delegation: Instructions for Nursing Task, dated 09/01/2023, showed the delegated task and expected outcome for R8 was "blood glucose testing [check blood sugar level]; delegated staff will check residents blood glucose levels. Under the section that showed specific medications delegated showed, check blood glucose twice daily before insulin administration and follow parameters. There were no specific parameters listed for review with the medication instructions. Under the section for healthcare provider name showed "on file". There was no documented name or phone number for the healthcare provider on the form for review.

In an interview on 10/18/2023 at 4:13 PM, Staff I, Medication Technician, stated they did not know who the RN delegator was for the facility. Staff I stated they would tell Staff B, RN/Resident Care Director, if there were any changes with any residents that had delegated tasks. Staff I stated they did not know who CC1 was. CC1 stated they were only observed to administer insulin by Staff B and never by CC1.

In an interview on 10/19/2023 at 11:23 AM, Staff E, Medication Technician, stated Staff B observed them administer insulin to the delegated residents. Staff E stated Staff B taught her how to administer insulin. Staff E stated they would notify Staff B if there were any changes with a resident's condition or delegated medications. Staff E stated R1 was not aware that they took medications all the time. Staff E stated R1 had dementia and required the medication technicians to direct R1 to take their medications and swallow them. Staff E stated R1 would not be able to communicate when R1 needed something.

In an interview on 10/31/2023 at 9:58 AM, CC1, stated they were the RN delegator for the facility. CC1 stated they documented their assessment of the resident, the rationale for the task, and expected outcome of the task on the nursing visit delegation form. CC1 stated they used Staff B's assessment for the resident for their delegation visits. CC1 stated they would write in big bold that the resident was stable and predictable on the nurse visit delegation form for each resident. CC1 stated they would typically document for a diabetic

outcome that they would maintain baseline for diabetic management. CC1 stated the medication technicians and Staff B would contact them if there were changes in a resident's delegated medication or a change in the resident's condition. CC1 stated they were taught there could be two RN's for one facility for nurse delegation. CC1 stated Staff B was the second RN delegator for the facility and co-signed on CC1's nurse delegation forms when they changed or observed the nurse delegated medication technicians for observation or training. CC1 stated that any resident that was prescribed by their healthcare provider for weight loss the injectable medication Ozempic would not be a delegated task for the medication technicians to administer.

In an interview on 11/03/2023 at 3:28 PM, CC1 stated R2 did not have a medical diagnosis for [REDACTED]. CC1 stated Staff B was to administer R2's Ozempic injection and not the nurse delegated medication technicians. CC1 stated they were unaware that the nurse delegated medication technicians were administering R2's weekly Ozempic injection.

This is an uncorrected deficiency previously cited on 08/22/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date



Residential Care Services Investigation Summary Report

Provider/Facility: Ocean Shores Assisted Living	Provider Type: Assisted Living Facility
License/Cert. #: 2615	Intake ID: 90940
Compliance Determination #: 26995	Region/Unit #: RCS Region 3 / Unit E
Investigator: Anissa Bearden	
Investigation Date(s): 07/24/2023 through 08/22/2023	
Complainant Contact Date(s):	

Allegation(s):

1. other- allegation of possible communicable disease outbreak in facility

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 9 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Family members Administrative Staff Residents Housekeeping staff
Record Reviews:	Medical records State reporting log Facility policies Staff training records

Investigation Summary:

1. Other- after observation, interview, and record review facility failed to report the residents positive COVID-19 case to the department and timely to the public health department. Facility failed to have adequate amount of PPE. There was failed practice with handwashing and removal of PPE with contamination.

Conclusion / Action:

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

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



Residential Care Services Investigation Summary Report

Provider/Facility: Ocean Shores Assisted Living

License/Cert.#: 2615

Compliance Determination #: 26995

Investigator: Anissa Bearden

Investigation Date(s): 07/24/2023 through 08/22/2023

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 90833

Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

- 1) allegation not following policy r/t weights
- 2) concerns with the meal serving process length
- 3) kitchen running out of entrees to serve residents
- 4) lack of alternatives according to special diets as in diabetic diets
- 5) lack of person centered meal planning, no dietician visits
- 6) concerns of the menu posted above level of sight in wheelchair.
- 7) concerns of lack of food assessible and lack of alternative food options
- 8) concern the food was not properly cooked.

Investigation Methods:

Sample: Total residents: 52
Resident sample size: 9
Closed records sample size: 0

Observations: Kitchen
Food preparation
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Residents
Identified resident

Interviews: Kitchen staff
Business office manager
Maintenance staff
Family members
Residents
Nursing staff

Record Reviews: Staff training records
Personnel files
Facility policies
Incident investigation
State reporting log

Investigation Summary:

- 1) Based on interview and record review the facility failed to weigh residents per their Negotiated Services Agreement (NSA - Facility version is the Needs and service plan).
 - 2) Based on observation and interview this concern could not be substantiated. The facility had a system in place to get residents their meals in a timely fashion.
 - 3) Based on observation and interview this concern could not be substantiated. The facility was able to serve all residents the entree that was being served.
 - 4) Based on observation, interview, and record review the facility failed to provide a lack of alternative options to diabetic residents.
 - 5) Based on observation, interview, and record review the facility failed to provide person centered meal planning to the residents. The menus were not approved by a dietician.
 - 6) Based on interview, observation, and record review the facility failed to provide an accurate menu that was posted at least one week in advance.
 - 7) Based on observation, interview, and record review the facility had lack of food assessible and lack of alternative options.
 - 8) Based on observation, interview, and record review cross contamination during the cooking process was found.
-

Conclusion / Action:

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



Residential Care Services Investigation Summary Report

Provider/Facility: Ocean Shores Assisted Living
License/Cert.#: 2615
Compliance Determination #: 26995
Investigator: Anissa Bearden
Investigation Date(s): 07/24/2023 through 08/22/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility
Intake ID: 91117
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

- 1) allegation the resident's call light was not being answered at night and don't give her medications
 - 2) resident receiving stool softeners and was not needed that caused accidents
-

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 9 Closed records sample size: 0
Observations:	Identified resident Staff to resident interactions Resident rooms Medication administration
Interviews:	Identified resident Nursing staff Residents Administrative staff
Record Reviews:	Medical records Facility policies Hospital records

Investigation Summary:

- 1) after interview and record review the facility was found to have failed practice in not answering call lights within a timely manner. Review of the residents medications showed there were no medication orders that were scheduled every 6 hours. resident was attempting to get pain medications earlier than it was allowed.
 - 2) resident was on routine bowel medication related to the pain medication and risk for not being able to go. resident did request for it to be changed to as needed. facility failed to notify the physician to get medication changed.
-

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: Ocean Shores Assisted Living

License/Cert.#: 2615

Compliance Determination #: 26995

Investigator: Anissa Bearden

Investigation Date(s): 07/24/2023 through 08/22/2023

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 91470

Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1) Concern regarding a resident verbally bullying another resident at the facility.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents Dining Resident to resident interactions
Interviews:	Residents Nursing staff Identified staff
Record Reviews:	Grievance log State reporting log Incident investigation Facility policies Staff training records

Investigation Summary:

1) Based on interview and record review the facility failed to investigate a grievance brought to the facility's attention, monitor the residents well being who were involved, promptly notify CRU, and put interventions in place to protect residents during the course of an investigation.

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

09/05/2023

Licensee: Greenlake Management Ocean Shores, LLC
Ocean Shores Assisted Living
4441 W. Airport FWY Ste 160
Irving, TX 75062

RE: Ocean Shores Assisted Living License # 2615

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 08/22/2023 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:

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

Greenlake Management Ocean Shores, LLC
Ocean Shores Assisted Living # 2615
08/22/2023
Page 2 of 154

Manfay Chan, 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)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

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



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 # 2615	Compliance Determination # 26995
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 3 of 154	Licensee: Greenlake Management Ocean Shores,	08/22/2023

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 07/24/2023 and 08/22/2023 of:

Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

This document references the following complaint numbers: 90940, 90833, 91117, 91470.

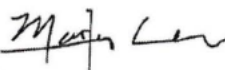
The following sample was selected for review during the unannounced on-site visit: 9 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors
Melissa Brunton, Regulatory QA Program Manager - Community Programs

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.



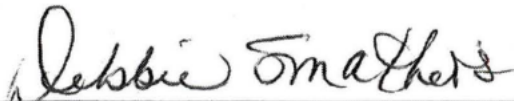
Residential Care Services

09/05/2023

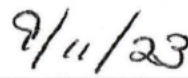
Date

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

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



Administrator (or Representative)



Date

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

(1) The assisted living facility must:

(c) Ensure all menus:

(ii) Indicate the date, day of week, month and year;

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

(v) Provide a variety of foods; and

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(ii) Individual preferences to the extent reasonably possible.

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

(3) The assisted living facility may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide snacks, accommodate resident diets, and have a dietary manual complete and accessible for review for 1 of 1 kitchen reviewed. These failure placed all 52 of 52 residents at risk of not having their nutritional needs met.

Findings included...

Record review of the facility's policy, titled, "Snacks", undated, showed a selection of snack foods and beverages should be available around the clock in a convenient place.

Record review on 07/27/2023 of the facility provided diet manual, undated, showed there were 15 dining service policies in the binder. There was no other documentation in the binder for review. There was no dietary manual signed off by an approved dietician for review.

Record review of the Cleveland Clinic document, titled, "Gluten Intolerance", undated, showed gluten was a protein found in wheat, barley, rye and other grains. Gluten was in a lot of common foods and drinks, including pasta and cereal.

In an observation on 07/24/2023 at 12:45 PM, there was a glass display cabinet that was secured on the wall in the hallway near the dining room. The glass display cabinet was located high on the wall close to the ceiling. The glass display cabinet had a weekly menu that showed, "Sunday, 8 through Saturday 14" at the top of the menu. There was no month or year listed on the top of the posted menu. There was a date on the bottom of the posted menu that showed 03/24/2023. There was no observed signature of a dietician located on the menu.

In an observation on 07/25/2023 at 6:49 AM, the glass display cabinet had a different weekly menu that was posted. The menu posted showed "traditional Sysco menu 15 through 21 spring/summer 2023". The displayed menu did not show a month documented. The weekly menu showed there was no signature documented by a dietician that reviewed and approved the meals listed.

In an interview on 07/25/2023 at 1:00 PM, Staff B, Resident Care Director/Registered Nurse, stated Staff E, Cook, had posted the menu that showed, "traditional Sysco menu 15 through 21 spring/summer 2023" on 07/25/2023.

In an observation on 07/24/2023 at 12:43 PM, Resident 14 (R14) was served a plate for lunch that had beige noodles that covered 75 percent of the plate with five medium sized meat balls. There were no vegetables, fruit, or any other sides observed.

In an interview on 07/24/2023 at 3:50 PM, Resident 10 (R10) stated they were unable to chew the food at times. R10 stated they would ask for a baked potato as an alternative. R10 stated Staff E told them they were unable to have the baked potato as an alternative. R10 stated Staff E told them, too many residents had asked them for a baked potato and was unable to provide them any longer. Resident 20 (R20) stated the facility had a rule that if you were served a meal that you didn't like, the alternative that was provided was a peanut butter and jelly sandwich.

In an interview on 07/25/2023 at 8:19 AM, Staff E stated Resident 7 (R7) was the only resident that required gluten free foods. Staff E stated they did not have gluten free bread available at the facility. Staff E stated egg noodles were gluten free and made them for R7.

Staff E stated they served R7 vegetables and meat.

In an observation on 07/25/2023 at 8:21 AM, there was a bag with a printed label, "enriched egg noodle product" on the shelf of the dry storages. Review of the ingredients listed on the back of the package showed durum wheat semolina (a type of coarse flour made from durum wheat), durum wheat flour. The bag showed in bold black print, "CONTAINS: wheat."

In an interview on 07/25/2023 at 10:11 AM, R7 stated the facility doesn't provide a low salt or diabetic diet. R7 stated they were gluten intolerant (a bodies in ability to break down the protein in gluten and causes one to get sick after eating gluten). R7 stated they didn't have any food for them to eat. R7 stated they were served breaded fish and noodles for a meal. R7 stated they had to buy their own gluten free foods.

In an interview on 07/26/2023 at 12:42 PM, Staff A, Executive Director, stated the facility's food supplier provided the menus for the facility to post. The menus were what the facility was to cook. Staff A stated the food supplier had a dietician that developed, reviewed, and approved the menus for the facility. Staff A stated the corporation of the facility only used the food supplier's dietician. Staff A stated Staff E would know the specific food accommodations for residents that were required. Staff A stated Staff E and the other cooks had a special menu to reference for the residents that required specific food accommodations.

In an interview on 07/26/2023 at 12:45 PM, Staff A stated any leftover food from a prior meal, or a sandwich would be provided if a resident requested an alternative meal. Staff A stated they were unaware if there was a list of alternative meal items offered daily for the residents to choose from. Staff A stated the caregivers and the medication technicians had access to the kitchen all the time to get a diabetic resident a snack. Staff A stated residents were offered any food left over from prior meals, fruits, sandwiches and sometimes crackers.

In an interview on 07/26/2023 at 3:07 PM, Staff P, Cook, stated the dietary manual was stored in the dietary office. Staff P stated the facility menus were approved by the facility's food supplier. Staff P stated they used the facility's food supplier's menus to ensure the food was within the facility's budget.

In an interview on 07/24/2023 at 12:47 PM, Staff B stated they provided the residents snacks twice a day or whenever a resident requested it. Staff B stated the snacks would be placed on the piano inside of the dining room so residents could pick them up as needed. Staff B stated if a resident were unable to come pick up a snack for themselves staff would deliver the food to them.

In an interview on 07/25/2023 at 10:17 AM, Resident 6 (R6), stated that they did not always have access to food. R6 stated sometimes the facility would set out cookies or popcorn for the residents to eat. R6 stated the food would be on a tray and residents could pick it up while it was there. R6 stated the food did not last long.

In an observation on 07/25/2023 at 1:35 PM, the piano in the dining room showed there

were no snacks accessible to residents.

In an observation on 07/25/2023 at 3:19 PM, the piano in the dining room showed there were no snacks accessible to residents.

In an interview on 07/26/2023 at 12:47 PM, Staff A stated the residents had a lot of complaints about the food. Staff A stated a few months ago the facility decided to use the facility food supplier's menus. Staff A stated there hadn't been a change and residents continued to express complaints with the food. Staff A stated Staff E and Resident 24 (R24) try to meet to discuss concerns about the food. Staff A was unsure how often or when the last meeting was held between Staff E and R24. Staff A stated during snack time the facility offered punch, juice, water, and coffee. Staff A stated the snacks that were offered outside of the meals and snack times were documented on the menus. Staff A stated snacks were provided upon the residents' request except for the facility serving daily fresh popped popcorn between 2:30 PM through 3:30 PM. Staff A stated they believed the facility served fresh fruits and vegetables with the resident's meals.

This is a recurring deficiency previously cited on 02/15/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023.

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2610 Infection control.

- (1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
- (2) The assisted living facility must:
 - (a) Develop and implement a system to identify and manage infections;
 - (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;
 - (f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all staff were fit tested for an N95 respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) for 13 of 23 Staff (Staff B, Staff F, Staff G, Staff N, Staff I, Staff O, Staff R, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, and Staff FF). The facility failed to ensure necessary infection control supplies were available for 1 of 1 sampled resident (Resident 9) that was on aerosol precautions positive with COVID-19 virus (Corona Virus Disease 2019- a respiratory illness). The facility failed to ensure the staff washed their hands per the recommended guidance for 2 of 2 staff members (Staff O and Staff I) observed. The facility failed to report a communicable disease to the Departments Complaint Resolution Unit (CRU) Hotline for 1 of 1 sampled resident (Resident 9). These failures resulted in staff and residents not having necessary infection control supplies and training that placed 52 of 52 residents, 26 staff, and all visitors that came into the facility at risk of being infected and spreading communicable diseases during a COVID-19 outbreak.

Findings included...

Record review of the document titled, "L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE", dated 03/30/2021, 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 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. COVID-19 is an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes." The "fit test" is to be completed every 12 months."

Record review of the Department of Health document, titled, "Respiratory Protection Program for Long-Term Care Facilities", undated, showed "providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department of Labor and Industries (L&I). Employers have an obligation to protect their employees from hazards in the workplace (General Duty WAC 296-126-094). In healthcare facilities, the tight-fitting disposable 'N95' respirator is a commonly used for respiratory protection. Respirator fit testing ensures that tight-fitting respirators seal properly and helps protect employees from exposure to airborne particles such as viruses and bacteria. Keep your employees safe and working by getting them fit tested and ready to properly use a respirator."

WAC 296-842-12010 Keep respirator program records. "(1) A written copy of the current respirator program must be kept by the employer. (2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include: (a) Employee name; (b) Test date; (c) Type of fit test performed; (d) Description (type, manufacturer, model, style, and size) of the respirator tested; (e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a printout, or other recording of the test."

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

Record review of the "Assisted Living Facility Guidebook, Partners in Protection", dated February 2018, under the section, "Appendix D other reporting requirements for assisted living facilities", showed communicable disease outbreak would be reported to the Department of Health and Social Services hotline. Under the section titled, "reporting guidelines for Assisted Living Facilities", showed communicable disease outbreak was required to be reported to the Local Health Department" and the Department of Social and Health Services hotline number.

Record review of the Washington State (WA) Department of Health (DOH) document, titled, "SARS-CoV-2 Infection Prevention and Control in Healthcare Settings Toolkit", dated June 2023, showed the WA DOH was in full alignment with CDC's guidance as it pertains to healthcare and COVID-19. Under the section titled, "Environmental Infection Control-Cleaning and Disinfection", showed dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection. Under the section titled Personal Protection Equipment (PPE) showed isolation carts that contained transmission-based precautions should be placed outside the door of a resident in quarantine or isolation.

Record review of the facility's policy, titled, "Respiratory Illness Outbreak", dated 12/15/2021, showed the community would prepare and take steps to reduce the risk of and respond to outbreaks of respiratory illness and contagious respiratory illnesses. The community was to always follow guidelines and recommendations from the CDC and the state and local public health department. Under the section, "Procedures, Prior to an outbreak", showed all staff would be trained on the following: reporting suspected respiratory illness, hand hygiene, the use of PPE, and the different types of precautions. Adequate PPE should be available all the time. Inventory counts of PPE would be conducted regularly by the wellness director or designee. The community was to immediately report all outbreaks of respiratory illness to the appropriate licensing office.

Record review of the facility's policy, titled, "Reporting of Communicable Diseases", dated 12/15/2021, showed the executive director or designee was responsible to report known or suspected communicable diseases or outbreaks to the local health department and licensing (department).

Record review of DOH's document 420-302, titled, "Interim COVID-19 Outbreak Definition for Healthcare Settings", updated 02/03/2023, showed on 01/01/2023 the DOH adopted the updated Council of State and Territorial Epidemiologists (CTSE) definition.

Record review of the Council for Outbreak Response Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) document, titled, "Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings", dated 08/10/2022, showed the definition of an outbreak for a long-term care facility was one or more facility acquired COVID-19 case in a resident. The document showed facility acquired referred to a long-term care resident that originated within the facility.

Record review of the Center of Disease Control and Prevention Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

Record review of the facility's policy, Hand hygiene, dated 12/15/2021, showed hand hygiene was a critical step in infection control. Hand hygiene would be used to aid in the prevention and spread/transmission of infections. Under the section, "Procedures", showed staff must wash their hands before and after putting on disposable gloves, before food preparation and after handling meat, before and after handling food or eating, after removal of any Personal Protective Equipment, and after contact with contaminated materials. The use of gloves did not replace handwashing or the use of alcohol-based hand sanitizer.

Record review of DOH's document 420-380 titled, "Taking PPE Off", dated February 2023, showed inside the room, stand near the exit door. Cross arms and grip gown on the shoulders. Remove gown in a controlled fashion. Roll the gown towards your hands. Remove the gloves with the gown. Dispose of the gloves and gown. Sanitize hands and exit the patient's room. Remove disposable eye protection and discard. Do not touch face. For reusable eye protection, place a wipe on a table. Remove the eye protection and place on the wipe. Do not touch your face. Sanitize your hands. Pinch the bottom strap of N95 respirator and pull far over your head. Pinch top strap and pull far over your head and discard. Do not touch your face or the front of the respirator when removing the N95 respirator. Sanitize your hands. If needing to put on a mask, this would happen now.

Record review of the facility's PPE policy, dated 12/15/2021, showed the community provided PPE for use by care staff during any job task that may result in contact with blood or other body fluids. PPE was to be supplied by the community and readily available for staff. PPE would be put on and removed according to the current Centers for Disease Control and Prevention (CDC) guidelines.

Reporting to CRU

Record review on 07/24/2023 of the Departments database showed the facility had not reported any positive COVID-19 resident's cases for the facility for dates 07/01/2023 through 07/24/2023.

In an interview and observation on 07/24/2023 at 1:27 PM, Staff B, Resident Care Director/Registered Nurse, was asked if the facility was to post signs when there was only one positive residents COVID-19 case. Staff B stated they were unaware of the facility's policy and how to communicate with family, visitors, and other residents that there was a positive COVID-19 case within the facility. Staff B stated either Staff A, Executive Director, or Staff C, Resident Care Coordinator, had contacted the local public health department about the positive resident case for guidance.

In an interview and observation on 07/24/2023 at 1:32 PM, Staff A stated Resident 9 (R9) tested positive for COVID-19 on 07/22/2023 evening. Staff A stated they were unsure who had called the local public health department about the positive COVID-19 resident case. Observed Staff A look to Staff B and Staff B stated they hadn't notified the local public health department. Staff A asked would the facility need to notify visitors, families, and other residents that there was a positive COVID-19 case but not an outbreak. Staff A stated they didn't know the definition of an "outbreak" for the facility. Staff B stated they were told a few weeks prior from the local public health department that two or more residents or staff would be considered an outbreak for the facility. Staff B stated they had called the local public health department when the facility staff had tested positive for COVID-19. Staff B was unable to provide the name or phone number for the local public health department they had contacted. Staff A stated they didn't know if the Department was notified that R9 tested positive with COVID-19.

In an interview on 08/03/2023 at 4:25 PM, Collateral Contact 14 (CC14), Local County Public Health Epidemiologist, stated Staff C contacted them on 07/24/2023. CC14 stated they were told that R9 tested positive on 07/22/2023.

FIT TESTING

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff B, Resident Care Director/Registered Nurse, was hired at the facility on 07/10/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff B for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff F, Caregiver, was hired at the facility on 05/22/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff F for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff G, Maintenance, was hired at the facility on 05/22/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff G for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff N, Housekeeping, was hired at the facility on 06/01/2022.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff N for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff I, Medication Technician, was hired at the facility on 06/01/2022.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff I for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff O, Caregiver, was hired at the facility on 06/02/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff O for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff R, Caregiver, was hired at the facility on 07/12/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff R for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff AA, Medication Technician, was hired at the facility on 05/19/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff AA for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff BB, Caregiver, was hired at the facility on 06/14/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff BB for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff CC, Maintenance, was hired at the facility on 06/01/2022.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff CC for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff DD, Medication Technician, was hired at the facility on 05/12/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder, showed there was no N95 fit testing records for Staff DD for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff EE, Caregiver, was hired at the facility on 11/04/2022.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff EE for review.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff FF, Caregiver, was hired at the facility on 01/06/2023.

Record review on 07/24/2023 of the facility's N95 respirator fit testing binder showed there was no N95 fit testing records for Staff FF for review.

In an interview on 07/24/2023 at 1:44 PM, Staff C, Resident Care Coordinator, stated, "I guess it would be me to fit test staff since [Staff S, Former Health Services Director] is not here". Staff C stated they were a qualified N95 respirator fit tester.

In an interview on 07/24/2023 at 6:27 PM, Staff R stated they were not fit tested for an N95 respirator.

Record review of the facility's document titled, "Safety Plan", dated 07/24/2023, showed PPE supplies were available for staff located near the positive COVID-19 resident's room in the black cabinet. The PPE supplies in the cabinet included gloves, gowns, face shields and

goggles, N95 masks, hand sanitizer, and PPE use instructional guides. There were hazard cans placed inside and outside the COVID-19 positive resident's room. All staff and residents would be tested for COVID-19. Staff who were not fit tested would be fit tested. All residents power of attorney's would be notified of the positive COVID-19 case within the facility by a letter that was either emailed or mailed. Staff were to be in-serviced for donning (put on) and doffing (take off) the PPE supplies. The facility would report the positive COVID-19 case to the Department.

In an interview and observation on 07/25/2023 at 8:29 AM, Staff G was unaware what being "fit tested for N95 respirator" meant. Staff G was observed to be wearing a NIOSH N95 respirator. The straps of the N95 respirator were on top of Staff G's baseball cap. Staff G had facial hair that was observed on the sides of the N95 respirator. Staff G stated when they started their shift, the Corporate Nurse handed them the N95 respirator and told Staff G they were told to put it on.

In an interview on 07/26/2023 at 2:38 PM, Staff R stated they still had not been fit tested for an N95 respirator as of 07/26/2023.

In an interview on 07/26/2023 at 2:53 PM, Staff B stated they were not fit tested for the N95 respirators the facility provided.

In an interview on 07/27/2023 at 4:58 PM, Staff W, Chief Executive Officer Veda Living Management Company, stated they were told that all staff had been fit tested. Staff A, Executive Director, stated they had been calling staff to come in to get fit tested for an N95 respirator. Staff A stated there had been staff that worked without being fit tested for an N95 respirator.

PPE Supplies

In an observation and interview on 07/24/2023 at 2:16 PM, Resident 9's (R9) apartment door to the room was closed. There was a precaution sign hung up on the door that showed they were on "aerosol generating precautions" (someone that is on precautions for airborne communicable disease or virus). There were no trash cans, or visible supply of N95 respirators, facial masks, gloves, disposable gowns, face shields or goggles, and hand sanitizer by or around R9's apartment door. Staff B stated that all staff that entered R9's room were required to wear full PPE. Staff B stated R9 was on airborne precautions (a communicable disease or virus that may infect someone through the air). Staff B stated all the PPE supplies for staff to use to enter R9's room was located at the nurse's station down the hall.

In an interview on 07/24/2023 at 2:33 PM, Staff B stated the PPE supplies for staff to use to enter R9's room was not in the nurse's station.

In an observation and interview on 07/24/2023 at 2:34 PM, there was a wooden cabinet to

the right of R9's apartment door. Staff B opened the two bottom doors. Staff B stated the PPE supplies were stored here for staff to use. On the two shelves of the cabinet were multiple boxes of puzzles and board games. On top of the puzzles were two bags of disposable gowns with one being open. There was one pair of blue foot protector covering loosely stored on top of a board game. There was a plastic clear bin that had 2 disposable face shields on the bottom. There were multiple white disposable individual packaged "3m Aura 1870+ NIOSH N95" respirators that were on top of the two packages of disposable face shields overflowing the clear plastic bin. The bin did not have a lid. There was no visible supply of hand sanitizer, trash can or trash bags, facial masks, or disposable gloves. Staff B stated the cabinet was there to store the activity supplies of board games and puzzles. Staff B was unsure if there was any further supply of PPE available for staff to access and use.

In an observation on 07/24/2023 at 5:28 PM, upon entering R9's room, it was noted there were multiple open big black plastic trash bags sitting on the floor just inside R9's door. There were multiple big brown cardboard boxes stacked against the left side of the wall with a black plastic trash bag opened on top. There were no PPE supplies, disposable gloves, hand sanitizer, or trash can observed near or around R9's door.

In an observation on 07/24/2023 at 5:27 PM, Staff I came into R9's room with the following PPE on, N95 respirator, disposable gown, gloves, and face shield. Staff I administered R9's medications to them along with their meal tray. Staff I observed to look for a trash can to use to throw the medication cup away. Staff I observed the trash can next to R9's reclining chair that didn't have a trash bag inside. Staff I entered R9's bathroom looking for a trash bag. Staff I was unable to find one and came back out to R9's counter. Staff I looked through some supplies then walked to the front door. Staff I looked through one big black plastic trash bag that was sitting on the ground next to the door, and one that was sitting on top of boxes that were stacked up against the wall. Staff I found a trash bag and placed it in the trash can next to R9's recliner.

In an observation and interview on 07/24/2023 at 5:37 PM, R9 stated the big brown cardboard boxes near their apartment door were a new supply of briefs. The black plastic trash bag on top of the boxes was observed to have disposed white N95 respirators, multiple disposable gowns, disposable gloves, and disposable face shields inside.

In an observation and interview on 07/24/2023 at 6:10 PM, there were an abundance supply of COVID-19 boxes of tests, multiple boxes of disposable different sized gloves, a large box of 1000 individually packaged "3m Aura 1870+ NIOSH N95" respirators, an open large box of disposable gowns, and a drawer of surgical masks. Staff M, Business Office Manager (BOM), stated the face shields were in a shed outside of the facility. Staff B stated the staff did not have access to the BOM's office unless they were at the facility. The BOM office was locked at all times. Staff B stated only specific management staff members had a key to access the office. Staff B stated Staff C was responsible to order and ensure enough PPE supply's were available at the facility for use. Staff B stated there was a shed outside of the facility that stored the face shields.

In an interview and observation on 07/24/2023 at 6:23 PM, there was a cream colored

shed outside to the right side of the facility. Staff A and Staff C were inside looking through boxes and other supplies stored inside. Staff C stated they weren't able to find any disposable face shields but found more masks. Staff A stated they would need to buy more face shields in the morning. Staff A stated the two disposable face shields observed in the activity cabinet would not be enough to last through the night for their staff to use and attend to R9's care needs.

Handwashing

In an observation on 07/25/2023 at 6:27 AM, the kitchen hand washing sink next to the grill was observed to be dry. There were no paper towels inside the paper towel dispenser. There was an ecolab poster above the paper towel dispenser that showed, "all employees must wash their hands before returning to work." There was a black "zak" drinking cup with a drinking straw on the counter by the handwashing sink.

In an observation on 07/25/2023 at 6:58 AM, Staff E, Cook, had blue disposable gloves on their hands. Staff E placed raw bacon on a baking sheet. Staff E continued to wear the disposable blue gloved and grabbed a bag of bread. Staff E removed some slices of bread with their gloved hands out of the bag and placed them into the toaster. Staff E continued to wear the blue disposable gloves to turn a timer that had alarmed off. Staff E grabbed with their blue gloved hands some seasoning containers off the shelf and wiped their gloved hands on a towel that was sitting on the counter.

In an observation on 07/25/2023 at 7:05 AM, Staff E with the same blue gloves on their hands first observed at 6:58 AM, had opened the door of the freezer and pulled a box out. Staff E grabbed frozen dough balls out of the box and plated them on a new baking sheet on the same counter as the bacon was plated. Staff E was not observed to clean the area prior to plating the frozen dough. Staff E grabbed two loaves of bread from the dry goods shelve and took them to the counter by the grill.

In an interview and observation on 07/25/2023 at 7:10 AM, Staff E stated they date all food items that were broken up. Staff E stated they used the labels from the supplier. Staff E observed to have the same gloves on as first observed at 6:58 AM, to pour hot water into the hot table and then placed the pot they used for the water onto the shelf with clean dishes. At 7:15 AM, Staff E closed the dishwasher door. Staff E opened the dishwasher door after it was completed. Staff E grabbed clean plates and baking tins with their same blue gloved hands and put them away with other clean dishes.

In an observation on 07/25/2023 at 7:18 AM, Staff E observed to remove their blue gloves off their hands. Staff E approached the handwashing sink and began to turn the water on, but then stopped. Staff E was observed to walk to the back of the kitchen and exited the kitchen.

In an observation on 07/25/2023 at 7:20 AM, Staff E entered through the front of the kitchen holding a roll of paper towels in their hands. Staff E was observed to wash their

hands for the first time in 22 minutes.

In an observation on 07/25/2023 at 7:25 AM, Staff E placed a new pair of blue disposable gloves on both hands.

In an observation on 07/25/2023 at 7:28 AM, Staff E observed to place a rack of dirty dishes in the dishwasher with gloved hands. Staff E closed the dishwasher door. Staff E came over to the grill/oven area. Staff E placed a black hand mitt over their gloved hand. Staff E removed a baking sheet of cooked bacon out of the oven.

In an observation on 07/25/2023 at 7:32 AM, Staff E grabbed a hold of the side of the black trash bag and pulled it out from under the counter. Staff E picked up and placed on the counter a box of whole unpeeled potatoes. Staff E filled up a white bucket with water and placed on the counter near the black trash bag.

In an observation on 07/25/2023 at 7:35 AM, Staff E picked up a potato and peeled it above the black trash bag. The peeled potato was placed in the white bucket of water and continued to peel more potatoes. Staff E was observed to be using the same blue disposable gloves that were placed on ten minutes prior, and the same gloves used to handle the trash.

In an observation on 07/25/2023 at 8:05 AM, Staff E observed to wash their hands at the handwashing sink next to the grill. Staff E put on a new pair of blue disposable gloves.

In an observation on 07/25/2023 at 8:09 AM, some boxes of food were delivered by the facility's food vendor. Staff E opened a cardboard box. Staff E opened the refrigerators door near the window of the kitchen. Staff E placed a box of liquid egg white cartons inside the fridge.

In an interview on 07/25/2023 at 8:09 AM, Staff F stated that some of the resident's orders were ready for Staff E to start plating.

In an observation on 07/25/2023 at 8:10 AM, Staff E was still wearing the blue disposable gloves that were put on at 8:05 AM. Staff E approached the hot serving table. Staff E grabbed the tickets that Staff E brought in that showed residents choices for the meal. Staff E grabbed the black "zak" beverage cup with a straw inside next to the handwashing sink and grill. Staff E took a drink from the black cup. Staff E reapproached the serving table grabbed a knife and a cutting board. Staff E opened a bag of bread, removed some slices of bread and placed in the toaster. Staff E grabbed a plate from the plate warmer. Staff E plated a scoop of scrambled eggs and arranged them on the plate with their gloved hands. Staff E grabbed the toasted bread from the toaster cut it in half and placed on the plate.

In an observation on 07/25/2023 at 8:15 AM, Staff E went to the dishwasher. Staff E placed

a rack of dirty dishes inside of the dishwasher, closed the dishwasher door to run the wash cycle. Staff E returned to the hot table and serving bar. Staff E grabbed a plate from the plate warm, scooped a spoon full of scrambled eggs and placed on the plate. Staff E touched the scrambled eggs to keep them on the plate together. Staff E grabbed three pieces of cooked bacon with their gloved hand and placed it on the plate with the scrambled eggs. Staff E grabbed with their gloved hand two pieces of toasted bread and placed them on the plate. Staff E placed the plated food on the serving shelf for the caregivers to deliver to the resident. Staff E continued to dish food onto two other resident's plates and make more toasted bread.

As of 07/25/2023 at 8:31 AM, Staff E had not changed their gloves or washed their hands in between tasks since last observed at 8:05 AM.

In an interview on 07/26/2023 at 1:43 PM, Staff F, stated they had not participated in any trainings by the facility about COVID-19 precautions and guidance, handwashing, use of PPE, and infection control and prevention.

In an interview on 07/27/2023 at 1:18 PM, Staff I stated they hadn't participated in a training by the facility about hand washing or infection control since last time they had COVID-19 earlier this year 2023.

This is a recurring deficiency previously cited on 01/23/2023 and 11/22/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Snather
Administrator (or Representative)

9/11/23
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special

needs;

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

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to update and implement their policy for infection control and respiratory illness pandemic, failed to develop a policy for the facility to have a respiratory protection program, and failed to implement their call light policy for 1 of 1 facility reviewed. This failure placed 52 of 52 residents and 26 staff members at risk of not having the proper guidance, training, personal protective equipment (PPE), and the risk to expose and continue the spread of an infectious communicable disease during an outbreak, and placed residents at risk of unmet care needs.

Findings included...

Record review of the Centers for Disease Control and Prevention's (CDC) document, titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019(COVID-19 [a respiratory illness]) Pandemic", updated 05/08/2023, showed the end of the federal COVID-19 Public Health Emergency (PHE) on May 11, 2023, and the CDC would no longer receive data needed to publish community transmission levels for SARS-CoV-2. The metric informed CDC's recommendations for broader use of source control in healthcare facilities to allow for earlier intervention, to avoid strain on a healthcare system, and to better protect individuals seeking care in these settings. Without the Community Transmission metric, healthcare facilities should identify local metrics that could reflect increasing community respiratory viral activity to determine when broader use of source control in the facility might be warranted.

Record review of the Dear Provider Letter (DPL) ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal Protective Equipment (PPE)", dated 04/30/2021, directed Long Term Care Facilities (LTCF) under WAC 296-842-12005 to develop and maintain a respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) 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 CDC guidance. Facilities were asked to revise their policies to reflect the updated guidance by 05/01/2023. Facilities may create their own policies that require staff and ask residents and visitors to wear a face covering, as long as they were at least as stringent as DOH and 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 Washington State Department of Health (DOH) document, "SARS-CoV2-2 [Corona Virus Disease 2019 (COVID-19) Infection Prevention and Control in Healthcare Settings Toolkit", dated June 2023, showed healthcare settings may use the toolkit to create flexible policies specific to their facility based on their individual risk assessment following CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Under the section titled, "Background and Purpose", showed the resources in the toolkit were tools that the facility could use to guide them to stay in line with the regulatory agency such as Washington State Labor and Industries, Washington State Department of Social and Health Services (DSHS), and DOH-Health Systems Quality Assurance (HSQA). When the facility creates their policy and procedures, healthcare settings should ensure they met regulatory requirements. Under the section, "PPE and Transmission-Based Precautions (TBP)", showed facilities should adhere to standard precautions and follow PPE recommendations according to TBP. When caring for patients with confirmed or suspected COVID-19, health care provider (HCP) must wear appropriate PPE that included national institute of occupational health and safety (NIOSH) approved respirator, gloves, gowns, and eye protection. Under the section titled, "Aerosol-generating Procedures (AGP)", showed facility's should include procedures that generate aerosol's (a suspension of particles or droplets in the air that includes airborne dust, viruses, mists, fumes, or smoke) into their respiratory protection plan and facility risk assessment.

Record review of the WA DOH document, titled, "Respiratory Protection Program for Long-Term Care Facilities", undated, showed "Providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department of Labor and Industries (L&I). Employers have an obligation to protect their employees from hazards in the workplace (General Duty WAC 296-126-094). In healthcare facilities, the tight-fitting disposable 'N95' respirator is a commonly used for respiratory protection. Respirator fit testing ensures that tight-fitting respirators seal properly, and helps protect employees from exposure to airborne particles such as viruses and bacteria. Keep your employees safe and working by getting them fit tested and ready to properly use a respirator."

Record review of the facility's policy, titled, "Respiratory Illness Outbreak", dated 12/15/2021, showed the facility would follow guidelines and recommendations from the CDC and the state and local public health department. If COVID-19 was suspected in either a resident or staff member the facility would review the recommendations contained in the "Coronavirus/COVID-19 Preparedness and Response Plan. The plan was based on the CDC recommendations and was periodically updated. The policy showed "due to the emergence of COVID-19, additional precautions should be taken, such as screening visitors and encouraging social distancing". The facility was to provide visitors with written instructions (respiratory hygiene/cough etiquette) about the precautions implement by the facility. Visits to the symptomatic residents were to be limited to essential visits (e.g., home health,

end of life, etc.) Under the section, "Resident Illness Intervention Protocol", showed due to the emergence of COVID-19, any staff exhibiting flu-like symptoms should be presumed to be infected with COVID-19 until confirmed otherwise by testing or other recommended methods. If a resident has signs or symptoms of a respiratory illness, staff would follow standard, contact, and droplet precautions. They would isolate the resident to their apartment and use the appropriate PPE that included gloves, disposable gown, mask, and eye protection anytime staff enter the apartment or otherwise have contact with the resident. As soon as a resident develops symptoms of respiratory illness the resident and if a roommate that was exposed would remain in their room, do not attend group activities, received meals in their room for seven days after the onset of symptoms or 24 hours after the resolution of symptoms, whichever was longer. All staff would be trained on hand hygiene, standard precautions, contact precautions, droplet precautions, and the use of PPE. Under the section titled, "Visitor Precautions and Protocol", showed visits to symptomatic residents should be limited to essential visits. The policy showed under "on-going communications", the executive director (ED) or designee would maintain a record of all contacts with local, state, and CDC officials and any directions given by the parties.

Record review of the facility's policy, titled, "Respiratory Illness Pandemic", dated 12/15/2021, showed staff, residents, and families would be informed of respiratory illness pandemic prevention plan. If the facility determined that a resident had a pandemic respiratory illness virus the ED would contact the public health department to notify them of the infection.

Record review of the facility's policy, titled, "Pendant/Pull Cord", dated 08/10/2021, showed "The Community will make available emergency call device to each resident and in the common areas. Resident Care Assistants and staff will monitor pagers and work stations for alerts. Resident Care Assistants and staff will respond to the alerts."

Policy

Record review of an email sent by Staff D, Western Washington Clinical Services Director Registered Nurse Delegator, to the Department on 07/26/2023 at 1:05 PM, showed there was no facility policy for the facility's RPP. Staff D attached the WA DOH document titled, "Healthcare Guidance Updated Part 2, Healthcare-Associated Infections and Antimicrobial Resistance", undated, for review.

Record review of an email sent to the Department on 07/26/2023 at 10:35 PM, showed the facility followed the WA DOH guidelines for the RPP. That was their policy.

In an interview on 07/24/2023 at 1:17 PM, Staff B, Resident Care Director/Registered Nurse, stated there was one resident that had tested positive with COVID-19 on 07/23/2023. Staff B was unaware if the local public health department had been contacted.

Record review of the Departments database on 07/24/2023 at 1:20 PM, showed the Department had not been notified by the facility of the positive COVID-19 resident case.

In an interview on 07/24/2023 at 1:27 PM, Staff B stated they were unaware of the facility's policy in relation to a positive COVID-19 resident's case in the facility. Staff B stated that there was no signage posted, nor was there a system in place to notify the visitors, other residents, and staff members that there was a positive COVID-19 resident case within the facility.

In an interview on 07/24/2023 at 1:32 PM, Staff A, ED, stated the residents had tested positive on the night of the 07/22/2023. Staff A was unsure who had called the local public health department to notify them of the positive COVID-19 resident case. Staff A then stated that the local public health department had not been notified yet.

In an observation and interview on 07/24/2023 at 2:16 PM, outside the door of Resident 9's (R9) apartment showed they were on "aerosol precautions". There was no PPE cart or supplies at the door entry way or a trash can for staff to use. Staff B was unsure where the PPE supplies were for the staff to put to enter R9's room.

In an observation and interview on 07/24/2023 at 2:34 PM, Staff B state the PPE supplies designated for R9's room was stored in the double doors of a cabinet that was to the right of R9's door. Observation inside the double doors there were two shelves with multiple boxes of puzzles and board games. On top of the puzzles were two packages of disposable gowns, a plastic bin that had two face shields at the bottom and multiple N95 respirators stacked on top. There was one pair of disposable foot protection loosely stored on top of a puzzle. There were no boxes of gloves, trash bags, or hand sanitizer.

In an interview on 07/24/2023 at 4:16 PM, Collateral Contact 7 (CC7), daughter of Resident 11 (R11), stated they were not notified there was a positive COVID-19 resident case within the facility. CC7 stated they had visited R11 on Sunday 07/23/2023, and no one had informed them of the outbreak. CC7 stated if they would have known, they would have worn their facial mask. CC7 stated their sister, Collateral Contact 8 (CC8), daughter of R11, would have told CC7 if they were notified by the facility that there was active COVID-19 cases.

In an interview on 07/24/2023 at 5:52 PM, Staff A stated they hadn't contacted the local public health department after R9 had tested positive for COVID-19. Staff B stated the last time they contacted the local public health department was two weeks prior when there were staff that had tested positive with COVID-19.

In an observation and interview on 07/24/2023 at 5:52 PM, Staff M, Business Office Manager (BOM), had stored some of the PPE supplies in the business office. There was no supply of face shields in the office. Staff M stated that Staff C, Resident Care Coordinator was responsible to order all of the PPE supplies.

In an interview on 07/25/2023 at 8:43 AM, Resident 13 (R13) stated they were notified by Resident 37 that there was a resident positive with COVID-19 within the facility.

Record review of an email sent to the Department by Staff A on 07/25/2023 at 12:49 PM, of the facility's most updated infection control and respiratory protection policy showed the policy titled, "Infection Control 18- Respiratory Illness Pandemic", dated 12/15/2021, was provided.

In an interview on 07/26/2023 at 12:36 PM, Staff A stated they had to review the infection control policy that was sent by them on 07/25/2023 to ensure that it was the most updated policy. Staff A reviewed the policy that was sent and stated they weren't sure if it was the updated version of the policy.

In an interview on 07/26/2023 at 12:39 PM, Staff A stated that there were no visitors allowed into R9's room except the staff with appropriate PPE on. Staff A was unable to provide how often the facility provided infection control, PPE usage, and hand hygiene education and in-servicing with the facility staff.

In an observation and interview on 07/26/2023 at 1:01 PM, Staff A showed Staff D the facility's policy titled, "Infection Control 18- Respiratory Illness Pandemic", dated 12/15/2021. Staff A stated that was not the current policy and that they updated it and go by the WA DOH guidance.

Call Lights

In an interview on 07/24/2023 at 6:19 PM, Staff B, Resident Care Director, stated five minutes was the time goal for facility staff to respond to a call light after a resident pushed it.

In an interview on 07/27/2023 at 1:13 PM, Staff I, Mediation Technician, stated the expected time to answer a residents call for assistance was three minutes. Staff I stated if they were unable to answer within that time frame, they were to call out on their radio's that the residents room number needed to be checked on.

In an interview on 07/24/2023 at 3:00 PM, R13 expressed concern that the night shift did not answer call lights in a timely matter. R13 recalled a time when they pressed their call light at 3:00 AM and did not get a response until 6:00 AM. R13 expressed concern that their call light was broken.

In an interview on 07/24/2023 at 3:00 PM, Resident 10 (R10) expressed concern regarding long wait times after they pushed their call light after a fall. R10 stated that they used their walking cane to bang on the wall which alerted staff to enter their room and provide them assistance. R10 expressed concern that their call light was broken.

In an interview on 07/24/2023 at 3:00 PM, Resident 20 (R20) stated after they experienced a fall, they did not use their call light to summon facility staff. R20 stated they crawled on the ground to their wheelchair to get themselves off the ground. R20 stated there was no point in using the call light because they thought staff would not respond.

In an interview on 07/27/2023 at 2:16 PM, Resident 4 (R4) stated the staff at the facility were spread thin. R4 stated the staff did not answer call lights in a timely manner.

Record review of the facility's Statistical Call Analysis, dated 07/23/2023, showed Resident 16 (R16) pressed their pendant at 6:45 AM and the response time was 99 minutes and 59 seconds. R16 pressed their pendant at 1:24 PM and the response time was 79 minutes and 19 seconds.

Record review of the facility's Statistical Call Analysis, dated 11/28/2022, showed Resident 6 (R6) pressed their pendant at 10:58 AM and the response time was 27 minutes and 14 seconds.

Record review of the facility's Statistical Call Analysis, dated 02/03/2023, showed R6 pressed their pendant at 5:32 PM and the response time was 30 minutes and 39 seconds.

In an interview on 07/25/2023 at 10:17 AM, R6 expressed concern about long call wait times at night.

In an interview on 07/25/2023 at 10:11 AM, R7 stated they had a fall a few days ago. R7 stated they had pushed their call light pendant to get assistance. R7 stated it took 20 minutes for them to come respond and check on R7.

Record review of the facility's Statistical Call Analysis, dated 07/22/2023, showed Resident 7 (R7) pressed their pendant at 8:52 AM and the response time was 38 minutes and 40 seconds.

Record review of the facility's Statistical Call Analysis, dated 07/25/2023, showed R7 pressed their pendant at 9:03 PM and the response time was 31 minutes and 54 seconds.

In an interview on 08/04/2023 at 11:03 AM, Collateral Contact 1, Case Manager, stated residents had expressed their concerns to them about long call wait times at the facility.

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

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report potential abuse, neglect, and exploitation incidents to the Complaint Resolution Unit (CRU) for 5 of 7 sampled residents (Resident 6, Resident 8, Resident 16, Resident 17, and Resident 20). This failure to notify CRU placed all 52 of 52 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 policy, titled, "Elder Abuse, Neglect, and Exploitation", dated 12/15/2021, showed all staff were mandated reporters. "If any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of any incident which appears to be any form of abuse, the incident will be immediately reported to the Wellness Director. If the Wellness Director is not available, the incident will be reported to the Executive Director... Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted... A thorough investigation will be conducted by the Wellness Director or Executive Director... If the potential abuse involves any missing resident property, an Incident Report will be completed to document any missing property... Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements."

Resident 16 (R16) and Resident 17 (R17)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 03/16/2023, showed R17 expressed concern their roommate R16 went through their belongings. R17 expressed concern R16 stole their clothes while they were at the hospital. The action taken section showed Staff S, Former Health Services Director, talked with R17 and R16 about the incident. Staff S wrote they talked with R17's family and determined R17 did not have the items they claimed were missing. The form indicated the concern and grievance were resolved. Staff A, Executive Director signed off on the document on 03/17/2023.

In an interview on 07/31/20203 at 11:00 AM, Staff O, Caregiver, expressed concern that R17 was bullied by their roommate R16. Staff O stated R17 repeatedly expressed their concern that they thought their roommate R16 was stealing from them. Staff O stated this concern had been reported to Staff A on multiple occasions. Staff O stated R17 and R16 had requested room moves on multiple occasions because they did not want to live with each other. Staff O stated the facility staff did nothing to intervene regarding R16 and R17 concerns.

In an interview on 07/26/2023 at 1:43 PM, Staff F, Caregiver, stated they had observed R16 and R17 yell at each other often and accused each other of stealing their personal belongings. Staff F stated they reported it to Staff A and kept R16 and R17 on their own side of the room they shared.

In an interview on 07/27/2023 at 12:10 PM, Staff A stated R16 and R17 had an off again on again roommate relationship. Staff A stated sometimes the residents got along whereas other times they did not. Staff A stated Staff S had mentioned to them there were concerns regarding theft amongst the residents.

Record review of the Departments data base showed the incidents between R16 and R17 had not been reported to the Department.

In an interview on 07/27/2023 at 12:12 PM, Staff D, Western Washington Clinical Services Director Registered Nurse Delegator, stated the facility would follow up and report the incident to CRU.

In an interview on 07/27/2023 at 1:55 PM, Staff Y, Senior Executive Director, expressed understanding that the facility needed to report the incident to CRU.

Resident 8 (R8) and Resident 15 (R15)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 05/29/2023, showed R8 expressed concern that after bingo they had gotten into a verbal argument with R15. R8 stated R15 cursed at them and R8 reported they called R15 names back. R8 stated they tried to explain what happened to Staff L, Activities, and that Staff L walked away while shaking their head. R8 wrote "I guess that will end my bingo". The action taken section showed Staff A talked to R8 and R15 and the residents agreed to avoid each other, not make disrespectful comments towards one another, and contact a facility staff member if they had any further issues with each other. The form indicated the concern and grievance was resolved. Staff A signed off on the document on 05/31/2023.

In an interview on 07/26/2023 at 3:54 PM, R8 stated R15 yelled at them, and they got in a verbal altercation with each other. R8 stated Staff L had been present during the altercation. R8 stated Staff L and R15 went into the office together. R8 stated they cannot participate in activities in the facility because R15 would curse at them. R8 stated that in the past R15 had destroyed their artwork on their room door by drawing over it.

In an interview on 07/25/2023 at 10:11 AM, R7 stated they heard R15 scream and curse at R8 down the hallway one week ago. R7 stated they were in their room with the door closed and could hear what R15 was saying to R8 clearly. R7 stated R15 had called R8 a "f**ker". R7 stated it made them feel uncomfortable and anxious.

Record review of the Departments data base showed the incidents between R8 and R15 had not been reported to the Department.

In an interview on 07/27/2023 at 12:12 PM, with Staff A and Staff D, Staff A stated there was a grievance report made between R8 and R15. Staff A stated the residents decided the resolution would be for the residents to not be around each other or look at each other. Staff A stated R8 stated R15 ripped up their drawings. Staff A stated R15 stated they did not rip up R8's drawings. Staff A stated they did not have proof of what happened. Staff A stated both R8 and R15 were upset about the incident. Staff A stated they were not aware R8 showed fear around R15. Staff A stated they were not aware that R8 stopped participating in activities because of the incident. Staff D stated what happened between R8 and R15 would be considered a resident to resident altercation. Staff D stated the facility would follow up with a report to CRU.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding that the facility needed to report the incident to CRU.

R8 Missing Item

In an interview on 07/24/2023 at 3:00 PM, R8 stated they admitted into the facility in [REDACTED] 2023. R8 stated a few months after their admission they had moved rooms. R8 stated after their room move their limited edition Nintendo switch (video game console) went missing. R8 stated after their Nintendo switch went missing, they saw Staff Q, Caregiver, play a limited edition Nintendo switch that looked like the one they were missing. R8 was under the impression that Staff Q stole their Nintendo switch.

In an interview on 07/26/2023 at 3:54 PM, R8 stated they reported to Staff I, Caregiver, their Nintendo switch went missing after their room move. R8 stated Staff I inquired with them about the color of their Nintendo switch and stated they saw Staff Q play with a switch that matched the description of R8's missing item. R8 reported their Nintendo Switch missing to Staff A. R8 stated staff A stated they would investigate their concern. R8 stated Staff A never followed back up with them regarding their missing Nintendo Switch.

In an interview on 07/27/2023 at 12:07 PM, Staff A stated they were aware there was a conversation between R8 and Staff Q having the same Nintendo switch. Staff A stated they talked to R8 and Staff Q regarding the concern. Staff A stated they informed Staff Q to not bring in their Nintendo switch to work. Staff A stated they were not aware that R8 reported

their Nintendo switch as stolen.

Record review of the Departments data base showed R8's concern of their missing Nintendo switch had not been reported to the Department.

In an interview on 07/27/2023 at 12:12 PM, Staff D, stated the facility would follow up with a report to CRU.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding the facility needed to report the incident to CRU.

Resident 20 (R20) and Resident 6 (R6)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 03/03/2023, showed R20 convinced R6 that they were an employee at the facility. "[R20] did not necessarily bully [seeking to harm, intimidate, or coerce someone perceived as vulnerable] [R6] but [R20] did confuse and manipulate [R6]."

Record review of the Departments data base showed the incident between R6 and R20 had not been reported to the Department.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding that the facility needed to report the incident to CRU.

R20 and Resident 17 (R17)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 06/16/2023, showed that multiple residents witnessed R20 bully R17 in the dining room. R20 called R17 a slob and that they did not want R17 sitting at their table.

Record review of the Departments data base showed the incidents between R17 and R20 had not been reported to the Department.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding that the facility needed to report the incident to CRU.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Lebbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
- (4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for incidents jeopardizing residents' health for 7 of 7 sampled residents (Resident 6, Resident 7, Resident 8, Resident 15, Resident 16, Resident 17, and Resident 20). These failures resulted in residents not being protected from potential abuse, neglect, and theft.

Findings included...

Record review of the facility's policy, titled, "Internal Incident Report and State Incident Report", dated 08/10/2021, showed, "Injury and unusual incidents will be reported in compliance with state regulatory requirements...An internal Incident Report is completed by staff for all unusual occurrences, injury, and incidents...Incidents are reported immediately to family/responsible party and physician. Document the date and time the report was made to the family/responsible party and physician in the narrative charting section...All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman, state licensing agency, and in the case of assault (physical or sexual), to local law enforcement..."

Record review of the facility's policy, titled, "Elder Abuse, Neglect, and Exploitation", dated 12/15/2021, showed all staff were mandated reporters. "If any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of any incident which appears to be any form of abuse, the incident will be immediately reported to the Wellness Director. If the Wellness Director is not available, the incident will be reported to the Executive Director...Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted...A thorough investigation will be conducted by the Wellness Director or Executive Director...If the potential abuse involves any missing resident property, an Incident Report will be completed to document any missing property...Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements."

Record review of Assisted Living Facility Guidebook, dated February 2018, showed "All alleged incidents of abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation must be thoroughly investigated. The investigation is done to determine: What occurred; and To make necessary changes to the

provision of care and services to prevent reoccurrence.”

Resident 16 (R16) and Resident 17 (R17)

Record review of the facility’s Resident/Family Concern/Grievance Form, dated 03/16/2023, showed R17 expressed concern their roommate R16 went through their belongings and stole their clothes while they were at the hospital. The action taken section showed Staff S, Former Health Services Director, talked with R17 and R16 about the incident. Staff S wrote they talked with R17’s family and determined R17 did not have the items they claimed were missing. The form indicated the concern and grievance were resolved. Staff A, Executive Director, signed off on the document on 03/17/2023.

In an interview on 07/31/2023 at 11:00 AM, Staff O, Caregiver, expressed concern that R17 was bullied by their roommate R16. Staff O stated R17 repeatedly expressed their concern that they thought their roommate R16 had stolen from them. Staff O stated this concern had been reported to Staff A, Executive Director (ED) on multiple occasions. Staff O stated R17 and R16 had requested room moves on multiple occasions because they did not want to live with each other. Staff O stated the facility staff did nothing to intervene regarding R16 and R17 concerns.

In an interview on 07/27/2023 at 12:10 PM, Staff A, ED, stated R16 and R17 had an off again on again roommate relationship. Staff A stated sometimes the residents got along whereas other times they did not. Staff A stated Staff S had mentioned to them there were concerns regarding theft amongst the residents.

In an interview on 07/27/2023 at 12:12 PM, Staff D, Western Washington Clinical Services Director Registered Nurse Delegator, stated the facility would follow up with a completed Internal Incident Report.

In an interview on 07/27/2023 at 1:55 PM, Staff Y, Senior Executive Director, expressed understanding that an Internal Incident Investigation needed to be completed for R16 and R17.

In an interview on 07/26/2023 at 1:43 PM, Staff F, Caregiver, stated they had observed R16 and R17 yell at each other often and accused each other of stealing their personal belongings. Staff F stated they reported it to Staff A and kept R16 and R17 on their own side of the room they shared.

As of 07/27/2023 there was no record to review that that facility completed an Internal Incident Report that showed documentation of the investigation that R16 and R17 accused each other of stealing. There was no documentation of the investigation that R17 was bullied by R16. There was no documentation that the facility determined the circumstance of the events, that the facility put measures in place to prevent similar situations from happening and protected the residents during the investigations.

Resident 8 (R8) and Resident 15 (R15)

Record review of the facility’s Resident/Family Concern/Grievance Form, dated 05/29/2023, showed R8 expressed concern that after bingo they had gotten into a verbal

argument with R15. R8 stated R15 cursed at them and R8 reported they called R15 names back. R8 stated they tried to explain what happened to Staff L, Activities, and that Staff L walked away while shaking their head. R8 wrote "I guess that will end my bingo". The action taken section showed Staff A talked to R8 and R15 and the residents agreed to avoid each other, not make disrespectful comments towards one another, and contact a facility staff member if they had any further issues with each other. The form indicated the concern and grievance was resolved. Staff A signed off on the document on 05/31/2023.

In an interview on 07/26/2023 at 3:54 PM, R8, stated R15 yelled at them, and they got in a verbal altercation. R8 stated Staff L had been present during the altercation. R8 stated Staff L and R15 went into the office together. R8 stated they could not participate in activities in the facility because R15 would curse at them. R8 stated that in the past R15 had destroyed their artwork on their room door by drawing over it.

In an interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated they heard R15 scream and curse at R8 down the hallway one week ago. R7 stated they were in their room with the door closed and could hear what R15 was saying to R8 clearly. R7 stated R15 had called R8 a "f**ker". R7 stated it made them feel uncomfortable and anxious.

In an interview on 07/27/2023 at 12:12 PM, with Staff A and Staff D, Staff A stated there was a grievance report made between R8 and R15. Staff A stated the residents decided the resolution would be for the residents to not be around each other or look at each other. Staff A stated R8 stated R15 ripped up their drawings. Staff A stated R15 stated they did not rip up R8's drawings. Staff A stated they did not have proof of what happened. Staff A stated both R8 and R15 were upset about the incident. Staff A stated they were not aware R8 showcased fear around R15. Staff A stated they were not aware that R8 stopped participating in activities because of the incident. Staff A stated an Internal Incident Report was not completed regarding these matters. Staff D, stated what happened between R8 and R15 would be considered a resident to resident altercation. Staff D stated the facility would follow up with a completed Internal Incident Report and report.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding that an Internal Incident Investigation needed to be completed for R8 and R15.

As of 07/27/2023 there was no record to review that that facility completed an Internal Incident Report that showed documentation of the investigation regarding R8 and R15's resident to residents' altercations. There was no documentation to review that the facility determined the circumstance of the event, that the facility put measures in place to prevent similar situations and protected the residents during the investigation.

Resident 7 (R7)

In an interview on 07/25/2023 at 10:11 AM, R7 stated they heard R15 scream and curse at R8 down the hallway one week ago. R7 stated they were in their room with the door closed and could hear what R15 was saying to R8 clearly. R7 stated R15 had called R8 a "f**ker". R7 stated it made them feel uncomfortable and anxious.

As of 07/27/2023 there was no record to review that that facility completed an Internal Incident Report that showed documentation of the investigation regarding R8 and R15's resident to residents' altercations. There was no documentation to review that the facility determined the circumstance of the event, that the facility put measures in place to prevent

similar situations and protected R7, R8, and R15 during the investigation.

R8 Missing Item Investigation

In an interview on 07/24/2023 at 3:00 PM, R8, stated they admitted into the facility in [REDACTED] 2023. R8 stated a few months after their admission they had moved rooms. R8 stated after their room move their limited edition Nintendo switch (video game console) went missing. R8 stated after their Nintendo switch went missing, they saw Staff Q, Caregiver, play a limited edition Nintendo switch that looked like the one they were missing. R8 was under the impression that Staff Q stole their Nintendo switch.

In an interview on 07/26/2023 at 3:54 PM, R8, stated they reported to Staff I, Caregiver, their Nintendo switch went missing after their room move. R8 stated Staff I inquired with them about the color of their Nintendo switch and stated they saw Staff Q play with a switch that matched the description of R8's. R8 reported their Nintendo Switch missing to Staff A. R8 stated staff A stated they would investigate their concern. R8 stated Staff A never followed back up with them regarding their missing Nintendo Switch.

In an interview on 07/27/2023 at 12:07 PM, Staff A stated they were aware there was a conversation between R8 and Staff Q having the same Nintendo switch. Staff A stated they talked to R8 and Staff Q regarding the concern. Staff A stated they informed Staff Q to not bring in their Nintendo switch to work. Staff A stated they never completed an internal incident report regarding the concern. Staff A stated they were not aware that R8 reported their Nintendo switch as stolen.

In an interview on 07/27/2023 at 12:12 PM, Staff D, stated the facility would follow up with a completed Internal Incident Report regarding R8's concern their Nintendo switch was stolen.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding that an Internal Incident Investigation needed to be completed for R8's missing Nintendo switch.

As of 07/27/2023 there was no record to review that that facility completed an Internal Incident Report that showed documentation of the investigation regarding R8's concern their Nintendo switch was stolen. There was no documentation to review that the facility determined the circumstance of the event, that the facility put measures in place to prevent similar situations and protected the residents during the investigation.

Resident 20 (R20) and Resident 6 (R6)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 03/03/2023, showed R20 convinced R6 that they were an employee at the facility. "[R20] did not necessarily bully [R6] but [R20] did confuse and manipulate [R6]."

In an interview on 07/27/2023 at 1:55 PM, Staff Y, Senior Executive Director, expressed understanding that an Internal Incident Investigation needed to be completed for R6 and R20.

As of 07/27/2023 there was no record to review that that facility completed an Internal

Incident Report that showed documentation of the investigation regarding when R20 confused and manipulated R6. There was no documentation to review that the facility determined the circumstance of the event, that the facility put measures in place to prevent similar situations and protected the residents during the investigation.

R20 and Resident 17 (R17)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 06/16/2023, showed that multiple residents witnessed R20 bully R17 in the dining room. R20 called R17 a slob and that they did not want R17 sitting at their table.

In an interview on 07/27/2023 at 1:55 PM, Staff Y expressed understanding that an Internal Incident Investigation needed to be completed for R17 and R20.

As of 07/27/2023 there was no record to review that that facility completed an Internal Incident Report that showed documentation of the investigation regarding when R20 bullied R17. There was no documentation to review that the facility determined the circumstance of the event, that the facility put measures in place to prevent similar situations and protected the residents during the investigation.

This is a recurring deficiency previously cited on 04/26/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to address and resolve 9 of 9 residents (Resident 1, Resident 7, Resident 8, Resident 10, Resident 13, Resident 16, Resident 17, Resident 20, Resident 21) grievances. These failures resulted in residents having unresolved concerns, and placed the residents at risk for decreased quality of life.

Findings included...

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."

RCW 70.129.080 (3) Privacy in Communications. "The resident has the right to privacy in communications, including the right to: (3) Have reasonable access within a reasonable time to the use of a telephone and other communication equipment where calls can be made without being overheard."

Record review of the facility's Grievance Policy, undated, showed, "It is the policy of Ocean Shores Assisted Living that each resident, family member, and visitor has the right to voice grievances, concerns, and/or issues related to any avenues of service without reprisal or recrimination...Immediately notify a staff member of any grievance. They will provide you with a grievance form upon which you can document your concern...Upon receiving the written or oral grievance, the Executive Director will designate an appropriate department director to assess and respond to the grievance...The department director should complete a written response and return it to the Executive Director within five (5) working days...The Executive Director will promptly notify you by phone of the result and resolution of the grievance...If unsatisfied with the resolution or have further concerns, you may contact the Regional Director."

Reporting Grievances

In an interview on 07/24/2023 at 3:00 PM, Resident 20 (R20), stated they did not know the facility's process of how to report a grievance.

In an interview on 07/24/2023 at 3:00 PM, Resident 21 (R21), stated they admitted into the facility in [REDACTED] 2023. R21 stated they did not know who to report their concerns to. R21 stated they had been missing their bed spread since their admission. R21 stated if they knew how to report their concern they would.

In an interview on 07/24/2023 at 3:00 PM, Resident 13 (R13) informed R20 and R21 that there were grievance forms at the front desk by the administration office and that they could fill out the forms as needed to report their concerns.

Record review of the facility's Grievance Log, dated 12/27/2022 through 05/29/2023, showed there were 10 total grievances reported.

Resident 17 (R17)

Record review of the facility's Resident/Family Concern/Grievance Form, dated 03/16/2023, showed R17 expressed concern their roommate Resident 16 (R16) went through their belongings. R17 expressed concern R16 stole their clothes while they were at the hospital. The action taken section showed Staff S, Former Health Services Director, talked with R17 and R16 about the incident. Staff S wrote they talked with R17's family and

determined R17 did not have the items they claimed were missing. The form indicated the concern and grievance were resolved. Staff A, Executive Director signed off on the document on 03/17/2023.

In an interview on 07/31/2023 at 11:00 AM, Staff O, Caregiver, expressed concern that R17 was bullied by their roommate R16. Staff O stated R17 repeatedly expressed their concern that they thought their roommate R16 was stealing from them. Staff O stated this concern had been reported to Staff A on multiple occasions. Staff O stated R17 and R16 had requested room moves on multiple occasions because they did not want to live with each other. Staff O stated the facility staff did nothing to intervene regarding R16 and R17 concerns.

In an interview on 07/26/2023 at 1:43 PM, Staff F, Caregiver, stated they had observed R16 and R17 yell at each other often and accused each other of stealing their personal belongings. Staff F stated they reported it to Staff A and kept R16 and R17 on their own side of the room they shared.

In an interview on 07/27/2023 at 12:10 PM, Staff A stated R16 and R17 had an on again off again roommate relationship. Staff A stated sometimes the residents got along whereas other times they did not. Staff A stated Staff S had mentioned to them there were concerns regarding theft. Staff A stated they would have to go back and look at their notes for more information. Staff A stated they personally never heard R16 and R17 fight with each other.

Resident 8 (R8)

R8 Resident to Resident Grievance

Record review of the facility's Resident/Family Concern/Grievance Form, dated 05/29/2023, showed R8 expressed concern that after bingo they had gotten into a verbal argument with R15. R8 stated R15 cursed at them and R8 reported they called R15 names back. R8 stated they tried to explain what happened to Staff L, Activities, and that Staff L walked away while shaking their head. R8 wrote "I guess that will end my bingo". The action taken section showed Staff A talked to R8 and R15 and the residents agreed to avoid each other, not make disrespectful comments towards one another, and contact a facility staff member if they had any further issues with each other. The form indicated the concern and grievance was resolved. Staff A signed off on the document on 05/31/2023. The form did not address follow up for when R8 reported Staff L walked away from them and R8's statement about them no longer attending bingo.

In an interview on 07/26/2023 at 3:54 PM, R8 stated in the past R15 yelled at them and they got in a verbal argument. R8 stated Staff L had been present during the altercation. R8 stated Staff L and R15 went into the office together. R8 stated they could not participate in activities in the facility because R15 would curse at them. R8 stated that in the past R15 had destroyed their artwork on their room door by drawing over it.

In an interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated they heard R15 scream and curse at R8 down the hallway one week ago. R7 stated they were in their room with the door closed and could hear what R15 was saying to R8 clearly. R7 stated R15 had called R8

a “f**cker” R7 stated it made them feel uncomfortable and anxious.

In an interview on 07/27/2023 at 12:10 PM, Staff A stated there was a grievance report made about R8 and R15’s verbal altercation. Staff A stated the residents decided the resolution would be for the residents to not be around each other or look at each other. Staff A stated R8 stated R15 ripped up their drawings. Staff A stated R15 stated they did not rip up R8’s drawings. Staff A stated they did not have proof of what happened. Staff A stated both R8 and R15 were upset about the incident. Staff A stated they were not aware R8 showcased fear around R15. Staff A stated they were not aware that R8 stopped participating in activities because of the incident. Staff A stated the residents did not report their concerns to them.

Record review of the facility’s Grievance Log, dated 12/27/2022 – 05/29/2023, showed there were no grievance reports to review regarding the concern that R15 physically ripped up R8’s drawings of their door.

R8 Missing Item Grievance

In an interview on 07/24/2023 at 3:00 PM, R8 stated they admitted into the facility in [REDACTED] 2023. R8 stated a few months after their admission they had moved rooms. R8 stated after their room move their limited edition Nintendo switch (video game console) went missing. R8 stated after their Nintendo switch went missing, they saw Staff Q, Caregiver, play a limited edition Nintendo switch that looked like the one they were missing. R8 was under the impression that Staff Q stole their Nintendo switch.

In an interview on 07/26/2023 at 3:54 PM, R8, stated they reported to Staff I, Caregiver, their Nintendo switch went missing after their room move. R8 stated Staff I inquired with them about the color of their Nintendo switch and stated they saw Staff Q play a Nintendo switch that matched the description. R8 reported their Nintendo Switch missing to Staff A. R8 stated staff A stated they would look into their concern. R8 stated Staff A never followed back up with them regarding their missing Nintendo Switch.

Record review of the facility’s Grievance Log, dated 12/27/2022 – 05/29/2023, showed there were no grievance reports to review regarding R8’s missing Nintendo switch.

In an interview on 07/27/2023 at 12:07 PM, Staff A stated they were aware there was a conversation between R8 and Staff Q having the same Nintendo switch. Staff A stated they talked to R8 and Staff Q regarding the concern. Staff A stated they informed Staff Q to not bring their Nintendo switch to work. Staff A stated they never completed a grievance report regarding the concern. Staff A stated they were not aware that R8 reported their Nintendo switch as stolen.

Food

In an interview on 07/24/2023 at 3:00 PM, Resident 20 (R20), stated if residents did not show up within the hour time frame for meals, then they would not get anything to

eat. R20 stated if a resident did not like what was being served the alternative option was to have a peanut butter and jelly sandwich.

In an interview on 07/24/2023 at 3:00 PM, Resident 1 (R1), stated if they did not show up within the time frame for meals, they would only get a peanut butter and jelly sandwich to eat.

In an interview on 07/24/2023 at 3:00 PM, Resident 13 (R13), stated if they did not show up within the time frame for meals, they would only be offered a peanut butter and jelly sandwich to eat. R13 expressed concern that the facility ran out of food that was supposed to be served.

In an interview on 07/26/2023 at 12:45 PM, Staff A stated any leftover food from a prior meal, or a sandwich would be provided if a resident requested an alternative meal.

In an interview on 07/26/2023 at 12:47 PM, Staff A stated the residents had a lot of complaints about the food. Staff A stated a few months ago the facility decided to use the facility food supplier's menus. Staff A stated there hadn't been a change and residents continued to express complaints with the food.

In an interview on 07/24/2023 at 3:00 PM, Resident 10 (R10) stated they were unable to chew the food at times. R10 stated they would ask for a baked potato as an alternative. R10 stated Staff E told them they were unable to have the baked potato as an alternative. R10 stated Staff E told them, too many residents had asked them for a baked potato and was unable to provide them any longer. Resident 20 (R20) stated the facility had a rule that if you were served a meal that you didn't like, the alternative that was provided was a peanut butter and jelly sandwich.

In an interview on 07/24/2023 at 3:00 PM, Resident 21 (R21) expressed concern that the facility ran out of food that was supposed to be served. R21 stated the facility ran out of everyday items. R21 stated the facility did not currently have mustard.

In an observation and interview on 07/25/2023 at 7:05 AM, the kitchen refrigerator showed a dry erase board with a list of items on it. The list contained peaches, mandarins, onions, sanitizer, floor cleaner, 2 ounce portion cups, yogurt, coffee, bacon, ground beef, orange juice, cranberry juice, oatmeal, eggs, cookies. Staff E, Cook, stated the list of items were supplies the kitchen was out of and needed to be restocked. Staff E stated the kitchen received their supplies twice weekly.

In an interview on 08/04/2023 at 11:03 AM, Collateral Contact 1 (CC1), Case Manager for 42 facility residents, stated the largest concern they received from residents surrounded the food quality at the facility. CC1 stated some residents were going to the local food bank to supplement their food. CC1 stated it had been reported that items that were supposed to be served would prematurely run out of stock.

In an interview on 07/26/2023 at 3:54 PM, R8 stated the food that had been served to them was cold. R8 expressed concern they could not ask for food in between meals. R8 stated the facility provided peanut butter and jelly sandwiches to the residents. R8 stated to their knowledge the facility tried to save the peanut butter and jelly sandwiches for the diabetic (the body's inability to make enough insulin or use it as well as it should) residents. R8 stated the facility stated they would provide snacks at 8:30 PM, but they did not have them available. R8 stated the facility would run out of food that was supposed to be served. R8 stated the food quality at the facility was poor.

Record review of the facility's Grievance Log, dated 12/27/2022 – 05/29/2023, showed there was one grievance regarding dining that was reported on 12/27/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Lebbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-3040 Laundry.

- (2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:
 - (b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;
 - (c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;
 - (e) Have a utility sink and a table or counter for folding clean laundry.
- (6) The assisted living facility must locate laundry equipment in rooms other than those used for open food storage, food preparation or food service.
- (7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:
 - (a) Equipped with:
 - (i) A utility sink;
 - (b) Arranged to reduce the chances of soiled laundry contaminating clean laundry.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 1 laundry rooms were accessible to residents and had appropriate infection control practices to keep clean and soiled laundry separated. The facility failed to ensure the laundry room had a utility sink. The facility failed to keep food stored out of the laundry room. This failure resulted in 52 of 52 residents and 26 staff not having appropriate conditions to do laundry.

Findings included...

Record review of the facility's Residence and Care Agreement Washington, undated, showed "Laundry facilities are available for resident use. Laundry services are available for linens, wash cloths and towels on a weekly basis or more often as necessary to maintain cleanliness."

Laundry Room Accessible to Residents

In an observation on 07/24/2023 at 2:22 PM, the laundry room showed the in and out-door to get inside of the laundry room was locked.

In an interview on 07/24/2023 at 2:22 PM, Staff J, Medication Technician, stated the laundry room remained locked and residents would ask facility staff to open the doors when needed.

In an interview on 07/24/2023 at 2:25 PM, Staff B, Resident Care Director, stated any resident was able to do their own laundry. Staff B stated the laundry room doors were kept locked all the time and the staff would need to open the doors for the residents. Staff B stated residents used the laundry room on the weekends. Staff B stated the housekeeper was so busy with other residents' laundry during the week, that there was no time for the other residents to do their laundry.

In an interview on 07/24/2023 at 2:40 PM, Staff N, Housekeeping, stated the laundry room entrance door was broken. Staff N stated the residents would ask facility staff to open the doors due to the out-door remaining locked. Staff N stated residents were allowed to use the laundry room on the weekend. Staff N stated residents could not use the laundry room during the week because housekeeping was in and out of the laundry room throughout the weekdays.

In an interview on 07/24/2023 at 3:00 PM, Resident 20 (R20), stated that the laundry room was not accessible to residents who utilized wheelchairs. R20 stated some facility staff members helped assist residents with laundry whereas other staff members would not. R20 stated they were informed they were only allowed to do their laundry on the weekend.

In an interview on 07/24/2023 at 3:00 PM, Resident 10 (R10), stated residents were only

allowed to do their laundry on the weekends. R10 stated clothes were left in the washer and dryers which caused long wait times.

In an interview on 07/25/2023 at 2:32 PM, Staff M, Business Office Manager, stated the residents could use the washers and dryers at any time. Staff M stated it would be difficult for the residents to use the washers and dryers during the weekday because housekeeping did laundry during the week. Staff M stated some residents did laundry at night after housekeeping left or on the weekends.

In an interview on 07/26/2023 at 12:57 PM, Staff A, Executive Director, stated there was only one washer and one dryer that was working out of three washers and three dryers. Staff A stated the residents were allowed to do their personal laundry on Saturday or Sunday. Staff A was unsure if the residents were allowed to do their laundry throughout the week. Staff A stated residents were allowed to wash one full load of clothing and one full load of bedding and linens. Staff A stated that if the resident had more than two loads or needed to be washed more often, the facility would contact the family to assist, or a fee would be charged. Staff A stated they needed to look at the admission agreement to check what the extra laundry fee was.

In an interview on 07/26/2023 at 1:42 PM, Staff N, Housekeeping, stated residents were allowed to do their laundry on the weekends. Staff N stated since they had to use the washers and dryer during the week there was too much going on for the residents to do their laundry. Staff N stated residents would not fit inside of the laundry room because there was not enough space. Staff N stated there were multiple laundry baskets on the floor and laundry in the washers and dryer that prevented the room from being accessible.

In an observation on 07/26/2023 at 2:13 PM, the laundry room showed two laundry carts by the outdoor way. There were eight laundry baskets of clean and soiled laundry located in various places on the floor. There were boxes on the floor that contained a variety of linens.

Clean and Soiled Laundry

In an interview on 07/24/2023 at 2:20 PM, Staff B stated any resident was able to do their own laundry. Staff B stated the laundry doors were locked all the time and the staff would need to open the doors for the residents.

In an observation and interview on 07/24/2023 at 2:22 PM, Staff B attempted to put the key into the door lock on the entrance door to the laundry room. Staff B was unable to insert the key inside. Staff J, Medication Technician, stated there was a broken key inside the lock and was unable to open the "in" (entrance) door to the laundry room. Staff J stated the key had been broke off in the door lock for a while.

In an interview on 07/24/2023 at 2:22 PM, Staff J stated a key broke inside of the laundry room in door. Staff J stated residents accessed the laundry room through the out-door.

In an observation on 07/24/2023 at 2:23 PM, the laundry room showed the right side of the laundry room had three washing machines and the left side of the laundry room had three drying machines. There was tape on the floor that indicated the right side of the room was the soiled side and the left side of the room was the clean side. For facility staff and residents to enter the laundry room they had to bring their soiled laundry through the clean side of the room to get to soiled side of the room where the washing machines were located.

In an interview on 07/24/2023 at 2:40 PM, Staff N stated the laundry room in door was broken. Staff N stated the residents and staff would enter the laundry room through the out-door.

In an interview on 07/27/2023 at 11:54 AM, Staff A stated they were aware the in- door to the laundry room had been broken. Staff A stated facility staff and residents were using the out- door to enter the laundry room.

Food Storage

In an observation on 07/24/2023 at 2:30 PM, the laundry room showed inside the cabinets had a bucket of jolly rancher candy and double cheese chips. In another cabinet there were three packages of gram crackers.

In an interview on 07/24/2023 at 2:30 PM, Staff B, Resident Care Director, stated food should not be in the laundry room.

Utility Sink

In an interview on 07/26/2023 at 1:42 PM, Staff N stated there was not a utility sink in the laundry room for residents and staff to utilize.

In an observation on 07/26/2023 at 2:13 PM, the laundry room showed there was not a utility sink for residents and staff to utilize.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 5 of 5 sampled pets (Resident 5's pet, Resident 12's pet, Resident 13's pet, Resident 14's pet, and Resident 15's pet) and all other pets on the premises had regular examinations and were certified by a veterinarian to be free of diseases transmittable to humans. This failure placed 52 of 52 residents and 26 staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility's Pet Policy, undated, showed, "A certificate signed by a licensed veterinarian or a State or local authority employer to inoculate [immunize] animals (or designated agent of such authority) stating that the pet has received all inoculations required by applicable State and local law... Dogs must be vaccinated in accordance with the appropriate State and local laws. This includes ... rabies ... shots as needed."

Record review of the facility's Visiting Pets Policy, dated 08/10/2021, showed "Visiting pets or "therapy animals" will be permitted providing the handlers adhere to the following guidelines: A) Animals are required to be in good health, certified by a veterinarian. B) Copies of current veterinarian health certificates are to be maintained on file at the community. C) All vaccinations and local licensing requirements are met..."

Resident 5 (R5)

Record review of Medical Notes for R5's dog [REDACTED], dated 09/07/2022, showed [REDACTED] was last seen for an examination on 11/17/2021. The notes showed R5's dog had a rabies vaccination on 11/17/2021 and it was valid for one year.

Resident 12 (R12)

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

Record review of the facility's pet binder, undated, showed there was no documentation of R12's unidentified pet named [REDACTED] current examination on file to review.

Resident 13 (R13)

Record review of the facility's pet binder, undated, showed there was no documentation of R13's cat [REDACTED] current examination on file to review.

Resident 14 (R14)

Record review of Veterinary Center document, dated 02/15/2021, showed R14's dog [REDACTED] was last seen for a semiannual health exam on 02/15/2021.

In an observation on 07/24/2023 at 12:25 PM, [REDACTED] the dog was with R14 in the community common living room.

Resident 15 (R15)

Record review of the facility's pet binder, undated, showed there was no documentation of R15's Cat [REDACTED] current examination on file to review.

In an observation and interview on 07/24/2023 at 6:10 PM, showed Staff B's, Resident Care Director, dog [REDACTED] was in the business office manager's office. Staff B stated their dog came to work with them. Staff B had a dog carrier for their dog to use as needed.

In an interview on 07/25/2023 at 1:00 PM, Staff B stated they did not have their dog [REDACTED] immunizations and examination records available to review.

In an interview on 07/25/2023 at 3:20 PM, Staff A, Executive Director stated they would provide additional pet records to review no later than 07/26/2023 by 8:00 AM.

In an interview on 07/26/2023 at 11:52 AM, Staff L, Activities, stated they were responsible for the upkeep of the facility's pet record binder. Staff L stated that they were unaware the residents were supposed to provide a copy of their pet's annual examination.

As of 07/31/2023 no additional pet records were provided to review.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Jebbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

- (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; and
- (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 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..."

Record review of facility's Residence and Care Agreement Washington, undated, showed the Medicaid information was not written on a page that was separate from other documents, written in at least 14 point font, and did not have a section for the resident or resident representative to sign.

In an interview on 07/25/2023 at 3:20 PM, Staff A, Executive Director, stated the section that covered Medicaid information was in the resident's admission agreement.

Resident 1 (R1)

Record review of R1's Face Sheet, undated, showed R1 admitted into the facility on [REDACTED]/2015. The face sheet showed the responsibility party section for R1 was blank.

Review of R1's Residence and Care Agreement Washington, Medicaid Addendum, showed it was not written on a page that was separate from other documents, written in at least 14 point font, and did not have a section for the resident or resident representative to sign.

Resident 2 (R2)

Record review of R2's face sheet showed R2 moved into the facility on [REDACTED]/2006. The face sheet showed R2 had a niece that was their responsible party and their power of attorney.

Review of R2's Residence and Care Agreement Washington, Medicaid Addendum, showed it was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 3 (R3)

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on [REDACTED]/2018. The face sheet showed under responsible party Collateral Contact 3 (CC3) was R3's Power of Attorney.

There was no record provided to review regarding R3's Residence and Care Agreement Washington, Medicaid Addendum.

Resident 4 (R4)

Record review of R4's face sheet showed, R4 moved into the facility on [REDACTED]/2020. The face sheet showed the responsibility party section for R4 was blank.

Record review of R4's Home and Community Services Assessment Current Annual, dated 07/12/2023, showed Collateral Contact 10 (CC10), family of R4, was R4's durable power of attorney of healthcare and financial and emergency contact.

Review of R4's Residence and Care Agreement Washington, Medicaid Addendum, showed it was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

Resident 5 (R5)

Record review of R5's face sheet showed they moved into the facility on [REDACTED]/2022. Collateral Contact 12 (CC12), son of R5, was listed as the responsible party for R5.

Review of R5's Residence and Care Agreement Washington, Medicaid Addendum, showed it was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident and/or the resident's representative.

Resident 6 (R6)

Record review of R6's Face Sheet, undated, showed R6 admitted into the facility on [REDACTED]/2022. Under responsible party showed Collateral Contact 2 (CC2) was R6's Power of Attorney.

Review of R6's Residence and Care Agreement Washington, Medicaid Addendum, showed it was not written on a page that was separate from other documents and written in at least 14 point font.

Resident 7 (R7)

Record review of R7's face sheet showed R7 moved into the facility on [REDACTED]/2023. The face sheet showed the responsibility party section for R7 was blank.

Record review of R7's Home and Community Services Assessment details, dated 05/26/2023, showed Collateral Contact 6 (CC6) daughter of R7, was the emergency contact and representative/protective payee for R7.

Review of R7's Residence and Care Agreement Washington, Medicaid Addendum, showed it was not written on a page that was separate from other documents, written in at least 14 point font, and was not signed and dated by the resident or resident representative.

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

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Hebbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 3 sampled staff (Staff A) had submitted a new Washington state name and background check every two years. This failure placed 52 of 52 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff A, Executive Director was hired on 06/01/2022.

Record review of Staff A's Washington state name and background check showed it was completed on 05/20/2021 and was valid through 05/20/2023.

In an interview on 07/25/2023 at 3:20 PM, Staff A stated they should have an updated background check to provide for review.

As of 07/31/2023 there were no further records provided to review that showed Staff A had a valid background check.

Statement of Deficiencies	License #: 2615	Compliance Determination #26995
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 48 of 154	Licensee: Greenlake Management Ocean Shores,	08/22/2023

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023.

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

Debbie Smathers
Administrator (or Representative)

9/13/2023
Date

WAC 388-78A-2040 Other requirements.

- (1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.
- (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 stay in compliance with the state Fire Marshal regulation codes related to maintaining fire extinguisher servicing. The facility also failed to have a system in place that prevented fire panels from being obstructed. Additionally, the facility failed to have a system in place to conduct routine fire drills and failed to secure oxygen cylinders. These failures placed 52 of 52 residents and 26 staff members life and safety at risk in the event of an emergency.

Findings included...

State Fire Marshall regulation code IFC 906.2 2015,2018

"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 the travel distance 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 three 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 NFPA10.

3. In Group 1-3, portable fire extinguishers shall be permitted to be located at staff locations."

State Fire Marshall regulation code IFC 0405.5 2018

"A working space of not less than 30 inches (762 mm [millimeter]) in width, 36 inches (914 mm) in depth and 78 inches (1981 mm) in height shall be provided in front of electrical service equipment. Where the electrical service equipment is wider than 30 inches (762 mm), the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. Exceptions: 1 Where other dimensions are required or allowed by NFPA 70. 2 Access openings into attics or under-floor areas that provided a minimum clear opening of 22 inches (559 mm) by 30 inches (762 mm)."

WAC 212-12-044 Fire drills. "In all Group I, Group E, and Group R2 Occupancies [including assisted living facilities] licensed by the state and inspected by the state fire marshal's office, at least twelve planned and unannounced fire drills shall be held every year."

State Fire Marshall regulation code IFC 0405.5 2018

"Records shall be maintained of required emergency evacuation drills and include the following information: 1. Identity of the person conducting the fire drill. 2. Date and time of the drill. 3 Notification method used. 4. Employees on duty and participating. 5. Number of occupants evacuated. 6. Special conditions simulated. 7. Problems encountered. 8. Weather conditions when occupants were evacuated. 9 Time required to accomplish complete evacuation."

State Fire Marshall regulation 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. "

Fire extinguishers

Record review of the facility's policy, Fire Extinguishers, undated, showed "It is the duty of the maintenance director to inspect fire extinguishers and arrange for annual inspection... At regular intervals, not exceeding one year apart or when specifically indicated by an inspection, extinguishers shall be thoroughly examined and/or recharged or repaired."

In an observation and interview on 07/24/2023 at 1:18 PM, the fire extinguisher next to the door that led to the back side of the facility showed it was last serviced February 2022. Staff G, Maintenance, stated that the facility fire extinguishers were supposed to be serviced yearly. Staff G stated they were working on finding out who was supposed to service the facility fire extinguishers because they were past due. Staff G stated they had just started checking the fire extinguisher monthly in May 2023.

In an observation on 07/24/2023 at 2:23 PM, the laundry room fire extinguisher showed it was last serviced in March 2022.

In an observation on 07/25/2023 at 7:08 AM, the kitchen fire extinguisher showed it was last serviced in February 2022.

In an observation on 07/25/2023 at 7:41 AM, in the kitchen next to the grill there was a class K fire extinguisher (a fire extinguisher that are designed to put out fires involving vegetable oils, animal oils, or fats utilized in commercial cooking appliances). The tag on the fire extinguisher showed it was last serviced in February 2021.

In an observation on 07/26/2023 at 1:10 PM, Staff A, Executive Director, opened the door to the maintenance office without the use of the key. Staff A was observed to pause and hesitate after the door was able to be opened without a key.

In an observation on 07/26/2023 at 4:00 PM, inside the maintenance office was a red fire extinguisher that was sitting on top of a two drawer metal filing cabinet unsecured.

Fire Panels

In an observation on 07/24/2023 at 12:58 PM, the housekeeping closet showed an electrical panel with a sign that read "do not block or store items on floor." There were three plungers and a blue stick that had a black plastic bag covering the top of it sitting in front of the electrical panel.

In an interview on 07/24/2023 at 12:58 PM, Staff B, Resident Care Director, stated that nothing was supposed to be on the floor in front of the electrical panel.

In an observation and interview on 07/26/2023 at 12:49 PM, the housekeeping room

showed a vacuum and mop that were placed in front of the electrical panel. Staff N, Housekeeping, stated that they knew the vacuum and mop were not supposed to be in front of the electrical panel. Staff N stated they were not the facility staff member who placed the items in front of electrical panel.

In an observation on 07/26/2023 at 3:55 PM, the electrical panel room showed an electrical panel with a sign that read "do not block." There was a chair placed in front of the electrical panel.

In an interview on 07/26/2023 at 3:55 PM, Staff M, Business Office Manager, stated the chair in front of the electrical panel should not be there.

Fire Drills

Record review of the facility's binder titled, "Fire Marshall and Life Safety Binder", showed the last recorded fire drill was during the night shift on 02/03/2023. The document showed there were three staff members that participated in the fire drill.

Record review of the facility's Fire Drill Noc (nocturnal) Shift, dated 02/03/2023, showed three facility staff members participated in the fire drill. There was no documentation to review that first shift and day shift staff participated in a February 2023 fire drill.

In an interview on 07/25/2023 at 2:32 PM, Staff M, Business Office Manager, stated they could not remember the last time they participated in a fire drill.

In an interview on 07/26/2023 at 1:42 PM, Staff N, Housekeeping, stated they could not remember the last time they participated in a fire drill.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff F, Caregiver, was hired on 05/22/2023.

In an interview on 07/26/2023 at 1:43 PM, Staff F stated they had not participated in a fire drill since that had been employed at the facility. Staff F stated they were unaware where to meet if the facility needed to be evacuated.

In an interview on 07/26/2023 at 4:40 PM, Staff A, Executive Director (ED) stated that maintenance staff were responsible for completing facility fire drills. Staff A was unsure of the timeframe of when the last fire drill occurred.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff G,

Maintenance, was hired on 05/22/2023.

In an interview on 07/31/2023 at 11:00 AM, Staff G stated they worked for the facility since May 2023. Staff G stated they never participated in a fire drill since they started working. Staff G stated they found paperwork in the maintenance office that indicated fire drills were supposed to take place monthly for morning, swing (a work shift from midafternoon to midnight), and night shift. Staff G stated they inquired with Staff A about how the fire drills were supposed to be completed. Staff G stated they were informed by Staff A not to worry about it.

In an interview on 07/31/2023 at 11:00 AM, Staff O, Caregiver, stated they had not participated in a fire drill since they started working for the facility.

Secured Oxygen Cylinders

In an observation on 07/27/2023 at 2:16 PM, Resident 4 had an oxygen cylinder behind their entry door that was lying up against the wall and the dresser unsecured.

In an interview on 07/26/2023 at 4:12 PM with Collateral Contact 9 (CC9), State Fire Marshall, stated the facility was required to have all oxygen cylinders and fire extinguishers secured. CC9 stated that all fire extinguishers were to be serviced yearly and checked monthly by the facility's maintenance staff. CC9 stated that facility was to conduct monthly fire drills.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-110-150 Assisted living service standards. In an assisted living facility with an assisted living contract, the contractor must meet the requirements of parts I and II of this chapter, and for residents served under the assisted living contract:

(1) Ensure that both the physical environment and the delivery of assisted living services are designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice and decision making of residents. The contractor must provide resident services in a homelike environment for residents who may have a range of needs and preferences.

(2) Must provide or arrange for, at no additional cost to the resident and consistent with chapter 388-78A WAC:

(c) Personal care services; and

(d) Supportive services that promote independence and self-sufficiency.

(4) Provide all residents with access to an on-site washing machine and dryer for resident use.

(5) Make beverages and snacks available to residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to maintain a home like environment for 8 of 8 sampled areas (activities room, lobby, common hallways, common courtyards, outside grounds, kitchen, maintenance, and laundry room). The facility also failed to provide services that reflected residents' choice and decision making regarding their care needs and failed to make beverages and snacks available. These failures resulted in 52 of 52 resident's experiencing a decreased quality of life while living at the facility.

Findings included...

WAC 388-110-020 Definitions

"Homelike" means an environment having the qualities of a home, including privacy, comfortable surroundings, and the opportunity to decorate one's living area and arrange furnishings to suit one's individual preferences. A homelike environment provides residents with an opportunity for self-expression, and encourages interaction with the community, family and friends.

Record review of the facility's Personal Rights policy, dated 08/10/2021, showed "Residents have a right to receive care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. A resident should have a safe, clean, comfortable, and homelife environment... Choose activities, schedules, and health care consistent with his or her interests... Make choices about aspects of his or her life in the facility that are significant to the resident..."

Record review of the facility's Green Lake Senior Living Ocean Shores Brochure, undated, showed "Our mission at Ocean Shores Assisted Living is to provide 24-hour personalized care to our residents in a caring, home-like environment... We offer a full range of services to help maintain your independence while giving you the assistance needed to ensure the quality of life you deserve. Our assisted living services are all-inclusive, which means we don't charge any additional level of care fees for our services."

Record review of the facility's Residence and Care Agreement Washington, undated, showed "Laundry services are available for linens, wash cloths and towels on a weekly basis or more often as necessary to maintain cleanliness. Personal laundry service will be provided for one load weekly. Additional laundry is available for an extra fee as set for in Appendix A." Appendix A Rate List as of 06/09/2023, showed personal laundry (Per Load) cost \$25.00. "Tray service. We will provide tray service to your Apartment during temporary illness, at no extra charge for up to 3 days. During other times, we will provide optional tray service to you at your request for an additional charge as set by the community." Appendix A Rate List as of 06/09/2023, showed tray service cost \$5.00 per tray.

Record review of the facility's policy titled, "Snacks", undated, showed "A selection of snack foods and beverages should be available around the clock in a convenient place." Examples of foods that can be available included crackers, chips, pretzels, fresh fruit, dried fruit, nuts, peanut butter, cheese, desserts, fruit juices, milk, coffee, and tea.

Record review of the facility's Green Lake Senior Living Ocean Shores Brochure, undated, showed their services included "Three chef-prepared meals served daily [and] snacks with special diets available."

Homelike Environment

Activities Room Environment

In an observation on 07/24/2023 at 12:10 PM, the activity room showed the right side of the doorway had multiple boxes and totes that were three quarters of the wall's height. The left side of the doorway showed there was a scale placed against the wall. The center of the room had a table with chairs. The table and chairs were not accessible as there were boxes and other various items placed on top of them. To the left side of the table there were more boxes stacked pushed towards the left corner of the room.

In an interview on 07/27/2023 at 11:51 AM, Staff A, Executive Director, stated residents typically did not enter the activities room to utilize the space.

In an interview on 07/27/2023 at 1:21 PM, Staff I, Medication Technician, stated they weighed all residents monthly. Staff I stated the only scale to weigh residents on was in the activity room. Staff I stated the scale had the ability to roll a wheelchair on it.

Lobby Environment

In an observation on 07/24/2023 at 12:29 PM, the common lobby area of the facility showed there were two white chairs that had a rip down the middle of them. Stuffing was observed from both chairs. The common lobby showed a yellow/green two person sofa. The right arm of the sofa had a hole that exposed yellow insulation. On the left side of the

sofa's seat cushion showed a red stain was visible.

In an observation on 07/24/2023 at 12:33 PM, the common lobby area showed a popcorn machine that had been coated in a yellow and brown substance. There were popcorn kernels on the bottom of the machine that were visible. The popcorn machine was placed on a blue tablecloth that had a variety of unknown substances on it. There was an Otis Spunkmeyer cookie machine that had brown and yellow substances on it.

In an interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated the computer that was available for them to use that offered the wifi (wireless internet services) was in the common area. R7 stated there was no privacy around the computer. R7 stated they didn't feel comfortable to do their banking, attend their church zoom (virtual meeting site on the computer) meetings, or anything private or personal on the computer.

In an observation on 07/27/2023 at 2:24 PM, showed the computer accessible to the internet was in the common area by the television sitting area and the dining room.

Hallway Environment

In an observation on 07/24/2023 at 1:08 PM, the lights outside of room 101 had spiderwebs inside of them.

In an observation on 07/24/2023 at 1:09 PM, there were four chairs in the hallway in the vicinity of room 102. The blue chair was worn on the arms as the upholstery was rubbed off. The bottom of the chair showed balls of fuzz that started to form. There were two green chairs that had multiple stains that varied in size. There was a brown chair that had brown stains that varied in length and size. There was a coffee pot observed to be placed on a tray that was between room [REDACTED] and [REDACTED]. The coffee pot had multiple cracks that started to cause a spider web effect.

In an interview on 07/24/2023 at 1:12 PM, Staff G, Maintenance, stated the coffee pot outside of room [REDACTED] was for Resident 22 (R22). Staff G stated the facility staff brought R22 coffee daily.

In an observation on 07/24/2023 at 2:04 PM, there were four chairs in the hallway in the vicinity of room 110, 111, 112, and 113. The red chair had been worn and had a variety of brown stains on it. The two brown chairs had brown stains that varied in length and size.

In an interview on 07/24/2023 at 2:04 PM, Staff B, Resident Care Director/Registered Nurse, stated they did not know what the brown markings were on the red chair.

In an observation on 07/24/2023 at 2:06 PM, outside of room 119 the chair had an

incontinent pad (absorbent pad that's used as a precaution against fecal or urinary accidents) placed on it. Outside of room 118 there was a brown chair that had a variety of stains on it. At 5:19 PM, the incontinent pad was still on the chair outside of room 119.

In an interview on 07/24/2023 at 2:06 PM, Staff B, stated they were unsure why an incontinent pad was placed on a chair. Staff B stated that facility staff were not supposed to do leave incontinent pads on facility chairs.

In an interview on 07/27/2023 at 12:06 PM, Staff D, Western Washington Clinical Services Director Registered Nurse Delegator, stated incontinent pads were not supposed to be left on facility chairs.

In an observation on 07/24/2023 at 2:07 PM, the hallway had a windowsill that did not have a bottom trim board. There was wood exposed.

In an interview on 07/24/2023 at 2:07 PM, Staff B, stated the windowsill ledge came off and they thought Staff G would fix it.

In an observation on 07/24/2023 at 2:12 PM, there was a floral chair outside of room 128 that had a variety of brown stains on it. Outside of room 139 and room 140 there were two chairs that had a variety of stains on them. The chairs had paint chipped out of the arm and legs of them.

In an observation and interview on 07/24/2023 at 2:33 PM, the postal area showed a black free standing water machine. The machine had an unknown white substance that was on it. Staff B stated they did not know if the machine was operational. Staff B stated the machine did not look like it had been recently cleaned. There were two green sofas by the mailboxes. One of the sofas had a stain on the arm rest. The other sofa had a variety of stains throughout the chair cushions.

In an interview on 07/26/2023 at 3:52 PM, Staff M, Business Office Manager, stated the facility staff did not clean the free standing water machine by the postal areal. Staff M stated they thought the company who replaced the water were responsible for cleaning the water machine.

Courtyards and Outside of the Facility Environment

In an observation and interview on 07/24/2023 at 2:13 PM, the outside smoking area showed a metal bench that had caution tape around it. Staff B stated they were unsure why there was caution tape on the bench. Staff B stated they thought the bench was broken. Across from the smoking section showed there were two support beams attached to the building where the wood started to rot on the corner trim. The outside wall of the facility showed moss. When entering the building from the outside smoking section showed the

door had a brownish orange substance that surrounded the top and sides of the door frame.

In an observation and interview on 07/24/2023 at 1:16 PM, the exit door by room 108 showed there was a donkey statue that had a chunk of material missing out of its neck. Staff B stated the statue was used to prop open the door as needed.

In an observation on 07/26/2023 at 1:43 PM, the exterior walk through showed on the east side of the building along the ocean there was an exterior light fixture that had exposed wires visible.

In an observation on 07/26/2023 at 1:47 PM, the exterior walk through showed the north end of the building had a black electrical box installed just above the ground level by the exit door. There were thick black cables that were cut and remained on the sidewalk next to the electrical box. The building showed there were paint trim pieces that had peeled off.

In an observation on 07/26/2023 at 1:50 PM, the exterior walk through showed the southwest corner of the building had dandelion's growing in the gutter on top of the downspout opening. The southwest corner of the building showed wood rot and a 6 inch by 12 inch area of wood that had been missing. At the southeast corner there was wood rot and a 6 inch by 6 inch area of wood that had been missing. There was a shed with a sign that read "DANGER – FUEL STORAGE AREA". The shed's double doors were held shut with a cinderblock leaning against them on the ground.

Kitchen Environment

In an interview on 07/25/2023 at 3:07 PM, Staff P, Cook, stated the refrigerators and freezers were cleaned anytime they cycled through meat. Staff P stated any time staff were finished with a container staff would take out the container and wipe the surfaces down.

In an observation and interview on 07/25/2023 at 3:49 PM, the kitchen freezer showed there were black spots located on the freezer next to the door frame. Staff P got a towel and wiped off the black substance. The towel showed brown and black residue. Staff P stated they were unsure if the substance was dirt, grime, or mold (fungus).

Maintenance Room Environment

In an observation on 07/26/2023 at 1:10 PM, Staff A, Executive Director, opened the door to the maintenance office without the use of the key. Staff A was observed to pause and hesitate after the door was able to be opened without a key.

In an observation on 07/26/2023 at 4:02 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors. The room did not have a clear walking pathway. There were a variety of tools inside of the room. Some of the tools were on a shelf whereas other tools and objects were laid out in the middle of the floor. There were a variety of tools scattered on desks and cabinets some of which included an electric drill, pressure washer machine, and carpet shampooer.

Laundry Room Environment

In an observation on 07/24/2023 at 2:22 PM, the laundry room entrance showed it was locked.

In an observation and interview on 07/24/2023 at 2:22 PM, Staff B attempted to put the key into the door lock on the laundry room entrance door. Staff B was unable to insert the key inside. Staff J, Medication Technician, stated there was a broken key inside the lock and was unable to open the entrance to the laundry room. Staff J stated the key had been broke off in the door lock for a while. Staff J stated because the in-door was unable to be opened, residents and staff accessed the laundry room through the laundry room out-door.

In an observation on 07/24/2023 at 2:24 PM, the laundry room showed because the in-door was broken, for anyone to enter the laundry room they had to go through the clean laundry area to gain access to the soiled laundry area. The laundry room had light green clothed incontinent pads (a reusable clothed pad that absorbs urine or bowel leakage) hung on all the windows.

In an interview on 07/24/2023 at 2:40 PM, Staff N, Housekeeping, stated the laundry room in-door had been broken. Staff N stated the residents and staff accessed the laundry room through the laundry room out- door.

In an interview on 07/26/2023 at 1:42 PM, Staff N stated out of the three washing machines only two were in working order. Staff N stated out of the three drying machines only one was in working order. Staff N stated the timeline varied for when the washer and dryers broke. Staff N stated there had been back up in laundry due to the machines being broken.

In an interview on 07/27/2023 at 11:54 AM, Staff A stated they were aware the in-door to the laundry room had been broken. Staff A stated facility staff and residents were using the out-door to enter into the laundry room.

In an interview on 07/26/2023 at 12:57 PM, Staff A, Executive Director, stated there was only one washer and one dryer that was working out of three washers and three dryers.

Laundry Room Accessibility

In an observation on 07/24/2023 at 2:22 PM, the laundry room showed the in and out-door to get inside of the laundry room were locked.

In an interview on 07/24/2023 at 2:22 PM, Staff J stated the laundry room remained locked and residents would ask facility staff to open the doors when needed.

In an interview on 07/24/2023 at 2:25 PM, Staff B stated the laundry doors were locked all the time and the staff would need to open the doors for the residents. Staff B stated the resident were allowed to only do their laundry on the weekends. Staff B stated the housekeeper was so busy with other residents' laundry during the week, that there was no time for the other residents to do their laundry.

In an interview on 07/24/2023 at 2:40 PM, Staff N stated the laundry room in-door was broken. Staff N stated the residents would ask facility staff to open the doors due the out-door remaining locked. Staff N stated residents were allowed to use the laundry room on the weekend. Staff N stated residents could not use the laundry room during the week because housekeeping was in and out of the laundry room throughout the weekdays.

In an interview on 07/24/2023 at 3:00 PM, Resident 20 (R20), stated that the laundry room was not accessible to residents who utilized wheelchairs. R20 stated some facility staff members helped assist residents with laundry whereas other staff members would not. R20 stated they were informed they were only allowed to do their laundry on the weekend.

In an interview on 07/24/2023 at 3:00 PM, Resident 10 (R10), stated residents were only allowed to do their laundry on the weekends. R10 stated clothes were left in the washer and dryers and it caused long wait times.

In an interview on 07/25/2023 at 2:32 PM, Staff M, Business Office Manager, stated the residents could use the washers and dryers at any time. Staff M stated it would be difficult for the residents to use the washers and dryers during the weekday because housekeeping did laundry during those times. Staff M stated some residents did laundry at night when housekeeping left or on the weekends.

In an interview on 07/26/2023 at 1:42 PM, Staff N stated residents were allowed to do their laundry on the weekends. Staff N stated since they had to use the washers and dryer during the week there was too much going on for the residents to do their laundry. Staff N stated residents would not fit inside of the laundry room because there was not enough space. Staff N stated there were multiple laundry baskets on the floor and laundry in the washers and dryer that prevented the room from being accessible.

In an observation on 07/26/2023 at 2:13 PM, the laundry room showed two laundry carts by the out-door way. There were eight laundry baskets located in various places on the

floor. There were boxes on the floor that contained a variety of linens.

In an interview on 07/26/2023 at 12:57 PM, Staff A, Executive Director, stated the residents were allowed to do their personal laundry on Saturday or Sundays. Staff A was unsure if the residents were allowed to do their laundry throughout the week.

Laundry Room Affordability

In an observation on 07/24/2023 at 12:52 PM, an unknown resident approached staff B, Resident Care Director, and inquired if laundry cost an additional \$25.00. Staff B informed the resident it does not cost additional money for residents to complete their laundry. The unknown resident informed Staff B there was a rumor going around the facility that laundry cost an additional \$25.00.

In an interview on 07/24/2023 at 3:00 PM, Resident 13 (R13) stated that if you did more than one load of laundry that it cost an additional \$25.00 per load. R13 stated Staff B stated laundry did not cost extra but Staff M, Business Office Manager, informed them it did cost extra.

In an interview on 07/24/2023 at 3:00 PM, Resident 20 (R20), stated they were informed by Former Staff 1, Resident Care Director, that the facility would only accommodate washing one load of laundry per week.

In an interview on 07/25/2023 at 2:32 PM, Staff M stated the agreement stated there was an additional fee if residents did more than one load of laundry.

In an interview on 07/26/2023 at 12:57 PM, Staff A stated residents were allowed to wash one full load of clothing and one full load of bedding and linens. Staff A stated that if the resident had more than two loads or needed to be washed more often, the facility would contact the family to assist, or a fee would be charged. Staff A stated they needed to look at the admission agreement to check what the extra laundry fee was.

Tray Service Affordability

In an interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated that she had to eat in the dining room. R7 stated if you were not sick the facility would charge the residents five dollars per meal tray if they were delivered to their room. R7 stated to have all three meals delivered would cost fifteen dollars a day to just eat in your room. R7 stated Staff S, Health Services Director Former, had told them of the charge. R7 stated that they preferred to eat in their room, but they don't because they only received a limited amount of money each month.

In an interview on 07/26/2023 at 1:55 PM, Resident 16 (R16) stated they were told by Staff C, Resident Care Coordinator, that they had to eat in the dining room or would be charged five dollars per tray to eat in their room.

In an interview on 07/26/2023 at 12:55 PM, Staff A, Executive Director, stated for any resident that didn't want to go to the dining room for meals, they would be charged a fee to have their meal trays delivered to their room. Staff A stated they wouldn't need to pay for their meal delivered if they were sick. Staff A stated this was in place per the facility's policy and admission agreement.

In an interview on 08/04/2023 at 11:03 AM, Collateral Contact 1 (CC1), Case Manager for 42 facility residents, stated Medicaid residents were charged a participation fee per month to live at the facility. CC1 stated beyond their fee they should not be charged additional amounts for services provided by the facility. CC1 stated if a resident were sick and restricted to their room then the tray service fee of \$5.00 should be waived.

Snacks and Beverages

In an interview on 07/24/2023 at 12:47 PM, Staff B, Resident Care Director, stated they provided the residents snacks twice a day or whenever a resident requested it. Staff B stated the snacks would be placed on the piano inside of the dining room so residents could pick them up as needed. Staff B stated if a resident were unable to come pick up a snack for themselves staff would deliver the food to them.

In an interview on 07/25/2023 at 10:17 AM, Resident 6 (R6), stated that they did not always have access to food. R6 stated sometimes the facility would set out cookies or popcorn for the residents to eat. R6 stated the food would be on a tray and residents could pick it up while it was there. R6 stated the food did not last long.

In an observation on 07/25/2023 at 1:35 PM, the piano in the dining room showed there were no snacks accessible to residents.

In an observation on 07/25/2023 at 3:19 PM, the piano in the dining room showed there were no snacks accessible to residents.

In an interview on 07/26/2023 at 12:45 PM, Staff A, Executive Director, stated the caregivers and medication technicians always had access to the kitchen to get the diabetic (a condition that the body is unable to regulate and maintain the amount of sugar within the body) residents a snack. Staff A stated the facility provided the following snacks to the residents that included any leftover foods, snacks, fruit, sandwiches, and sometimes individual crackers. Staff A stated during the "snack time" the facility offered juice, punch, water and coffee. Staff A stated the drinks outside of the snack time were available upon request. Staff A stated the snack options were posted on the menus. Staff A stated the snacks were served upon request other than popcorn that was made and served daily

between 2:30 PM and 3:30 PM.

In an interview on 07/26/2023 at 2:20 PM, Resident 1 (R1) stated they did not always have access to food at the facility. R1 stated if they went to the store then they would have food to eat but they had not gone to the store for a few weeks. R1 stated since the change in management took place food had gotten scarce.

In an interview on 07/26/2023 at 11:52 AM, Staff L, Activities, stated the evening snack for the resident would be put out in the dining room on the counter by the handwashing sink.

In an interview on 07/26/2023 at 3:07 PM, Staff O, Cook, stated they put snacks out for the residents every night. Staff O stated the residents were usually offered honey gram crackers, bananas, lays potato chips, and wheat thins as an option. Staff O stated if there was room in the budget, they would provide grandma cookies to the residents. Staff O stated they made peanut butter and jelly sandwiches for the residents. Staff O stated they would try and save the peanut butter and jelly sandwiches for the diabetic residents.

In an observation on 07/26/2023 at 3:08 PM, the kitchen showed the snack supply was out of stock of honey gram crackers, lays potato chips, and wheat thins.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Lebbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents, or their

responsible party's signed the Resident Needs and Service Plans (facility's version of the negotiated service agreement [NSA]) for 7 of 9 sampled residents (Resident 2, Resident 3, Resident 4, Resident 6, Resident 7, Resident 8, and Resident 16). This failure placed residents or their responsible party's at risk for being denied the opportunity to negotiate and agree to the resident's care needs and services being provided.

Findings included...

Record review of the facility's policy, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed the wellness director ensured the NSA was signed and dated by the community representative and the resident and/or responsible party as appropriate. A copy was to be given to the family/responsible party.

Resident 2 (R2)

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed R2 was identified to have a Developmental Disability.

Record review of R2's Face Sheet, undated, showed R2 moved into the facility on [REDACTED]/2006. The face sheet showed R2 had a niece that was their responsible party and power of attorney for R2.

Record review of R2's initial Department of Health and Services Home and Community Services assessment, dated 06/27/2006, showed R2 had a primary diagnoses of [REDACTED] and [REDACTED]. Under the section reason for assessment, showed R2 was developmentally disabled with symptoms of obsessive-compulsive disorder.

Record review of R2's Washington Resident Assessment, dated 05/08/2023, under the section Decision Making Authority, showed R2's niece was the power of attorney for R2.

Record review of R2's Needs and Services Plan, undated, showed R2 and Staff A, Executive Director, had signed the document on 06/07/2023. There was no signature from R2's responsible party/power of attorney. Under the section Service Plan Evaluations, showed there was no documented date, the person documented that completed the NSA, and who all attended the NSA meeting to review the NSA.

Resident 3 (R3)

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on

██████████/2018. The primary diagnosis section showed R3 had a diagnosis of ██████████. Under responsible party showed Collateral Contact 3 (CC3) was R3's Power of Attorney.

Record review of R3's Needs and Services Plan, undated, showed the document was not dated, the completed by section was blank, the persons at meeting section was blank, and the notes section was blank. There was no signatures from the resident, residents responsible party, and a representative of the assisted living facility.

In an interview on 08/08/2023 at 10:20 AM, CC3, stated the facility staff only ever contacted them when it regarded notifying them R3's billing statement was going to get raised. CC3 stated the communication they received from the facility was nonexistent. CC3 stated they were unsure if R3 had experienced any kind of change of condition. CC3 stated they did not visit R3 often and they felt the facility interpreted this as not needing to communicate with them regarding R3's care needs.

Resident 4 (R4)

Record review of R4's Face Sheet, undated, showed R4 moved into the facility on ██████████/2020 with multiple medical diagnoses including ██████████. The face sheet showed the responsibility party section for R4 was blank.

Record review of R4's Home and Community Services Assessment Current Annual, dated 07/12/2023, showed Collateral Contact 10 (CC10), family of R4, was R4's durable power of attorney of healthcare and financial and emergency contact.

Record review of R4's Needs and Services Plan, undated, showed the document was not signed by the resident and/or responsible party and the authorized community representative. Under the section Service Plan Evaluations, showed there was no documented date, the person documented that completed the NSA, and who all attended the NSA meeting to review the NSA.

In an interview on 07/25/2023 at 10:11 AM, R7 stated that they haven't seen any document that they were reviewed with and signed about the care and services they were to be provided here at the facility.

Record review of R6's Face Sheet, undated, showed R6 admitted into the facility on ██████████/2022. Under responsible party showed Collateral Contact 2 (CC2) was R6's Power of Attorney.

Record review of R6's Needs and Service Plan, undated, showed the document was not

dated, the completed by section was blank, the persons at meeting section was blank, and the notes section was blank. There were no signatures from the resident and a representative of the assisted living facility. The only signature on the needs and service plan was CC2.

Resident 6 (R6)

Record review of R6's Face Sheet, undated, showed R6 moved into the facility on [REDACTED]/2022. Collateral Contact 2 (CC2), daughter of R6, was R6's Power of Attorney and responsible party.

Record review of R6's Needs and Services Plan, undated, showed there was a signature from CC2. There were no signatures documented from the authorized community representative.

Resident 7 (R7)

Record review of R7's Face Sheet, undated, showed R7 moved into the facility on [REDACTED]/2023. The face sheet showed the responsibility party section for R7 was blank.

Record review of R7's Home and Community Services Assessment details, dated 05/26/2023, showed Collateral Contact 6 (CC6) daughter of R7, was the emergency contact and representative/protective payee for R7.

Record review of R7's Needs and Services Plan, undated, showed there was no signatures document for the resident, responsible party, or authorized community representative for review. Under the section Service Plan Evaluations, showed there was no documented date, the person documented that completed the NSA, and who all attended the NSA meeting to review the NSA.

In an interview on 07/25/2023 at 10:11 AM, R7 stated they have never participated in a meeting to review the care and services the facility was to provide for them. R7 stated they have not been asked to sign a needs and services plan since they have moved into the facility.

Resident 8 (R8)

Record review of R8's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2022 with multiple medical diagnoses including [REDACTED]

[REDACTED] and [REDACTED]. The face sheet showed the responsibility party section for R8 was blank.

Record review of R8's Needs and Services Plan, undated, showed there was no resident, responsible party, or authorized community representative signatures for review. Under the section Service Plan Evaluations, showed there was no documented date, the person documented that completed the NSA, and who all attended the NSA meeting to review the NSA.

Resident 16 (R16)

Record review of R16's Face Sheet, undated, showed R16 moved into the facility on [REDACTED]/2023. The face sheet showed there was no responsible party documented for R16.

Record review of R16's Needs and Services Plan, undated, showed there was no signature by the resident or the authorized community representative for review. Under the section Service Plan Evaluations, showed there was no documented date, the person documented that completed the NSA, and who all attended the NSA meeting to review the NSA.

In an interview on 07/25/2023 at 3:20 PM, Staff A, Executive Director, stated the resident's signed needs and services plan were in their resident charts. Staff A stated they would follow up with Staff B, Resident Care Director, about where the resident's signed needs and services plans were located.

In an interview on 07/27/2023 at 11:15 AM, Staff D, Western Washington Clinical Services Director/Registered Nurse Delegator, stated the residents needs and service plans were the facility's version of the negotiated services agreement. Staff D stated residents signed the needs and service agreement. Staff D stated if the resident was not in agreement with the document, then it would be edited and taken back to the resident to be signed.

In an interview on 08/22/2023 at 12:15 PM, Staff B, Resident Care Director/Registered Nurse, stated the residents needs and services plan were signed immediately after they were reviewed by the resident, resident representative, resident physician, and anyone else pertinent to add information regarding the residents care.

This is a recurring deficiency previously cited on 02/15/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023.

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-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 provide care agreed upon in the needs and services plan (the facility's version of the negotiated service agreement [NSA]) for 3 of 9 sampled residents (Resident 3, Resident 11, and Resident 16). This failure impacted the resident's quality of life by not having their care needs provided.

Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed "Negotiated Service Agreements will be updated as frequently as necessary to ensure they reflect current resident care needs and preferences..."

Resident 3 (R3)

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on [REDACTED] 2018. The primary diagnosis section showed R3 had a diagnosis of [REDACTED]

Record review of R3's Needs and Services Plan, undated, showed R3 needed total assistance with bathing, grooming, dressing, meals, and toileting. R3 was total assist with bathing. R3 was "Dependent on staff for showering..." The schedule showed R3 received their baths Monday's and Thursday's in the morning. R3 was total assist with meals. "Resident needs [their] food cut, prompting throughout meal to stay in dining room and how to eat daily. Finger foods work best for [R3] because [R3] is forgetting how to use the

silverware at times... The following services will be provided for this directed care resident: monitor weight, ensure resident safety strategies are in place, insure resident consuming meals and snack daily, communication with family and representative." R3 was total assist with toileting. R3 was "Dependent on staff to take resident to the bathroom to use toilet, pulling pants up and down, peri care [cleaning the private areas], changing incontinent [involuntary control of bowel and bladder] undergarments, washing and drying hands daily... Skin care integrity to be checked and the frequency on each resident as follows: weekly or as needed."

Record review of R3's Shower Audit, dated 05/01/2023 through 05/31/2023, showed R3 received a shower on 05/10/2023, 05/24/2023, and 05/31/2023. R3 received 3 out of 9 showers they were scheduled for.

Record review of R3's Shower Audit, dated 06/01/2023 through 06/30/2023, showed R3 received a shower on 06/07/2023, 06/11/2023, 06/18/2023, 06/21/2023, and 06/25/2023. R3 received 5 out of 9 showers they were scheduled for.

Record review of R3's Shower Audit, dated 07/01/2023 through 07/31/2023, showed R3 received a shower on 07/02/2023, 07/05/2023, 07/12/2023, 07/19/2023, and 07/28/2023. R3 received 5 out of 9 showers they were scheduled for.

Record review of Monthly Vitals, dated June 2023, showed R3's weight was 102 pounds.

Record review of Monthly Vitals, dated July 2023, showed R3's weight was not documented to review.

In an observation on 07/25/2023 at 7:58 AM, R3 left the dining room. R3 returned to the dining room at 7:59 AM and announced that they needed to use the bathroom. Resident 13 (R13) informed R3 to follow Staff J, Medication Technician, and that Staff J would help R3. Staff J walked past R3 and wheeled another resident out of the dining room to provide care. R3 walked down the hallway on their own and returned at 8:01 AM. R13 instructed R3 to sit at their table to eat. Staff K, Caregiver had delivered R3 a whole banana and left it on R3's table. R13 got up from their table and approached R3's table, R13 opened and peeled R3's banana, and instructed R3 to eat. R3 started to eat the banana. R13 took R3's coffee cup, refilled it, and returned R3's coffee. Staff K delivered R3 cereal at 8:04 AM. Staff K did not help assist R3 with eating the cereal. At 8:17 AM Staff K delivered R3 whole bacon strips, toast that was cut in half, and eggs. R3 asked "what do I do?" Staff K told R3 to eat their food. Staff K did not assist R3 with eating their food or cutting their food.

In an interview on 07/26/2023 at 11:52 AM, Staff L, Activities, stated they picked up shifts as a facility medication technician. Staff L stated R3 was cognitively impaired. Staff L stated R3 needed continued prompting with their activities of daily living. Staff L stated R3 needed full mental assistance but did not need full physical assistance. Staff L stated R3 could eat on their own but needed to be brought to the dining room for all their meals. Staff L stated R3 got flustered and would walk out of dining room. Staff L stated R3 would need to be

redirected back into the dining room to eat. Staff L stated R3 needed assistance with cutting up their food. Staff L stated R3 repeated "what do I do, what do I do, what do I do" often.

In an interview on 07/31/2023 at 11:00 AM, Staff O, Caregiver, stated R3's food was not cut up for them on a regular basis. Staff O reported at times R3 refused to come into the dining room to eat. Staff O stated when R3 refused to come into the dining room facility staff would not take food to them. Staff O stated on two different occasions they witnessed R3 not come to the dining room for breakfast and lunch. Staff O stated on those days they would bring R3 to the dining room before their shift ended at 2:00 PM and would feed R3 cereal. Staff O stated "[R3] inhaled the cereal in like four bites [R3] was so hungry."

In an interview on 08/08/2023 at 10:20 AM, Collateral Contact 3 (CC3), R3's Power of Attorney, stated historically they had concerns that R3 was not getting bathed regularly. CC3 stated when they would visit R3 they had greasy hair and long unkept fingernails. CC3 stated they visited R3 for their birthday on 07/18/2023 and expressed concern about their nail care. CC3 stated they did not think the facility staff paid great attention to R3's care needs. CC3 stated facility staff were supposed to escort resident to meals. CC3 stated R3 would get up from the dining room regularly. CC3 stated facility staff were supposed to remind R3 to eat. CC3 stated a healthy weight for R3 was 115 pounds. CC3 was unsure of R3's current weight.

Resident 16 (R16)

Record review of R16's face sheet showed R16 moved into the facility on [REDACTED] /2023. R16 had multiple medical diagnoses that included [REDACTED]

and [REDACTED].

Record review of R16's Home and Community Services Assessment Details History Annual, dated 05/22/2023, under the section bathing showed R16 required physical assistance with bathing tasks. Staff were to provide assistance upon R16's request. Staff were to standby while R16 bathed and transferred in and out of the shower.

Record review of R16's Needs and Services Plan, undated, showed R16 required one-person physical assistance with their bathing. Staff were to assist with washing R16's back, legs, and feet. Under the section, "bathing", date added was 06/18/2023, showed staff would provide R16 assistance to wash their upper and lower body while allowing R16 to participate to their potential. R16's showers were scheduled every morning on Tuesdays and Fridays.

In an interview and observation on 07/26/2023 at 1:55 PM, R16 stated they needed help with their showers. R16 stated they would take a shower daily if it was available. R16's hair

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was observed to be ungroomed. R16 wore a pull up and their night gown. R16 stated they had a rash from not getting their showers.

Records were requested from the facility on 08/08/2023 for R16's May - July 2023 shower sheets be provided for review no later than 08/09/2023 by 12:00 PM.

As of 08/09/2023 at 12:00 PM, the facility were unable to provide R16's May - July 2023 shower sheets to review as requested.

Resident 11 (R11)

Record review of R11's face sheet showed they moved into the facility on [REDACTED] /2022 with multiple medical diagnoses that included [REDACTED] and [REDACTED]

Record review of R11's Needs and Services Plan, dated 05/29/2023, showed R11 required one person total assistance with getting in and out of the shower. Staff were to wash R11's back, body, hair, and peri area. R11 required assistance with getting dressed after their showers that were scheduled every morning on Tuesday and Saturday's. Under the section titled, "Bathing", date added 05/29/2023, showed R11 required assistance.

Record review of an email sent by Staff A, Executive Director, on 08/08/2023 at 3:53 PM, showed the facility was unable to provide documented shower audits that were completed for R16 and R11.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbi Smathers
Administrator (or Representative)

9/13/2023
Date

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

- (1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;
- (2) Ensure employees working as food service workers obtain a food worker card according

to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff completed proper hand hygiene, prevented cross contamination, prepared food properly, and had accurate storage and labeling procedures for 2 of 2 areas (lobby and kitchen) reviewed. The facility also failed to ensure staff received their food handlers training for 3 of 7 sampled staff (Staff F, Staff H, and Staff X). These failures placed 52 of 52 residents at risk for receiving food that was incorrectly prepared by an unqualified staff and at risk for exposure to food-borne illnesses.

Findings included...

Washington Administrative Code (WAC), 246-215-02310 Hands and arms—When to wash (FDA Food Code 2-301.14). FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) After handling soiled EQUIPMENT or UTENSILS; (6) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (7) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (8) Before donning gloves for working with READY-TO-EAT FOOD unless a glove change is not the result of contamination; and (9) After engaging in other activities that contaminate the hands or gloves.

WAC 246-215-03300 Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305.

WAC 246-215-03342 Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.

WAC 246-215-03610 Labeling—Food labels (FDA Food Code 3-602.11). (1) FOOD PACKAGED in a FOOD ESTABLISHMENT must be labeled as specified in LAW, including chapters 69.04 and 15.130 RCW; 21 C.F.R. 101 - Food Labeling; and 9 C.F.R. 317 - Labeling, Marking Devices, and Containers. (2) Label information must include: (a) The common name of the FOOD or, absent a common name, an adequately descriptive identity statement; (b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and

chemical preservatives, if contained in the FOOD; (c) An accurate declaration of the quantity of contents; (d) The name and place of business of the manufacturer, packer, or distributor; (e) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or unusual name of the respective ingredient; (3) Bulk FOOD that is available for CONSUMER self-dispensing must be prominently labeled with the following information in plain view of the CONSUMER: (a) The manufacturer's or processor's label that was provided with the FOOD; or (b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section.

Food Handler Cards

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

WAC 246-217-025 (1)(8)- “(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee. (8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials.”

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

Record review of the facility's policy, “Food Storage”, undated, showed “Employees use appropriate tools to identify and prevent potential hazards in the storing of food process.” In dry storage “To ensure freshness, store opened items in tightly covered containers. Use the First In, First Out (FIFO) rotation method, dating packages and placing incoming supplies in the back so that older supplies will be used first.” In refrigeration showed “All refrigerated foods should be dated and properly sealed... Store frozen foods immediately using the First In, First Out (FIFO) method. Remember to check the “use by” dates... Store frozen foods in their original containers or wrap tightly in moisture-proof material or containers to minimize loss of flavor, as well as discoloration, dehydration (drying out), and absorption of odors. Clearly label containers with the contents, delivery date, and/or use-by date.”

Record review of the facility's policy titled, “Foodborne Illnesses”, undated, showed the facility should ensure that the residents do not suffer from foodborne illnesses by adhering to the proper precautions. Preventing foodborne illness was a simple process that involves recognizing the common problem areas and taking specific steps to avoid them.

Record review of the facility's policy titled, "Handwashing", undated, showed dining service workers must wash their hands the right way frequently. All employees need to make sure to wash their hands with soap and warm water for at least 20 seconds whenever hands were soiled, after using restroom, eating, using the phone or smoking, after handling inventory, after handling raw food, after touching or scratching areas on the body, such as ears, mouth, nose or hair, after cleaning, scraping, or washing dirty plates or utensils, and after removing trash and debris.

Record review of the facility's policy, "Cross Contamination", undated, showed employees understand how to prevent cross-contamination, which is the transfer of bacteria from food-to-food, hand-to-food, or equipment-to-food. The employees must thoroughly clean a surface after preparing food. Under the section titled, "hand-to-food cross-contamination", showed always wash your hands before working with food, and between working with different foods. People could pick up bacteria by touching raw foods, then transfer it to cooked or ready-to-eat food.

Cross Contamination-Handwashing

In an observation on 07/25/2023 at 6:27 AM, the kitchen hand washing sink next to the grill was observed to be dry. There were no paper towels inside the paper towel dispenser or available at the handwashing sink. There was an "ecolab" poster above the paper towel dispenser that showed, "all employees must wash their hands before returning to work." There was a black "zak" drinking cup with a drinking straw on the counter by the handwashing sink.

In an observation on 07/25/2023 at 6:58 AM, Staff E, Cook, had blue gloves on their hands. Staff E picked up and placed the raw bacon on a baking sheet. Staff E grabbed a bagged loaf of bread. Staff E took reached in the bag and grabbed some pieces of bread. Staff E placed the pieces of toast into the toaster. Staff E turned a timer, that had alarmed off. Staff E then grabbed a container of seasoning off the shelf and wiped their gloved hands on a towel that was sitting on the counter.

In an observation on 07/25/2023 at 7:05 AM, Staff E continued to wear the same blue gloves on their hands first observed at 6:58 AM. Staff E grabbed the door of the freezer by the kitchen window. Staff E took a box out. Staff E removed frozen dough balls out of the plastic bag in the box. Staff E plated them on a new baking sheet on the same counter as the bacon was plated. Staff E was not observed to clean the area prior to plating the frozen dough. Staff E grabbed two loaves of bread from the dry goods shelf and took them to the counter by the grill while continuing to wear the same blue disposable gloves.

In an observation on 07/25/2023 at 7:18 AM, Staff E observed to remove their blue disposable gloves off their hands. Staff E approached the handwashing sink and began to turn the water on, but then stopped. Staff E turned away from the sink and walked to the back exit door of the kitchen.

In an observation on 07/25/2023 at 7:20 AM, Staff E entered through the front door of the kitchen holding a roll of paper towels in their hands. Staff E turned the water on and washed their hands and used the paper towels to dry them.

In an observation on 07/25/2023 at 7:25 AM, Staff E placed a new pair of blue disposable gloves on both hands.

In an observation on 07/25/2023 at 7:28 AM, Staff E observed to place a rack of dirty dishes in the dishwasher with gloved hands. Staff E closed the dishwasher door. Staff E came over to the grill/oven area. Staff E placed a black hand mitt over their gloved hand. Staff E removed a baking sheet of cooked bacon out of the oven.

In an observation on 07/25/2023 at 7:32 AM, Staff E grabbed a hold of the side of the black trash bag and pulled it out from under the counter. Staff E picked up and placed on the counter a box of whole unpeeled potatoes. Staff E filled up a white bucket with water and placed on the counter near the black trash bag.

In an observation on 07/25/2023 at 7:35 AM, Staff E picked up a potato and peeled it above the black trash bag. The peeled potato was placed in the white bucket of water and continued to peel more potatoes. Staff E was observed to use the same blue disposable gloves that were put on at 7:25 AM.

In an observation on 07/25/2023 at 8:05 AM, Staff E observed to wash their hands at the handwashing sink next to the grill. Staff E put on a new pair of blue disposable gloves on both of their hands.

In an observation on 07/25/2023 at 8:09 AM, some boxes of food were delivered by the facility's food vendor. Staff E opened a cardboard box. Staff E opened the refrigerators door near the window of the kitchen. Staff E placed a box of liquid egg white cartons inside the fridge.

In an interview on 07/25/2023 at 8:09 AM, Staff F stated that some of the resident's orders were ready for Staff E to start plating.

In an observation on 07/25/2023 at 8:10 AM, Staff E was still wearing the blue disposable gloves that were put on at 8:05 AM. Staff E approached the hot serving table. Staff E grabbed the tickets that Staff E brought in that showed residents choices for the meal. Staff E grabbed the black "zak" beverage cup with a straw inside next to the handwashing sink and grill. Staff E took a drink from the black cup. Staff E reapproached the serving table and grabbed a knife and a cutting board. Staff E opened a bag of bread, removed some slices of bread and placed in the toaster. Staff E grabbed a plate from the plate warmer. Staff E plated a scoop of scrambled eggs and arranged them on the plate with their gloved hands. Staff E grabbed the toasted bread from the toaster cut it in half and placed on the

plate.

In an observation on 07/25/2023 at 8:15 AM, Staff E went to the dishwasher. Staff E placed a rack of dirty dishes inside of the dishwasher, closed the dishwasher door to run the wash cycle. Staff E returned to the hot table and serving bar. Staff E grabbed a plate from the plate warm, scooped a spoon full of scrambled eggs and placed on the plate. Staff E touched the scrambled eggs to keep them on the plate together. Staff E grabbed three pieces of cooked bacon with their gloved hand and placed it on the plate with the scrambled eggs. Staff E grabbed with their gloved hand, two pieces of toasted bread and placed them on the plate. Staff E placed the plated food on the serving shelf for the caregivers to deliver to the resident. Staff E continued to dish food onto two other resident's plates and made more toasted bread.

As of 07/25/2023 at 8:31 AM, Staff E had not changed their gloves or washed their hands in between tasks since last observed at 8:05 AM.

Storage and Labeling Kitchen

In an observation on 07/25/2023 at 6:58 AM, the preparation area of the kitchen, there was a bottle of Worcester sauce that had been opened. There was no documented date when it had been opened. There was a bottle of white cooking wine that had been opened. The bottle was not labeled with the date it had been opened.

In an observation on 07/25/2023 at 7:02 AM, inside the refrigerator, there was a large bag of white shredded mozzarella cheese. The bag was open and not securely closed. There was no label or date to show when the cheese was opened. There were three packages of orange blocks wrapped in clear wrap. There was no labels or dates as to what the blocks were or when they were opened. There was a bag of finely grated white parmesan cheese that had a rubber band around the package. There was no documented date when the cheese was opened.

In an observation on 07/25/2023 at 7:09 AM, the kitchen showed there was a package of ranch dressing powder mix that had been opened. The package was not securely closed and was open to air. The package had not been labeled with the date it had been opened.

In an observation on 07/25/2023 at 7:10 AM, on the bottom shelf of the dry storage there was three clear plastic bins with lids. Inside the plastic bins were beige/yellow strips that looked like noodles. There was no label or date documented on the containers of what the product was or when it had been opened. On the top shelf of the dry storage was a box with a bag of pancake mix. The bag was not securely closed. The pancake mix was left open to air. There was no labeled date when it had been opened.

In an observation on 07/25/2023 at 7:10 AM, Staff E continued to wear the same gloves as first observed at 6:58 AM. Staff E poured hot water into the hot table and then placed the

pot they used for the water onto the shelf with clean dishes. At 7:15 AM, Staff E grabbed the handle of the dishwasher and closed it to run the cycle. At 7:17 AM, Staff E grabbed the handle on the dishwasher and opened the door. Staff E grabbed clean plates and baking tins with their hands still gloved with the blue disposable gloves. Staff E placed the clean dishes with the other clean dishes on the shelves.

In an observation on 07/25/2023 at 7:12 AM, inside the refrigerator, there was a square plastic container with clear plastic wrap covering the top. Inside the container there was a large chunk of brown meat substance with black spots on top. There was no label on the container that showed when the food was made/opened and what the food was. There was a short square container with a green lid. The container had brown thick substance. There was a label that showed, "gravy". The gravy was made eight days prior on 07/17/2023.

In an observation on 07/25/2023 at 7:13 AM, under one of the preparation counters were, six large clear cylinder plastic container with lids. The first container was labeled with the word "rice". There was no documented date when the rice had been opened. The second container had a green like seed substance. The container was not labeled with the product or dated. The third container had what appeared to be dried white beans inside. The third container did not have a label of the food item or was dated. The fourth container had what appeared to be dried brown beans. The fourth container was not labeled or dated. The fifth container had what appeared to be rice. The container was not labeled or dated. The sixth container had an unknown white powder/granule substance. The container was not labeled or dated.

In an observation on 07/25/2023 at 7:20 AM, under the preparation counter, under the spice and seasoning shelf, there were three plastic containers. The plastic containers were colored blue, yellow, and white. The blue container had a substance that appeared to be oatmeal. The blue container had not been labeled or dated. The yellow container was labeled "oatmeal". The yellow container had not been labeled with the date the oatmeal had been opened. The white container had a label "popcorn kernels". The white container had not been labeled with the date it had been opened.

In an observation on 07/25/2023 at 7:24 AM, inside the first of three freezers there was an open box and bag of thin white flat pieces of fish. The bag was not securely closed or dated when it had been opened. There was a box of frozen cubed beef steaks that were securely closed. There was no label to show when the steaks had been opened. Inside the second of the three freezers there was an open bag of frozen shredded potatoes and frozen onion rings securely closed with rubber band. There were no labels on either bag or box to show when the onion rings and cubed steaks had been opened.

In an observation on 07/25/2023 at 7:33 AM, of the third freezer of three freezers showed there was a small round dish with a scoop of hard ice cream. The ice cream was not covered, there was no label that showed what kind of ice cream or date when it was scooped.

In an observation on 07/25/2023 at 7:35 AM, the dry storage shelves of the kitchen had a clear bag of white puffs inside. There was no label of what the food was, or a date documented on the bag. There was a bag of marshmallows that had been opened and was wrapped with clear plastic. There was no label on the bag to show when it was opened.

In an observation on 07/26/2023 at 3:48 PM, the refrigerator had a bag of white shredded cheese that had been opened. There was no documented opened date labeled on the bag of cheese. There were three blocks of orange substance that was wrapped in clear wrap. There were no documented labels of what the items were or date they were opened.

Record review of the facility's, "Safety Plan", received by the department on 07/26/2023 at 6:49 PM, showed "begin immediate corrective actions" Food Borne Illness concern, the health services director (HSD) or the designee would conduct an audit to determine if any residents had any signs or symptoms of abdominal discomfort, nausea (feeling of throwing up), vomiting, diarrhea, and temperature. All staff would be in-serviced on monitoring for signs and symptoms of effects from food borne illness. HSD or the designee would monitor the residents for the next 48 hours each shift for any symptoms or signs. Food storage and dating concern: The ED (Executive Director) or the designee would immediately remove all foods opened and non-sealed for disposal. ED or designee would dispose of all foods without open dates. The facility would place a food order tomorrow 07/27/2023. ED to in-service on proper labeling and storage. ED or the designee would monitor food labeling weekly for four weeks. Mold outside refrigerator concern: ED or the designee were to clean all equipment with bleach per label. The facility would provide education and implement a cleaning schedule. Ed or the designee would conduct weekly audits to ensure equipment was free of mold for four weeks. Proper Handwashing: HSD or the area nurse would in-service staff on proper handwashing in food services and during direct care. HSD or the area nurse of the designee would monitor staff of proper handwashing for two days. The HSD or the designee would monitor handwashing randomly for four weeks.

In an observation and interview on 07/27/2023 at 3:42 PM, the kitchen freezer showed there was a package of round patties of frozen raw meat. There was a large hole on the top of the package that exposed the frozen raw meat open to air. There was no label that showed when it was open and what the raw meat was. There was a plastic bag that was not secured closed and open. Inside the bag was multiple white frozen flat thin pieces. There was no label on the plastic bag or any label of the product and the date it was opened. There was a plastic packaged bag of "onion rings". The bag had been opened and was secured closed with rubber band. There was no label that showed when the product had been opened. There was brown large round container of ice cream. The lid was not properly closed and had been opened. There was no label that showed when the ice cream was opened. On the dry goods shelf inside a box by the back kitchen doors was a white bag with blue lettering of packaged powder gravy. The package had the corner removed and was inside the box not secured closed. There was no labeled date when the package was opened. There was a plastic bag of marshmallows that had been opened and was secured closed with clear wrap. There was no label on the bag that showed when the product had been opened. There was a clear bag of tiny white puffs that had been opened. The clear bag was not properly secured closed. There was no label on the bag to show what the product was or when it had been opened. On the shelf of spice's there was a square plastic container with white and black grounds inside. The labeled date showed that container was opened on 01/27/2018. There was a plastic container with "turmeric" spice.

There was a label on the container that showed it was opened on 06/10/2018. In the refrigerator by the ice machine was a pitcher of thick white substance. The label on the side of the pitcher showed, "juice". There was no date recorded. Staff A, Executive Director, stated that juice was for Resident 2 (R2). Staff A and Staff Y, Senior Executive Director, stated that the items identified were not properly stored or labeled and dated as required. Staff Y stated the facility staff would get rid of all the food that was not properly stored and dated.

Cleanliness

In an observation on 07/25/2023 at 7:24 PM, inside the one of three freezers was multiple clustered tiny black dots that was in the area where the door made contact with the freezer.

In an interview on 07/25/2023 at 7:30 AM, Staff E stated that the freezer wasn't cleaned that often. Staff E stated they tried to clean the fridge every couple of days. Staff E stated there were only three cooks and they didn't document the cleanings. Staff E was unable to say when the last time the fridge and freezers were cleaned.

In an observation on 07/25/2023 at 7:47 AM, on the white wall beside the hand washing sink near the front exit door of the kitchen was brown dried splatters. Under the hand washing sink was a white pipe. There was thick black substance covering the area of the two pipes that connected to each other. There were large amounts of brown liquid standing on the shelf under the white pipe. There was a cardboard box with packets of creamer inside that the liquid was touching. The brown liquid was observed to spill off the shelf onto the ground.

Common Lobby Area

In an observation on 07/24/2023 at 12:33 PM, in the common lobby was a popcorn machine. Next to the popcorn machine was an opened salt container that was a quarter of the way full. There was no label with the date it had been opened. There was a bottle of Johnny seasonings popcorn salt that had been opened. There was no label to show when it had been opened. There were an opened four pack of variety of seasonings that had a printed expiration dated, January 2023. There was a clear container that had round light brown and yellow seeds in a clear container. The container was not labeled with what the food item was or dated when it had been opened.

In an interview on 07/25/2023 at 6:59 AM, Staff E, Cook, stated the facility staff used the Sysco label provided by their supplier to determine when they received their condiments and food. Staff E stated facility staff did not label the condiments with the date it had been opened.

In an interview on 07/25/2023 at 7:10 AM, Staff E stated they date all food items that were

broken up (taken apart out of the original package). Staff E stated they used the labels from the supplier.

In an interview on 07/26/2023 at 3:07 PM, Staff P, Cook, stated depending on what the item was determined how it was labeled. Staff P stated if the facility staff got an item in from their supplier that already had a label it should have the date it was shipped. Staff P stated if the facility staff opened an item, they labeled it with the date it was opened.

In an interview on 07/26/2023 at 3:30 PM, Staff P, stated they would wash their hands anytime they change a task, enter, or exit the kitchen or room, after the use of the bathroom, and before and after eating. Staff P stated they would change their disposable gloves after one task and then throw them away. Staff P stated the facility had a good supply of disposable masks for them to use.

In an interview on 07/27/2023 at 11:28 AM, Staff U, Clinical and Compliance Directors, stated they were told the kitchen was cleaned and foods removed that were no labeled or dated.

In an interview on 07/27/2023 at 4:17 PM, Staff W, Chief Executive Officer Veda Living Management Company, stated they were informed that the facility staff completed a walkthrough of the kitchen the morning of 07/27/2023 and that the concerns in the safety plan had been addressed.

Food Handler Cards

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff F, Caregiver, was hired on 05/22/2023.

There was no record provided to review that Staff F completed their food handler's certificate.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff H, Medication Technician, was hired on 05/19/2023.

There was no record provided to review that Staff H completed their food handler's certificate.

Record review of the facility's Employee Roster, dated 07/24/2023, showed Staff X, Medication Technician, was hired on 06/01/2022.

Record review of Staff X's Washington State Food Worker Card, valid from 05/14/2020 to 05/14/2023, showed it had expired.

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

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Lebbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

This requirement was not met as evidenced by:

Based on record review, observation, and interview the facility failed to keep exterior grounds and assisted living structures safe and in good repair for 3 of 3 areas within the facility (maintenance room, resident restroom, and outside common areas). This failure placed 52 of 52 residents at risk due to unsafe and unmaintained living conditions.

Findings included...

Record review of the facility's policy, titled, "Equipment", undated, showed "All equipment will be maintained in high state of cleanliness and repair."

Record review of the facility's policy, titled, "Personal Rights", dated 08/10/2021, showed "Residents have a right to receive care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. A resident should have a safe, clean, comfortable, and homelike environment..."

Maintenance Room

In an observation on 07/26/2023 at 1:10 PM, Staff A, Executive Director, opened the door to the maintenance office without the use of the key. Staff A was observed to pause and hesitate after the door was able to be opened without a key.

In an observation on 07/26/2023 at 4:02 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors. The room did not have a clear walking pathway. There were a variety of tools inside of the room. Some of the tools were on a shelf whereas other tools and objects were laid out in the middle of the floor. There were a variety of tools scattered on desks and cabinets some of which included an electric drill, pressure washer machine, and carpet shampooer. Inside the room there were multiple chemicals that were not locked. There was "zep" commercial stain resistant floor sealer (clear water based sealer designed to protect floors from stains), simple green all-purpose cleanser (removed dirt, grease, and stains), Red Carpet I Capsol encapsulating interim cleaning chemical (used to crystalize stains and dirt during vacuuming), Windex (surface cleaner), and a clear spray bottle that was unlabeled with "odor eliminator" handwritten on it.

In an observation on 07/27/2023 at 3:01 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors.

Resident Restroom

In an observation on 07/24/2023 at 12:51 PM, the public bathroom door had a sign that posted that showed, "lock at all times" with big capital letters. The public door was able to be opened. The door was not locked.

In an interview on 07/24/2023 at 12:51 PM, Staff B, Resident Care Director/Registered Nurse, stated the restroom was supposed to remain locked. Staff B stated the facility staff did not want dementia residents to wander into the area without assistance from facility staff.

Outside Common Area

In an observation and interview on 07/24/2023 at 2:13 PM, the outside smoking area showed a metal bench that had caution tape around it. Staff B stated they were unsure why there was caution tape on the bench. Staff B stated they thought the bench was broken.

Plan/Attestation Statement

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

Lebbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2710 Disclosure of services.

- (1) The assisted living facility must disclose to residents, the resident's representative, if any, and interested consumers upon request, the scope of care and services it offers, on the department's approved disclosure forms. The disclosure form shall not be construed as an implied or express contract between the assisted living facility and the resident, but is intended to assist consumers in selecting assisted living facility services.
- (2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide a completed copy of their Disclosure of Services for 1 of 1 facility's reviewed. This failure effected 52 of 52 residents, resident representatives, and any visitor at the facility from having knowledge of what services the facility provided.

Findings included...

Record review of the Department document, titled, "Assisted Living Facility Request for Documentation", dated 07/24/2023, Attachment B showed Disclosure of Services (Attachment L) was due to the licensor within two hours of entry of the facility.

The facility's disclosure of services was requested on 07/24/2023 at 12:35 PM.

Record review of the facility's disclosure of services, undated, provided on 07/24/2023 at 2:43 PM, showed the document did not have any documented services that showed what services the facility provided.

The facility's disclosure of services was requested on 07/25/2023.

Record review of the facility's disclosure of services, undated, provided on 07/25/2023 at 2:15 PM, showed the document did not have any documented services that showed what services the facility provided.

In an interview on 07/26/2023 at 12:33 PM, Staff A, Executive Director, stated the facility did have a disclosure of services and it was in the front nurse's office.

In an interview on 07/26/2023 at 1:01 PM, Staff D, Western WA Clinical Services Director/Registered Nurse Delegator, stated Staff A would have the facility's disclosure of Services. Staff D stated Staff A was responsible for the disclosure of services and not the nursing department.

In an interview on 07/26/2023 at 1:03 PM, Staff A stated that Staff F, Health Services Director, had kept the disclosure of services form for the facility.

As of 07/31/2023 the department had not received a completed disclosure of services for the facility to review.

Plan/Attestation Statement

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

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

(a) Required disclosure information prior to moving into the assisted living facility; and

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 52 of 52 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 notification must be made prior to or upon admission. Receipt of the information must be acknowledged in writing."

Record review of facility's Residence and Care Agreement Washington, undated, showed the disclosure of services information in Appendix F did not provide a detailed description of what services the residents received from the facility. The disclosure of services section

only provided a signature section from the resident or resident representative and a signature from the community representative.

Resident 1 (R1)

Record review of R1's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

Resident 2 (R2)

Record review of R2's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

Resident 3 (R3)

Record review of R3's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

Resident 4 (R4)

Record review of R4's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

Resident 5 (R5)

Record review of R5's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

Resident 6 (R6)

Record review of R6's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

Resident 7 (R7)

Record review of R7's Residence and Care Agreement Washington, Appendix F, undated, showed there was not a completed disclosure of services form to review of what services the facility provided.

In an interview and record review on 07/25/2023 at 12:24 PM, Staff A, Executive Director, stated that all residents receive and sign the document titled "appendix F Washington Disclosure of Services" that was a page of the residence and care agreement contract.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-3060 Storage space. The assisted living facility must:

- (1) Provide adequate storage space for supplies, equipment and linens;
- (2) Provide separate, locked storage for disinfectants and poisonous compounds; and
- (3) Maintain storage space to prevent fire or safety hazards.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to have adequate storage space that was free of safety hazards for 5 of 5 rooms (activities room, business office managers office, maintenance room, housekeeping room, and electrical panel room). The facility failed to ensure chemicals were locked and stored appropriately. This failure effected 52 of 52 residents and 26 staff by not having proper storage systems in place that resulted in unsafe areas.

Findings included...

Record review of the facility's policy, "Equipment", undated, showed "Housekeeping equipment and supplies will be stored, maintained and cleaned in accordance with manufacture's directions." "No chemicals will be stored in unlabeled containers." "Housekeeping equipment will be stored in locked designated areas when not in use."

Findings included...

Activities Room

In an observation on 07/24/2023 at 12:10 PM, the activity room showed multiple boxes and totes that were stacked more than halfway up the height of the wall to the right side of the doorway. The left side of the doorway there was a scale placed against the wall. The center of the room had a table with chairs. The table and chairs were not accessible as there were boxes and other various items placed on top of them. To the left side of the table there were more boxes stacked pushed towards the left corner of the room.

In an interview on 07/26/2023 at 10:02 AM, Staff L, Activities, stated they did not use the activities room often due to limited space.

In an interview on 07/27/2023 at 11:51 AM, Staff A, Executive Director, stated residents typically did not enter the activities room to utilize the space.

In an interview on 07/27/2023 at 1:21 PM, Staff I, Medication Technician, stated they weigh all residents monthly. Staff I stated the only scale to weigh residents on was in the activity room. Staff I stated the scale had the ability to roll a wheelchair on it.

Business Office Managers Office

In an interview on 07/24/2023 at 2:20 PM, Staff M, Business Office Manager, stated that the personal protective equipment (PPE) was not located in their office. Staff M stated the PPE was located at the nurse's station.

In an interview on 07/24/2023 at 2:35 PM, Staff B, Resident Care Director/Registered Nurse, stated they thought the back up supply of PPE was in the business office managers office.

In an interview on 07/24/2023 at 5:52 PM, Staff A, Executive Director, Staff B, and Staff C, Resident Care Coordinator, stated that the PPE was not located at the nurse's station, in the activities room, or the business office managers office. Staff C stated the PPE was in an office in the backroom. Staff C and Staff B went to look for the additional PPE. Staff C and Staff B confirmed some of the PPE was located in the business office managers office.

In an observation on 07/24/2023 at 6:11 PM, the business office manager office showed Staff M removed a variety of items before they had access to the PPE in their office. The PPE was in the right corner of the room. Staff M had to physically remove Staff B's dog, dog

carrier, a rolling chair, multiple black bags of unknown items, multiple blankets, and multiple pillows before they had access to the PPE.

Maintenance Room

In an observation on 07/26/2023 at 1:10 PM, Staff A opened the door to the maintenance office without the use of the key. Staff A was observed to pause and hesitate after the door was able to be opened without a key.

In an observation on 07/26/2023 at 4:02 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors. The room did not have a clear walking pathway. There were a variety of tools inside of the room. Some of the tools were on a shelf whereas other tools and objects were laid out in the middle of the floor. There were a variety of tools scattered on desks and cabinets some of which included an electric drill, pressure washer machine, and carpet shampooer. Inside the room there were multiple chemicals that were not locked. There was "zep" commercial stain resistant floor sealer (clear water based sealer designed to protect floors from stains), simple green all-purpose cleanser (removed dirt, grease, and stains), Red Carpet I Capsol encapsulating interim cleaning chemical (used to crystalize stains and dirt during vacuuming), Windex (surface cleaner), and a clear spray bottle that was unlabeled with "odor eliminator" handwritten on it.

In an observation on 07/27/2023 at 3:01 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors.

Housekeeping

In an observation on 07/24/2023 at 12:58 PM, the housekeeping closet showed an electrical panel with a sign that read "do not block or store items on floor." There were three plungers and a blue stick that had a black plastic bag covering the top of it placed in front of the electrical panel.

In an interview on 07/24/2023 at 12:58 PM, Staff B stated that nothing was supposed to be on the floor in front of the electrical panel.

In an observation and interview on 07/26/2023 at 12:49 PM, the housekeeping room showed a vacuum and mop that were placed in front of the electrical panel. Staff N, Housekeeping, stated that they knew the vacuum and mop were not supposed to be in front of the electrical panel. Staff N stated they were not the facility staff member who placed the items in front of electrical panel.

Electrical Panel Room

In an observation on 07/26/2023 at 3:55 PM, the electrical panel room showed an electrical panel with a sign that read "do not block." There was a chair placed in front of the electrical panel.

In an interview on 07/26/2023 at 3:55 PM, Staff M stated the chair in front of the electrical panel should not be there.

Locked Storage for Disinfectants and Poisonous Compounds

In an observation on 07/24/2023 at 1:01 PM, one of the three outside courtyards showed behind one of the planter boxes there was a bag of potting mix expert garden which read keep out of reach of children. The bag read it recommended to wear garden gloves and wash hands after use. The bag contained a variety of substances which included nitrate (chemical common in fertilizer and explosives), nitrogen (a colorless odorless gas used to make fertilizer), and phosphate (nutrient used in fertilizer).

In an observation on 07/24/2023 at 2:22 PM, the laundry room showed there was a bucket of house and trim paint (a colored substance to used to decorate or provide a protective coating) by the in door doorway. The bucket read caution do not take internally and to avoid contact with eyes and skin. The bucket read contact physician or local poison control if swallowed.

In an observation and interview on 07/24/2023 at 2:25 PM, the laundry room showed an unlocked cabinet that had a clear spray bottle with a liquid inside of it. The spray bottled had handwriting that said "carpet cleaner" on it. Staff B stated the spray bottle had not been properly labeled. Staff B stated there was no way to identify what chemical was inside the bottle. Staff B stated the doors to the laundry room were normally kept locked. Staff B stated residents had access to the laundry room and the chemicals should be locked. The laundry cabinet showed a bottle of peroxide multi surface cleaner and disinfectant (used to clean inanimate objects), a bottle of V05 pomegranate bliss shampoo (hair care product), and a bottle of silkience hair care pro formula hydrating shampoo (hair care product).

In an interview on 07/24/2023 at 2:38 PM, Staff N stated the chemical bottle in the laundry room with handwriting on it had not been labeled properly. Staff N stated the paint inside the laundry room should be in the maintenance office. Staff N stated the paint was not normally stored in the laundry room.

In an observation on 07/26/2023 at 12:49 PM, the housekeeping supply room showed there was a typed sign that read "Please do not leave any spray bottles with chemicals out. All spray bottles need to be returned to the housekeeping closet when you are done using them. Also, no food or drinks in the laundry room. Please keep all food and drinks in the employee break room."

In an interview on 07/26/2023 at 1:42 PM, Staff N stated chemicals inside the facility were supposed to be kept locked.

In an interview on 07/31/2023 at 11:00 AM, Staff G, Maintenance, stated chemicals in the facility were supposed to be locked and secured.

Plan/Attestation Statement

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair,
- (c) Keep facilities, equipment and furnishings clean and in good repair, and

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 7 of 7 areas within the building (activities room, lobby, hallways, courtyard/outside areas, laundry room, kitchen, and maintenance). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 52 of 52 residents at risk for 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, "Personal Rights", dated 08/10/2021, showed "Residents have a right to receive care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. A resident should have a safe, clean, comfortable, and homelike environment..."

Activities Room

In an observation on 07/24/2023 at 12:10 PM, the activity room showed to the right side of the doorway had multiple boxes and totes that were stacked three quarters up the wall. The left side of the doorway there was a scale placed against the wall. The center of the room had a table with chairs. The table and chairs were not accessible as there were boxes and other various items placed on top of them. To the left side of the table there were more boxes stacked pushed towards the left corner of the room.

In an interview on 07/26/2023 at 10:02 AM, Staff L, Activities, stated they did not use the activities room often due to limited space.

In an interview on 07/27/2023 at 11:51 AM, Staff A, Executive Director, stated residents typically did not enter the activities room to utilize the space.

In an interview on 07/27/2023 at 1:21 PM, Staff I, Medication Technician, stated they weigh all residents monthly. Staff I stated the only scale to weigh residents on was in the activity room. Staff I stated the scale had the ability to roll a wheelchair on it.

Lobby

In an observation on 07/24/2023 at 12:29 PM, the common lobby area of the facility showed there were two white chairs that had a rip down the middle of them. Stuffing was observed from both chairs. The common lobby showed a yellow/green two person sofa. The right arm of the sofa had a hole that exposed yellow insulation. On the left side of the sofa's seat cushion a red stain was visible.

In an observation on 07/24/2023 at 12:33 PM, the common lobby area showed a popcorn machine that had been coated in a yellow and brown substance. There were popcorn kernels on the bottom of the machine that were visible. The popcorn machine was placed on a blue tablecloth that had a variety of unknown substances on it. There was an Otis Spunkmeyer cookie machine that had brown and yellow substances on it.

In an interview on 07/27/2023 at 1:27 PM, Staff I, Caregiver, stated that the popcorn machine was "disgusting". Staff I stated that they saw the Licensors observe the popcorn machine. Staff I stated the popcorn machine looked like it hadn't been cleaned in a long time. Staff I stated the popcorn machine was to be cleaned once a week.

In an interview on 07/27/2023 at 12:05 PM, Staff A stated the popcorn machine and cookie machine did not have a set cleaning schedule that was followed. Staff A stated any facility staff member could clean the machines.

In an interview on 07/24/2023 at 12:46 PM, Staff B, Resident Care Director/Registered Nurse, stated the chairs in the facility were cleaned daily.

In an interview on 07/26/2023 at 1:42 PM, Staff N, Housekeeping, stated the chairs in the facility were cleaned as needed. Staff N stated if a chair had been soiled in then it would get cleaned. Staff N stated cleaning the facility chairs were not a part of their regular job responsibilities. Staff N stated the maintenance department would periodically go around and clean the facility chairs.

In an interview on 07/27/2023 at 12:06 PM, Staff A stated the chairs in the facility were supposed to be cleaned on the night shift.

In an interview on 07/31/2023 at 11:00 AM, Staff G, Maintenance, stated they cleaned the facility chairs when a residents soiled themselves while sitting on them. Staff G stated historically they cleaned the chairs when they thought they found blood on them.

Hallways

In an observation on 07/24/2023 at 1:08 PM, the lights outside of room 101 had spiderwebs inside of them.

In an observation on 07/24/2023 at 1:09 PM, there were four chairs in the hallway in the vicinity of room 102. The blue chair was worn on the arms as the upholstery was rubbed off. The bottom of the chair showed balls of fuzz that started to form. There were two green chairs that had multiple stains that varied in size. There was a brown chair that had brown stains that varied in length and size. There was a glass serving pot with a black handle that had brown liquid inside sitting on top of a tray with a used meal plate in the common area near resident rooms [REDACTED] and [REDACTED]. The pot on the side of the glass had a larger area that was shattered but still intact with the shape of the pot. The glass was not smooth to touch.

In an interview on 07/24/2023 at 1:09 PM, Staff B stated that the pot looked like a coffee pot the facility serves with. Staff B stated they would get rid of the pot.

In an interview on 07/24/2023 at 1:12 PM, Staff G, Maintenance, stated the coffee pot outside of room [REDACTED] was for Resident 22 (R22). Staff G stated the facility staff brought R22 coffee daily.

In an observation on 07/24/2023 at 2:04 PM, there were four chairs in the hallway in the vicinity of room 110, 111, 112, and 113. The red chair had been worn and had a variety of brown stains on it. The two brown chairs had brown stains that varied in length and size.

In an interview on 07/24/2023 at 2:04 PM, Staff B stated they did not know what the brown stains were on the red chair.

In an observation on 07/24/2023 at 2:06 PM, outside of room 119 the chair had an incontinent pad (absorbent pad that's used as a precaution against fecal or urinary accidents) placed on it. Outside of room 118 there was a brown chair that had a variety of stains on it. At 5:19 PM, the incontinent pad was still on the chair outside of room 119.

In an interview on 07/24/2023 at 2:06 PM, Staff B, stated they were unsure why an incontinent pad was placed on a chair. Staff B stated that facility staff were not supposed to leave incontinent pads on chairs.

In an interview on 07/27/2023 at 12:06 PM, Staff D, Western Washington Clinical Services Director Registered Nurse Delegator, stated incontinent pads were not supposed to be left on facility chairs.

In an observation on 07/24/2023 at 2:07 PM, the hallway had a windowsill that did not have a bottom trim board. There was wood exposed.

In an interview on 07/24/2023 at 2:07 PM, Staff B stated the windowsill ledge came off and they thought Staff G would fix it.

In an observation on 07/24/2023 at 2:12 PM, there was a floral chair outside of room 128 that had a variety of brown stains on it. Outside of room 139 and room 140 there were two chairs that had a variety of stains on them. The chairs had paint chipped out of the arm and legs of them.

In an observation and interview on 07/24/2023 at 2:33 PM, the postal area showed a black free standing water machine. The machine had an unknown white substance that was on the device. Staff B stated they did not know if the machine was operational. Staff B stated the machine did not look like it had been recently cleaned. There were two green sofas by the mailboxes. One of the sofas had a stain on the arm rest. One of the sofas had a variety of stains throughout the chair cushions.

In an interview on 07/26/2023 at 3:52 PM, Staff M, Business Office Manager, stated the facility staff did not clean the free standing water machine by the postal area. Staff M stated they thought the company who replaced the water were responsible for cleaning the water machine.

Courtyards and Outside of the facility

In an observation on 07/24/2023 at 1:01 PM, one of the three outside courtyards showed a garden hose had been left in the middle of the sidewalk. There were four planter boxes placed in a rectangle shape in the middle of the courtyard. In the middle of the planter

boxes there was an uneven surface that had multiple cement blocks that varied in level of evenness. Behind one of the planter boxes showed a bag of potting mix expert garden which read keep out of reach of children. The bag read it recommended to wear garden gloves and wash hands after use. The bag contained a variety of substances which included nitrate (chemical common in fertilizer and explosives), nitrogen (a colorless odorless gas used to make fertilizer), and phosphate (nutrient used in fertilizer).

In an observation and interview on 07/24/2023 at 2:13 PM, the outside smoking area showed a metal bench that had caution tape around it. Staff B stated they were unsure why there was caution tape on the bench. Staff B stated they thought the bench was broken. Across from the smoking section showed there were two support beams attached to the building where the wood started to rot on the corner trim. The outside wall of the facility showed moss. When entering the building from the outside smoking section showed the door had rust that surrounded the top and sides of the door frame.

In an observation on 07/24/2023 at 2:14 PM, the facility building was observed to have thick light green fuzzy substance that was hanging off the side of the white trim.

In an observation on 07/24/2023 at 2:15 PM, before re-entering into the facility from the back door by the designated smoking area, there was a wooden furniture that had a seat on both sides and a table in between that was connected as one piece. The furniture had been painted blue. There was gray wood was observed in between the blue paint. There were flakes of blue that were loose all over the furniture. There were pieces of the wooden furniture that had separated that cause parts of the wood to lift.

In an observation and interview on 07/24/2023 at 1:16 PM, the exit door by room 108 showed there was a donkey statue that had a chunk of material missing out of its neck. Staff B stated the statue was used to prop open the door as needed.

In an observation on 07/24/2023 at 6:23 PM, outside on the right side of the facility there were plants growing out of the roofs gutter. The plant had green leaves, yellow colored flower blooms, brown colored flower blooms, and stood tall.

In an observation on 07/26/2023 at 1:43 PM, the exterior walk through showed on the east side of the building along the ocean there was an exterior light fixture that had exposed wires.

In an observation on 07/26/2023 at 1:47 PM, the exterior walk through showed the north end of the building had a black electrical box installed just above the ground level by the exit door. There were thick black cables cut that remained on the sidewalk. The building showed there were paint trim pieces that had peeled off.

In an observation on 07/26/2023 at 1:50 PM, the exterior walk through showed the southwest corner of the building had weeds growing in the gutter on top of the downspout

opening. The southwest corner of the building showed wood rot and a 6 inch by 12 inch area of wood that had been missing. At the southeast corner there was wood rot and a 6 inch by 6 inch area of wood that had been missing. There was a shed with a sign that read "DANGER – FUEL STORAGE AREA". The shed's double doors were held shut with a cinderblock leaning against them on the ground.

In an interview on 07/31/2023 at 11:00 AM, Staff G, Maintenance, stated the outside walkway had an uneven surface. Staff G expressed concern for the residents who used the pathway because the ocean was nearby, and it posed a safety risk.

Laundry Room

In an observation on 07/24/2023 at 2:22 PM, the laundry room in door showed it was locked.

In an interview on 07/24/2023 at 2:22 PM, Staff J, Medication Technician, stated a few weeks ago a key broke inside of the laundries in door. Staff J stated because the laundry entrance door was unable to be opened, residents and staff accessed the laundry room through the laundry room out-door.

In an observation on 07/24/2023 at 2:24 PM, the laundry room showed because the entrance door was broken, in order for anyone to enter the laundry room they had to go through the clean laundry area to gain access to the soiled laundry area. There were two incontinent pads that been placed over the windows to use as curtains.

In an interview on 07/24/2023 at 2:40 PM, Staff N, Housekeeping, stated the laundry room entrance door had been broken. Staff N stated the residents and staff accessed the laundry room through the laundry room out-door.

In an interview on 07/26/2023 at 12:57 PM, Staff A stated there was only one washer and one dryer that was working out of three washers and three dryers.

In an interview on 07/26/2023 at 1:42 PM, Staff N stated out of the three washing machines only two were in working order. Staff N stated out of the three drying machines only one was in working order. Staff N stated the timeline varied for when the washer and dryers broke. Staff N stated the washing machines and dryers were regular sized not industrial sized machines. Staff N stated there had been back up in laundry due to the machines being broken.

In an interview on 07/27/2023 at 11:54 AM, Staff A stated they were aware the entrance door to the laundry room had been broken. Staff A stated facility staff and residents were using the out-door to enter into the laundry room. Staff A stated they would have to follow up with Staff M to find out when the door was going to get fixed.

Kitchen

In an observation and interview on 07/24/2023 at 8:03 AM, Staff F, Caregiver, brought in a rolling cart into the kitchen that had multiple pitchers of different beverages. There was a glass servicing pot with a black handle that have clear liquids inside. On the outside of the glass serving pot was a shattered area in the glass. Staff E placed the glass serving pot on the side of the handwashing sink next to the other stored glass serving coffee pots. Staff E stated they had served residents hot water from the glass serving pot with the shattered glass. Staff E shook their head vigorously left to right, shoulder to shoulder when they were asked if it was safe to serve any beverages from the shattered glass serving pot.

In an interview on 07/25/2023 at 8:25 AM, Staff A stated they would not serve any beverages from the broken glass serving pot. Staff B stated the same glass serving pot was seen yesterday 07/24/2023 sitting on a tray while touring the facility.

In an observation and interview on 07/25/2023 at 6:51 AM, the kitchen handwashing sink showed there were no paper towels accessible to be used. The sink did not have water droplets on it. Staff E, Cook, stated that the sink was the handwashing used for the kitchen.

In an observation on 07/25/2023 at 6:57 AM, the kitchen showed above the kitchen stove there were three yellow bottles that were unlabeled or undated with a liquid substance inside of them. The yellow bottles had a brown film on the outside of them.

In an interview on 07/25/2023 at 3:07 PM, Staff P, Cook, stated the refrigerators and freezers were cleaned anytime they cycled through meat. Staff P stated any time staff were finished with a container staff would take out the container and wipe the surfaces down.

In an observation and interview on 07/25/2023 at 3:49 PM, the kitchen freezer showed there were black spots located on the freezer next to the door frame. Staff P got a towel and wiped off the black substance. The towel showed brown and black residue. Staff P stated they were unsure if the substance was dirt, grime, or mold (fungus).

Maintenance Room

In an observation on 07/26/2023 at 1:10 PM, Staff A opened the door to the maintenance office without the use of the key. Staff A was observed to pause and hesitate after the door was able to be opened without a key.

In an observation on 07/26/2023 at 4:02 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors. The room did not have a clear walking pathway.

There were a variety of tools inside of the room. Some of the tools were on a shelf whereas other tools and objects were laid out in the middle of the floor. There were a variety of tools scattered on desks and cabinets some of which included an electric drill, pressure washer machine, and carpet shampooer. Inside the room there were multiple chemicals that were not locked. There was "zep" commercial stain resistant floor sealer (clear water based sealer designed to protect floors from stains), simple green all-purpose cleanser (removed dirt, grease, and stains), Red Carpet Capsol encapsulating interim cleaning chemical (used to crystalize stains and dirt during vacuuming), Windex (surface cleaner), and a clear spray bottle that was unlabeled with "odor eliminator" handwritten on it.

In an observation on 07/27/2023 at 3:01 PM, the maintenance room was unlocked and accessible to residents, staff, and visitors.

This is a recurring deficiency previously cited on 04/27/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) <u>10/6/2023</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Debbie Smathers</u> Administrator (or Representative)	<u>9/11/2023</u> Date

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

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

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in (e) of this subsection, the facility must provide an outdoor area for residents that:

(iii) Has areas protected from direct sunshine and rain throughout the day;

(iv) Has walking surfaces that are firm, slip-resistant and free from abrupt changes, and suitable for individuals using wheelchairs and walkers;

(v) Has outdoor furniture;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide an outdoor common space for 3 of 3 common courtyards observed (courtyard 1, courtyard 2, and courtyard 3) that was protected from the elements, had safe walking pathways, and furniture accessible for residents to use. This failure placed 52 of 52 residents' at risk for exposure to unsafe environments and decreased quality of life.

Findings included...

Record review of the Department database showed the facility had an Enhanced Adult Residential Care contract with a start date of 06/01/2022 and was valid through 05/31/2026.

Common Courtyard One

In an observation on 07/24/2023 at 1:01 PM, courtyard one showed there was not a covered area in the courtyard that protected the residents from the outside elements such as the sun and rain. The courtyard did not have outdoor furniture accessible to the residents. The outer edge of the sidewalk had a garden hose that had been left in the middle of the area blocking the path. There were four planter boxes placed in a rectangle shape in the middle of the courtyard. In the middle of the planter boxes there was an uneven surface that had multiple cement blocks that varied in level of evenness.

Common Courtyard Two

In an observation on 07/24/2023 at 2:19 PM, courtyard two showed there was not a covered area in the courtyard that protected the residents from the outside elements such as the sun and rain. The courtyard did not have outdoor furniture accessible to the residents.

Common Courtyard Three

In an observation on 07/24/2023 at 5:40 PM, courtyard three showed there was not a covered area in the courtyard that protected the residents from the outside elements such as the sun and rain. The courtyard did not have outdoor furniture accessible to the residents.

In an interview on 07/24/2023, Staff B, Resident Care Director, stated the facility had three common courtyards the residents had access to.

In an interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated they wouldn't recommend anyone to go outside and walk in the courtyards. R7 stated the pathway is unlevel, dangerous, and a trip hazard for anyone that had any balance issues.

In an interview on 07/27/2023 at 2:16 PM, Resident 4 (R4), stated the sidewalk in the courtyards were not safe to walk on. R4 stated they got the wheel of their wheelchair stuck in one of the cracks between the concrete sidewalk. R4 stated they don't use the courtyards or walks ways anymore.

In an interview on 07/27/2023 at 11:57 AM, Staff A, Executive Director, stated the residents at the facility did not often use the common courtyard space that had been accessible to them.

In an interview on 07/27/2023 at 11:57 AM, Staff D, Western Washington Clinical Services Director Registered Nurse Delegator, stated they were unaware if the common courtyard pathways were unstable and presented a fall risk since they had not been outside in the common courtyards.

In an interview on 07/31/2023 at 11:00 AM, Staff G, Maintenance, stated the three common court yards accessible to residents had not been maintained. Staff G stated the three common court yards did not have a stable pathway for the residents to use. Staff G expressed concern that due to the ocean tides the facility pathways were uneven and were a safety concern.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2550 Administrator training documentation. The assisted living facility must maintain for department review, documentation of the administrator completing:

- (1) Training required by chapter 388-112A WAC;
- (2) Department training in an overview of Washington state statutes and administrative rules related to the operation of an assisted living facility;
- (3) As applicable, certification from a department-recognized national accreditation health or personal care organization; and
- (4) As applicable, the qualifying administrator-training program.

Statement of Deficiencies	License #: 2615	Compliance Determination #26995
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 99 of 154	Licensee: Greenlake Management Ocean Shores,	08/22/2023

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have an administrator trained on Washington state laws and regulations for the Assisted Living Facility (ALF) for 1 of 1 Administrator reviewed. This failure placed 52 of 52 residents and 25 staff members at risk of not having an administrator that knows and implements the ALF laws and regulations.

Findings included...

WAC 388-112A-0800 What is residential care administrator training? (1) Residential care administrator training is specific training on the administration of the care and services required to obtain a license or manage a facility. The training covers the facility specific Washington state statutes and administrative rules related to the operation of a long-term care facility. (3) Assisted living facility (ALF) administrator training. (a) ALF administrator training curricula must be based on the requirements described in chapter 388-78A WAC.

Record review of Staff A, Executive Director, Licensure Board for Residential Care Administrators, dated 01/17/2007, showed Staff A had met the requirements for licensure and was entitled under the laws and rules of the State of Idaho to operate as a residential care facility administrator.

In an interview on 08/03/2023 at 10:07 AM, Staff L, Activities, stated Staff A's Idaho Residential Care Administrator Certificate was their current license for administrator that they update every year.

Record review of an email the department received on 08/07/2023 at 5:40 PM, showed Staff A was asked to provide documentation that Staff A completed training on Washington State ALF laws and rules. Staff A was unable to provide documentation that they had completed a training course that covered the Washington state statutes and administrative rules for ALF's.

Plan/Attestation Statement

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L. Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify Department of Social and Health Services (DSHS) of a change in the administrator that had changed in June 2022 for 1 of 1 facility reviewed. This failure placed the 52 of 52 residents and family members at risk for emotional distress related to not having most current contact information available.

Findings included...

Review of DSHS database on 07/18/2023 showed, Staff T, Former Executive Director (ED (facility's version of an administrator)), was the active administrator for the facility since 11/18/2021.

Record review of an email received on 07/19/2023 at 8:20 AM, from the Department Business Analysis Applications Unit, showed the Department received an administrator change application on 05/11/2022. The Departments database was last updated on 05/11/2022, that showed Staff T was the current ED.

In an interview on 07/24/2023 at 12:41 PM, Staff A, ED, stated they had been ED at the facility since August 2022.

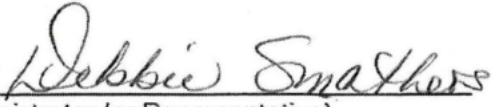
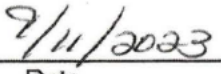
In an interview on 07/26/2023 at 12:40 PM, Staff A stated at the end of August 2023 they would have been the ED for the facility for a year. Staff A stated the corporation staff would have sent the administrator change form to the department when they became acting ED.

In an interview on 07/27/2023 at 4:15 PM, Staff U, Clinical and Compliance Director, stated the ED at the facility were responsible to update and send the change of administrator form to the Department.

Plan/Attestation Statement

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

 _____ Administrator (or Representative)	 _____ Date
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WAC 388-78A-2590 Management agreements General.

- (1) If the proposed or current licensee uses a manager, the licensee must have a written management agreement that is consistent with this chapter.
- (2) The proposed or current licensee must notify the department of its use of a manager upon:
 - (a) Initial application for a license;
 - (b) Retention of a manager following initial application;
 - (c) Change of managers; and
 - (d) Modification of existing management agreement.
- (3) The proposed or current licensee must provide to the department a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations.
- (4) The written management agreement must be submitted:
 - (a) Sixty days before:
 - (i) The initial licensure date;
 - (ii) The proposed change of ownership date; or
 - (iii) The effective date of the management agreement; or
 - (b) Thirty days before the effective date of any amendment to an existing management agreement.
- (5) The proposed licensee or the current licensee must notify the resident and their representatives sixty days before entering into a new management agreement.
- (6) A proposed licensee must submit a management agreement attestation form, as required by the assisted living facility application.

This requirement was not met as evidenced by:

Based on interview and record review, the licensee failed to notify the Department of Social and Health Services of a change in Management company for 1 of 1 facility reviewed. This failure placed 52 of 52 residents and 26 staff members at risk of emotional distress related to not having the most updated information about the facility.

Findings included...

Record review on 07/18/2023 of the Department of Social and Health Services database showed the management company was last updated on 05/11/2022. The database showed Greenlake Senior Living, LLC had been the management company since 11/18/2021.

In an interview on 07/27/2023 at 4:55 PM, Staff W, Chief Executive Officer of Veda Living Management Company, stated they took over as the management company for the facility on 06/01/2023. Staff W stated their attorney did not file or send the change of manager application to the Department for review and update the database.

Plan/Attestation Statement

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Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 3 of 6 sampled Staff (Staff H, Staff K, and Staff G) received all required Tuberculosis (infectious bacterial disease of the lungs) testing within the required time frame. This failure placed 52 of 52 residents and 26 staff at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of the facility's policy, "Infection Control Tuberculosis Care Staff", dated 08/10/2021, showed each newly hired staff person was screened for TB within three days of employment. The assisted living facility must ensure that all TB testing was done through either intradermal (injection of TB solution just under the skin) administration with the test results to be read within 48 – 72 hours of the test or a blood test. Unless the staff

person met the requirements to only have one test completed, the facility must ensure that each staff person has the two-step skin test. An initial skin test would be completed within three days of employment and a second test would be completed one to three weeks after the first step.

Record review of the Centers of Disease Control document "TB Screening and Testing of Health Care Personnel", updated 08/30/2022, showed if a tuberculin skin test was used to test health care personnel upon hire, a two-step should be completed. Some people that have latent TB infection could have a negative reaction when they were tested years after they had been infected. The first skin test could stimulate or boost a reaction. The document showed Step 1 was to be administered by proper protocol and the results would be reviewed. The second skin test would be done one to three weeks after the first skin test results were read. The second skin test would be administered and then reviewed for the results. The results were to be documented.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff H, Medication Technician, was hired at the facility on 05/19/2023.

Record review of Staff H's Tuberculosis Skin Test Screening Form, dated 06/02/2023 showed Staff H did not have a history of a positive TB skin test. Staff H was administered the first step TB skin test on 06/02/2023. The first step TB skin test was read on 06/04/2023 with no documented results of the skin test. Staff H was administered a second TB skin test on 06/20/2023. The second step TB skin test showed there was no documented result or if the test had been read.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff K, Caregiver, was hired at the facility on 06/01/2022.

Record review of Staff K's TB symptom screening questionnaire and skin testing form, dated 05/06/2011, showed Staff K did not have a history of a positive TB skin test. Staff K was administered the first step skin test on 05/06/2011. The first TB skin test was read and documented on 05/09/2011. There was no second step TB skin test documented to have been administered to Staff K. There were no other records provided that showed Staff K had a two step TB skin test completed.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff G, Maintenance, was hired at the facility on 05/22/2023.

Record review of Staff G's TB skin test screening form, dated 06/14/2023, showed Staff G did not have a history of a positive TB skin test. Staff G was administered the first skin test on 06/14/2023 and was read with documented results on 06/16/2023. There was no second step TB skin test documented to have been administered to Staff G. There were no other records provided that showed Staff K had completed a two step TB skin test after they were hired.

In an interview on 07/31/2023 at 11:00 AM, Staff G stated they never completed their two step TB testing for the facility.

In an interview on 07/26/2023 at 12:40 PM, Staff A, Executive Director, stated the nursing department administered all TB skin testing for new hired employees. Staff A stated Staff M, Business Office Manager, was responsible for auditing the staff files to ensure their TB skin tests were completed.

Plan/Attestation Statement

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Debbie Smathers
Administrator (or Representative)

9/11/2023
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 interview and record review, the facility failed to keep 20 of 20 resident's (Resident 20, Resident 24, Resident 25, Resident 16, Resident 26, Resident 13, Resident 17, Resident 28, Resident 11, Resident 33, Resident 10, Resident 4, Resident 34, Resident 22, Resident 29, Resident 30, Resident 31, Resident 32, Resident 5, and Resident 23) information kept confidential to other residents, visitors, and the public for review. This failure allowed the public, visitors, and other residents to review private medical information without the resident's consent and a breach of confidentiality.

Findings included...

Record review of the facility's policy, "Confidentiality", dated 08/10/2021, showed all resident data and information are considered confidential. Resident records, information were kept inaccessible to visitors and individuals not involved in the direct care and admission of the resident.

Record review of the facility's binder labeled "survey binder", showed there was a copy of the inspection Statement of Deficiencies citation dated 02/15/2023. The last page of the

statement of deficiency was a document titled "Resident/Staff List Confidential Information Do Not Disclose to the Public", dated 02/15/2023, showed Resident 20 (R20), Resident 24, Resident 25, Resident 16, Resident 26 (R26), Resident 13, Resident 27, and Resident 28's names were listed on the document.

Record review of the facility's binder labeled "survey binder", showed there was a copy of the inspection Statement of Deficiencies citation dated 03/07/2023. The last page of the statement of deficiency there was a document titled "Resident/Staff List Confidential Information Do Not Disclose to the Public", dated 03/07/2023, showed Resident 11, Resident 33, R20, Resident 10, Resident 4, Resident 34.

Record review of the facility's binder labeled "survey binder", showed there was a copy of the inspection Statement of Deficiencies citation dated 04/26/2023. The last page of the statement of deficiency there was a document titled "Resident/Staff List Confidential Information Do Not Disclose to the Public", dated 04/14/2023, showed Resident 22, Resident 29, Resident 30, Resident 31, Resident 32, Resident 5, R26, and Resident 23's names were listed on the document.

In an interview on 07/24/2023 at 12:35 PM, Staff B, Resident Care Director Registered Nurse, stated the resident and staff list forms inside the public copy survey binder, were not to be in the binder and were not to be made available to the 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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

- (1) Individual's recent medical history, including, but not limited to:
 - (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;
 - (b) Chronic, current, and potential skin conditions; or

- (c) Known allergies to foods or medications, or other considerations for providing care or services.
- (2) Currently necessary and contraindicated medications and treatments for the individual, including:
- (a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;
- (b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and
- (c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.
- (3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.
- (4) Individual's sensory abilities, including:
- (a) Vision; and
- (b) Hearing.
- (5) Individual's communication abilities, including:
- (a) Modes of expression;
- (b) Ability to make self understood; and
- (c) Ability to understand others.
- (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:
- (a) History of substance abuse;
- (b) History of harming self, others, or property; or
- (c) Other conditions that may require behavioral intervention strategies;
- (d) Individual's ability to leave the assisted living facility unsupervised; and
- (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.
- (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:
- (a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

- (b) Developmental disability;
- (c) Dementia. While screening a resident for dementia, the assisted living facility must:
 - (i) Base any determination that the resident has short-term memory loss upon objective evidence; and
 - (ii) Document the evidence in the resident's record.
- (d) Other conditions affecting cognition, such as traumatic brain injury.
- (8) Individual's level of personal care needs, including:
 - (a) Ability to perform activities of daily living;
 - (b) Medication management ability, including:
 - (i) The individual's ability to obtain and appropriately use over-the-counter medications; and
 - (ii) How the individual will obtain prescribed medications for use in the assisted living facility.
- (9) Individual's activities, typical daily routines, habits and service preferences.
- (10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.
- (11) Who has decision-making authority for the individual, including:
 - (a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;
 - (b) The presence of any legal document that establishes a current substitute decision maker; and
 - (c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within 14 days of the resident's move-in date for 1 of 2 sampled residents (Resident 8 [R8]). This failure placed R8 at risk for their care needs and services not being met.

Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed the assisted living facility must complete a full assessment within 14 days of the resident's move in date.

Record review of R8's face sheet showed they moved into the facility on [REDACTED] /2022 with multiple medical diagnoses including [REDACTED]

and [REDACTED]

Record review of R8's Washington Resident Assessment, dated 03/20/2023, showed R8 had a history of domestic violence (violent or aggressive behavior), history of substance abuse (excessive use of a drug that is harmful to self and others), and was identified to have safety considerations of hoarding.

In an interview on 07/27/2023 at 11:47 AM, Staff D, Western WA Clinical Services Director Registered Nurse Delegator, stated the facility nurse was responsible to complete the residents assessments within the required time frames and as needed to ensure care and services were updated for the residents needs.

In an interview on 08/08/2023 at 3:26 PM, Staff D stated that R8's 03/20/2023 Assessment was the first assessment to be documented on R8 after they moved into 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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers

Administrator (or Representative)

9/11/2023

Date

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040 , that is the resident's primary special need.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to have 3 of 6 sampled staff (Staff F, Staff H, and Staff G) complete the required developmental disability training. This failure placed Resident 2 at risk for unmet care needs and support services provided by untrained staff.

Findings included...

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed Resident 2 (R2) was identified to have a Developmental Disability.

Record review of R2's face sheet showed R2 moved into the facility on [REDACTED]/2006.

Record review of R2's initial Department of Health and Services Home and Community Services assessment, dated 06/27/2006, showed R2 had a primary diagnoses of [REDACTED] and [REDACTED]. Under the section reason for assessment, showed R2 had a diagnosis of [REDACTED]. R2's family was unable to care for R2 and were requesting placement into the assisted living facility.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff F, Caregiver, was hired at the facility on 05/22/2023.

Record review on 07/25/2023 of the employee documents provided showed Staff F did not have the required specialty training for developmental disability for review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff H, Medication Technician, was hired at the facility on 05/19/2023.

Record review on 07/25/2023 of the employee documents provided showed Staff H did not have the required specialty training for developmental disability for review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff G, Maintenance, was hired at the facility on 05/22/2023.

Record review on 07/25/2023 of the employee documents provided showed Staff G did not have the required specialty training for developmental disability for review.

In an interview on 07/26/2023 at 1:43 PM, Staff F stated they had not completed a specialized training for developmental disabilities.

In an interview on 07/27/2023 at 4:31 PM, Staff D, Western WA Clinical Services Director/Registered Nurse Delegator, stated they were told if the resident weren't receiving funds for their developmental disability, then the staff were not required to have the

specialize training.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

- (1) The care and services necessary to meet the resident's needs, including:
 - (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 full assessments;
 - (ii) On-going assessments of the resident;
 - (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;
- (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;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure necessary information was documented in needs and services plan (facility's version of the negotiated services agreement) for 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7). This failure placed the residents at risk for unmet care needs.

Findings included...

Record review of the facility's policy, titled, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed "The Negotiated Service Agreement is to include services as applicable for all areas addressed on the Resident Assessment and is to be individualized based on the resident's needs and preferences."

Resident 2 (R2)

Record review of R2's Face Sheet, undated, showed R2 moved into the facility on [REDACTED]/2006 with multiple medical diagnoses including [REDACTED]

and [REDACTED]

Record review of R2's Morse Fall Scale (an assessment that assess a residents fall risk), dated 05/08/2023, showed R2 scored at a level three that indicated for the facility to implement high fall risk prevention interventions.

Record review of R2's Washington Resident Assessment, dated 05/08/2023, showed R2 was insulin dependent. R2 had a developmental disability and dementia. R2 required thickened liquids. R2 required multiple behavioral interventions, required their food cut, chopped, or pureed. R2 required assistance with oxygen coordination with outside agency, catheter, complex wound/skin care, diabetic management, and lab monitoring.

Record review of R2's charting note dated, 06/27/2023 at 6:53 PM, showed R2 had their catheter changed by the Assured Home Health Nurse.

Record review of R2's Home and Community Services Assessment Details Current Annual, dated 06/07/2023, showed R2 had multiple medical diagnoses including [REDACTED]

[REDACTED] and [REDACTED]

The assessment showed R2 took their medication from the staff at the facility and in applesauce. R2 received home health services for the management of their indwelling catheter. R2 had long and short-term memory impairment. R2 had listed behaviors that included R2 being easily irritable/agitated that required interventions, R2 could be verbally aggressive and raises their voice towards people that were new to them and R2 experiencing extreme and rapid mood swings. R2 was documented to have an unsteady gait (unsteady with walking), poor balance, and had general and left sided weakness. R2 doesn't walk and uses a manual wheelchair to move around and required one-person extensive physical assistance with the wheelchair use. R2 was bedfast or wheelchair fast most of the time. R2 required one-person extensive physical assistance with all transfers. R2 was incontinent of bowel and continent of urine. R2 required the use of incontinent briefs and barrier cream on their buttocks/skin area. R2 required one-person extensive physical assistance with their dressing and bathing. Staff were to help avoid getting water in R2's face. R2 required a low sodium (salt) and mechanically altered (food cut up from original form) diet.

Record review of R2's Needs and Service Plan, undated, showed R2 required total assistance with grooming, dressing, transfers, toileting, and bathing. R2 required significant assistance by the medication technicians for their medications. There was no documentation that showed R2 required insulin injections or diabetic management. There was no documentation that showed if R2 required nurse delegation. R2 used outside agency oxygen, and had a wound. There was no documentation that showed the name and contact information of the outside agency that R2 had services provided by. There was no documentation of any wound or skin impairment on R2. There was no interventions documented to guide the caregivers if there were concerns related to their wound and or skin. R2 did not have any falls. There were no interventions documented for R2. R2 required preparation for their meals only and occasionally assistance with ambulation. Under the section titled, Dysphagia, dated 06/07/2023, showed R2 required their foods to be cut as ordered. Under the section Catheter, indwelling (Foley) updated 06/07/2023 showed staff were to assist R2 with cleansing the catheter as ordered by the physician. There was no documentation what to do if there were concerns with the catheter. There was no outside provider documented that changed R2's catheter.

Resident 7 (R7)

Record review of R7's Face Sheet, undated, showed R7 moved into the facility on [REDACTED]/2023.

Record review of R7's physician's report Washington, dated 05/24/2023, showed R7 was not able to manage their own treatment, medications, or equipment. The physician wrote R7 expressed recently forgetting to take their medications and needed to be reminded by the caregivers. R7 was documented to have mild cognitive impairments. R7 was documented to be independent with transfers to and from bed. R7 was documented to have a physical condition that caused them to be non-ambulatory.

Record review of R7's morse fall scale (a simple method of assessing a resident's fall risk), dated 05/19/2023, showed R7 scored at a level two that indicated for the facility to implement standard fall prevention interventions.

Record review of R7's dietary communication notification, dated [REDACTED]/2023 showed R7 required gluten free diet (diet that eliminates foods with gluten that is a protein found in wheat and other grains) and small portions. The notification showed R7 was allergic to gluten.

Record review of R7's physician clinic chart summary, dated 06/09/2023, showed R7 had multiple medical diagnoses including [REDACTED] and [REDACTED].

R7 had an order for them to use an electric wheelchair, an order to use pneumatic compression device (an inflatable garment for the arm or leg and an electrical pump that fills the garment with compressed air), use as tolerated for R7's edema in legs, an order for a wheeled walker with a seat. R7 had an order for them to administer their own medications with reminders from staff to take their medications on time. R7 had an allergy to Sulfa medications.

Record review of R7's Washington Resident Assessment, dated 06/12/2023, showed R7 with multiple medical diagnoses including [REDACTED]

[REDACTED] and [REDACTED] R7 was unable to manage their own treatments, medications, and equipment per the physician's order. R7 was able to make themselves understood and was able to understand others. R7 didn't have a history of harming self or others. R7 had memory issues. R7's prescribed medications were ordered by the facility staff. R7 was responsible to obtain any over the counter medications. R7 ate a regular diet with no modifications or preferences. R7 had a power of attorney to make decisions.

Record review of R7's Home and Community Services Assessment Details Current Interim, dated 05/26/2023, showed R7 had multiple medical diagnoses that included [REDACTED]

[REDACTED] and [REDACTED] There was no documented medical diagnosis for [REDACTED] R7 complained of daily pain to their back, hip, and other areas. R7 had additional medical concerns that included being pre-diabetic and had hepatic stenosis (a condition when the liver has extra fat). R7's ability to administer their medications fluctuated that contributed to R7 had forgot to take their medications. R7 would require the facility to provide assistance with their medications. R7 required the use of an adaptive-sero ventilation (a machine that provides air pressure to the persons breathing pattern) for their sleep apnea when they slept. R7 was easily irritable/agitated that required intervention that they preferred to be left alone. R7 had a history of suicidal ideation and depression that contributed to low self-esteem and feeling alone. R7 had a history of occasionally had choking/swallowing issues, that could happen at any time. R7 was frequently incontinent of urine and required use of briefs and pads. R7 still able to preform own toileting care without assistance. R7 required assistance by the facility to put on and take off

compression socks on their legs.

Record review of R7's Needs and Services Plan, undated, showed R7 only required reminders and cues with their bathing. R7 was independent with their grooming, dressing, meals, toileting, ambulation, and transfers. R7 had no falls. There were no interventions documented to assist in preventing falls. The document did not show if R7 could leave the premises unassisted. There were no documented medical diagnoses for R7 listed. R7 had a history of anxiety (mental disorder of feeling overwhelmed or excessively worried). Staff were to provide R7 medications if anxiety presented. R7 was documented to be diabetic. R7 was documented to have sleep apnea. Staff were to assist R7 with sleeping position for optimal breathing effort. There was no documentation that R7 used a sleep apnea machine when they slept.

In an interview and observation on 07/25/2023 at 10:11 AM, R7 had an electric wheelchair in their room. There was a sleep apnea machine on their bedside table next to their bed. R7 stated they recently had a fall in their room when their foot got caught on their four wheeled walker. R7 stated they used their electric wheelchair to go to the dining room for meals and all long distances. R7 stated they have lymphedema. R7 stated they were unable to walk long distances and had been this way prior to moving into the facility. R7's legs were observed to have fluid built up on the legs. R7 stated they do elevate their legs at time to help with the fluid buildup. R7 stated that they were gluten intolerant and required a gluten free diet. R7 stated they were not diabetic but pre-diabetic. R7 stated they received an injection to help aid in their weight loss that they had started a few weeks prior to them admitting to the facility. R7 stated they used a shower bench when they take a shower. R7 state the medication technicians provide their medication for them except the two medications for their Meniere's disease that they keep at their bedside.

Resident 4 (R4)

Record review of R4's Face Sheet, undated, showed R4 moved into the facility on [REDACTED]/2020 with multiple medical diagnoses including [REDACTED]

and [REDACTED]

Record review of R4's Washington Resident Assessment, dated 06/06/2023, showed R4 had multiple medical diagnoses including [REDACTED]

and [REDACTED]

[REDACTED] R4 required Medication Technicians to assist with their medications. Staff were to monitor R4 for any signs of shortness of breath, increase in edema (accumulation of fluid in the legs and arms), any increase in pain, and any behavioral outbursts. R4 was treated for glaucoma and required use of glasses. R4 was able to communicate their needs. R4 had a history of experiencing delusions (a belief that is not true and indication of an abnormality in the affected person's content of thought). R4 has a history of outbursts of yelling at staff and other residents. Staff were to listen to R4 completely before speaking to prevent behaviors of R4 yelling and screaming. R4 had a mental disorder Bipolar (mental disorder that causes unusual shifts in mood from anger, happy and sad) and short-term memory loss. Staff were to redirect R4 in

a calming voice and reorient. If R4 became agitated staff were to leave the room after ensuring R4 was safe. R4 required their food to be chopped up. R4 required one person assistance with transfers and total assistance or wheelchair escort to and from activities and meals. R4 required oxygen and were to coordinate with outside agency. The assessment was not signed or dated by the resident, responsible party, or the authorized community representative.

Record review of R4's Needs and Services Plan, undated, showed R4 required total assistance with grooming, dressing, toileting, ambulation, transfers. R4 required significant total assistance by the medication technician for their medications. Under the section Safety, showed yes for falls. There were no documented interventions in place to help prevent further falls and incidents from occurring. There was no direction as to how, what, when to preform any care needs for R4. Under the section Special Care Needs, showed oxygen next to allergies. There was no further documentation that showed any further details for R4's oxygen.

Record review of R4's Home and Community Services document titled, Assessment Details Current Annual, dated 07/12/2023, showed R4 had three falls within the last six months. R4 had a fear of falling. R4 used glasses as their vision was impaired with their depth perception. R4 had multiple medical diagnoses that included [REDACTED]

[REDACTED] and [REDACTED] R4 experienced daily back pain that required the facility medication technicians to apply and provide medications their back. R4 received weekly skilled physical therapy services provided by a home health agency. R4 required oxygen therapy. R4 required one-person physical extensive assistance with the use of their walker for any transfer. R4 was bedfast or chair fast all or most of the time. R4 required staff to physically assist with repositioning when they were in bed. R4 was frequently incontinent of bowel and bladder. R4 required extensive one-person physical assistance with the toileting assistance and their dressing tasks. R4 required a shower bench and handheld shower to assist in their ability to shower. R4's dentures do not fit but didn't require any altered nutritional approaches.

In an interview and observation on 07/27/2023 at 2:16 PM, R4 stated they had a hard time hearing and had to have their television up loud. Observed when R4 was talking they had continuous mouth movements and their dentures would fall out of their mouth. There was an oxygen concentrator (a machine that produces oxygen from the air) that was connected to the oxygen tubing that R4 worn under their nose. There was a four-wheel walker that was sitting in front of the residents chair they were sitting on with an oxygen tank hanging in a black bag off of the front with oxygen tubing that was connected. R4 stated they had pain daily all over their body from their arthritis and scoliosis (a sideways curve of the spine) in their back. R4 stated their dentures were too big and made it difficult to bite their food. R4 stated they used to take antipsychotic medications that caused them to have tardive dyskinesia (a condition where the face, body, or both make sudden, irregular movements which the person cannot control) effects to their mouth. R4 stated they use oxygen all the time for their lungs since the last time they went to the hospital. The oxygen concentrator showed a label "Lincare". R4 stated that they bring their medications to them and apply the ointment to their back. R4 stated that they needed assistance from the caregivers with their showers, toileting, and dressing. R4 stated they don't have control of

their bladder and required to use pull ups. In R4's chair they were sitting on, there was a cloth incontinent pad. Observed in R4's shower showed there was a shower bench. R4 stated they needed the shower bench to sit on to take a shower.

Resident 6 (R6)

Record review of R6's Face Sheet, undated, showed R6 admitted into the facility on [REDACTED]/2022. The primary diagnosis section showed R6 had a diagnosis of [REDACTED]

Record review of R6's Needs and Service Plan, undated, medication section showed R6 needed total assistance from the medication technician. The needs and service plan did not show how R6 took their medication. The needs and service plan did not show R6's preferences for activities and how they would be supported.

Record review of R6's Department of Social Health Services Assessment Details, dated 09/23/2022, showed R6 required assistance with self-administration of their medication. Client limitations showed R6 had a complex medication regimen, their ability fluctuated, they did not follow their frequency or dosage, and they forgot to take their medications. Caregiver instructions showed staff were to provide assistance at resident's request, document medication taken, hand medication in a cup or bowl, put medications in a lockbox, inform resident of each medication given, open containers, re-order medications, and report adverse reactions.

In an interview on 07/25/2023 at 10:17 AM, R6 stated the facility staff were responsible to provide them their medication. R6 stated the staff brought them their medication, left it on their counter, and it was up to them to take their medication.

Resident 3 (R3)

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on [REDACTED]/2018. The primary diagnosis section showed R3 had a diagnosis of [REDACTED]

Record review of R3's Needs and Services Plan, undated, medication section showed R6 needed total assistance from the medication technician. The needs and service plan did not show how R6 took their medication. The needs and services section was blank. The needs and service plan did not show R3's preferences for activities and how they would be supported.

Resident 1 (R1)

Statement of Deficiencies	License # 2615	Compliance Determination #26995
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 117 of 154	Licensee: Greenlake Management Ocean Shores,	08/22/2023

Record review of R1's Face Sheet, undated, showed R1 admitted into the facility on [REDACTED] /2015. The primary diagnosis section showed R1 had diagnoses of [REDACTED] and [REDACTED].

Record review of R1's Needs and Services Plan, undated, under the medication section showed R1 needed total assistance from the medication technician. The needs and service plan did not show how R1 took their medication. The needs and service plan did not show R1's preferences for activities and how they would be supported.

Record review of R1's Department of Social Health Services Assessment Details, dated 06/08/2023, medication section showed R1 required assistance with self-administration of their medication. Client limitations showed R1 did not follow frequency or dosage, forgot to take their medication, and unaware of dosages. Caregiver instructions showed document medication taken, hand medication in a cup or a bowl, re-order medications, and report adverse reactions.

Resident 5 (R5)

Record review of R5's Face Sheet, undated, showed R5 admitted into the facility on [REDACTED] /2022. The primary diagnosis section showed R5 had diagnosis of [REDACTED] and [REDACTED].

Record review of R5's Needs and Services Plan, undated, showed no interventions if R5 experienced behavioral changes related to their diagnosis of [REDACTED]. The needs and service plan did not show R5's preferences for activities and how they would be supported.

This is a recurring deficiency previously cited on 04/26/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) <u>10/6/2023</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Lebbie Smathers</u> Administrator (or Representative)	<u>9/11/2023</u> Date

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

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 with medication changes, after a fall, a change in residents' condition, and after admission to the facility for 8 of 8 sampled residents (Resident 1, Resident 3, Resident 4, Resident 6, Resident 7, Resident 8, Resident 11, and Resident 16). This failure placed residents at risk for unmet and unidentified care needs.

Findings included...

Record review of facility's policy, titled, "Narrative Charting", dated 12/15/2021, showed "Narrative charting will be maintained to promote clear communication regarding resident care... The suggested format for narrative charting is: D = Data Enter all essential facts related to resident status. A = Action State the actions/interventions made in response to the data. R = Response Follow up and document the resident's response to the action taken... A narrative entry addressing current resident status is made every shift (or more often if necessary) for 48 hours after a fall or sentinel event."

Record review of the facility's policy, titled, "Alert Charting", dated 08/10/2021, showed "Alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring... Alert charting procedures will be initiated if a resident: a) is new to the Community. b) Exhibits a change in condition. c) Is returning from the hospital, ER (Emergency Room), or urgent care. d) Has Fallen. e) Has eloped from the community. f) Is prescribed a new order for an antibiotic, controlled substance, or psychotropic medication. g) Exhibits a change in the resident's expected or customary pattern in physical, emotional, behavioral, or mental function. h) Any other reason deemed appropriate by the Wellness Director... Each resident placed on alert charting will be monitored for at least 48 hours

following the initiation of alert charting... Changes in the residents Negotiated Service Agreement will be made, as appropriate.”

Resident 4 (R4)

Record review of R4's Face Sheet, undated, showed R4 moved into the facility on [REDACTED]/2020 with multiple medical diagnoses including [REDACTED]

and [REDACTED]

Record review of R4's Internal Incident Report, dated 05/03/2023 at 5:15 PM, showed R4 had slipped off their bed landing with their head against the nightstand. Emergency Medical Technicians were called to evaluate R4. R4 was not transported to the hospital.

Record review of R4's charting notes, dated 05/01/2023 through 07/24/2023, showed there was no documentation about R4's fall out of bed on 05/03/2023. There was no documentation that showed the fall had occurred. There was no further follow up documentation after the fall that showed if R4 had been placed on alert for any possible changes or injuries to their head or body.

Record review of R4's Internal Incident Report, dated 05/15/2023 at 3:17 PM, showed R4 had tried to open their window when they fell and hit their right hip. The document showed that R4's oxygen saturation level (a percentage that shows how much oxygen is attached and carried through the blood) was 90 percent on three liters of oxygen per minute. Under the section "Follow-up- briefly describe any follow-up actions that has occurred since the incident", showed there was nothing documented.

Record review of R4's charting notes, dated 05/01/2023 through 07/24/2023, showed there was no documentation about R4's fall on 05/15/2023. There was no documentation that showed the resident had fallen and placed on alert for any possible changes or injuries to their right hip or related to their breathing and oxygen level.

Record review of R4's Internal Incident Report, dated 05/20/2023 at 11:00 PM, showed R4 had tried to open a drawer on their bedside cabinet and rolled out of bed. R4 had their head in between their bed and that bedside cabinet.

Record review of R4's charting notes, dated 05/01/2023 through 07/24/2023, showed there was no documentation about R4 rolling out of bed on 05/20/2023. There was no documentation that showed the resident had rolled out of bed and had their head stuck in between their furniture. There was no follow up documentation that showed R4 was placed on alert for any possible injuries to their head.

Resident 7 (R7)

Record review of R7's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2023.

Record review of R7's charting notes, dated 05/30/2023 through 06/01/2023, showed there was no follow up documentation how R7 was adjusting from their admission to the facility.

Record review of R7's Physician Communication, dated 06/19/2023, showed R7 had a sore on the back of their inner thigh with a hole (pinpoint) in the center. The facility was requesting medical cream to help clear up the wound.

Record review of R7's charting notes, dated 06/16/2023 through 06/24/2023, showed there was no documentation that the sore was existed on the back of R7's thigh. There was no documentation that the physician was contacted. There was no further documentation to show if any changes with R7 related to the sore on their thigh.

Resident 11 (R11)

Record review of R11's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2022 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R11's, Internal Incident Report, dated 07/21/2023 at 10:49 AM, showed R11 reported to Staff C, Resident Care Coordinator, at 11:05 AM that they had a fall in their room. R11 told Staff C they had paged for help but no one came and R11 got them self-up off of the ground. Staff C documented that R11 was very upset that no one had answered their page for help.

Record review of R11 charting notes, dated 12/21/2022 through 07/24/2023, showed there was no documentation that R11 had a self-reported fall on 07/21/2023.

Resident 16 (R16)

Record review of R16's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED].

Record review of R16's Medication Administration Record (MAR), dated 07/01/2023 through 07/24/2023 showed R16 reported to Staff J, Medication Technician, they had loose stools on 07/01/2023 and 07/17/2023. On 07/20/2023 and 07/24/2023, showed Staff J documented that R16 wanted their stool softening medication changed to as needed.

Record review of R16's charting note, dated 05/25/2023 at 1:47 PM, showed R16 had loose stool's and was not feeling well.

Record review of R16's charting notes, dated 05/26/2023 through 07/24/2023, showed there was no further documentation about R16 experiencing loose stools or that the physician was notified to change R16's stool softening medications to as needed.

Record review of R16's chart note, dated 07/12/2023 at 6:41 PM, showed R16 has sent to the local hospital at 3:30pm that day. R16 had complaint of being in pain and spasms on their sides. R16 was having a hard time using the bathroom. Physician gave an order to go to the emergency room or urgent clinic.

Record review of R16's charting notes, dated 07/12/2023 through 07/24/2023, showed there was no further documentation that showed when R16 returned to the facility. There was no documentation how R16's pain and spasms were after the visit from the hospital and overall condition.

Resident 6 (R6)

Record review of R6's Face Sheet, undated, showed R6 admitted into the facility on [REDACTED]/2022. The primary diagnosis section showed R6 had a diagnosis of [REDACTED]

Record review of R6's Needs and Service Plan, undated, showed R6 was a fall risk. The goal was for R6 to avoid injury from falls. The interventions in place included R6 wearing their glasses and staff to remind resident to use their walker as needed if R6 were observed to be ambulating without the device.

Record review of R6's Physician Communication, dated 06/04/2023, showed a fax to R6's physician that stated R6 had fallen at approximately 9:00 PM. R6 stated they were locking their door, felt lightheaded, and fell which resulted in them hitting their head on the floor. The fax showed emergency services were called to evaluate R6 and they helped R6 off the floor. The fax showed the physician instructions, signature, and date sections were blank.

Record review of R6's internal Incident Report, dated 06/04/2023, showed that when R6 went to lock their door, they got lightheaded, fell, and hit their head. R6 did not want to go to the hospital but emergency services were called and evaluated R6 and helped R6 off the floor. The notification section if the physician responded to the fax was blank. The follow up after the incident section was blank. R6 follow up with their physician section was blank.

Record review of R6's Narrative Charting, dated 05/01/2023 through 05/12/2023, showed

no notes after 05/12/2023 to review regarding R6's condition post fall on 06/04/2023.

Record review of R6's Charting Notes – All Time, dated 06/09/2023 through 06/24/2023, showed no charting notes prior to 06/09/2023 to review regarding R6's condition post fall on 06/04/2023.

In an interview on 07/25/2023 at 10:17 AM, R6 stated they experienced a fall at night and hit their head. R6 stated the knot on their head that formed was huge.

In an interview on 07/26/2023 at 12:15 PM, Collateral Contact 2 (CC2), R6's Power of Attorney, stated R6 had experienced a fall on 06/04/2023. CC2 stated R6 fell when they locked their door and turned away from it. CC2 stated R6 hit their head.

Resident 1 (R1)

Record review of R1's Face Sheet, undated, showed R1 admitted into the facility on [REDACTED]/2015. The primary diagnosis section showed R1 had diagnoses of [REDACTED] and [REDACTED].

Record review of R1's Needs and Services Plan, undated, showed staff were to report any changes in R1's balance, cognition, signs of hyper (high) hypo (low) glycemia (sugar in the blood).

Record review of R1's Charting Notes – All time, dated 05/26/2023 at 12:49 PM, showed Staff V, Medication Technician, wrote R1 stated they had low blood pressure this morning and it was 90/60 and wanted it rechecked. R1's recent blood pressure was 102/64 manually.

Record review of R1's Charting Notes – All time, dated 05/26/2023 at 5:54 PM, Staff V wrote R1 reported they felt weak. R1 stated they experienced the same symptoms from when they had a blood infection. Staff V wrote before dinner R1's blood glucose (blood sugar level) was 73 and after dinner it was 103. Staff V stated R1 felt better and would notify staff of any more concerns.

There were no further charting notes to review regarding R1's concern for their blood pressure and blood glucose levels.

Record review of R1's Charting Notes – All time, dated 05/30/2023 at 6:47 PM, Staff V wrote around dinner R1 reported they were shaky. R1's blood glucose was 84. R1 was given orange juice and guided back to dinner. Staff V wrote they asked on coming shift to monitor and check R1's blood glucose again.

There were no further charting notes to review regarding R1's concern for their blood glucose levels. There were no further charting notes that showed R1's blood glucose was rechecked.

Record review of R1's Physician Communication, dated 05/17/2023, showed a fax to R1's physician that stated R1 had experienced loose stool for three days. R1 reported every time they ate, they felt as if the food went through them. R1 had requested a medication to help with their symptoms. The physician instructions, signature, and date section were blank.

Record review of R1's Charting Notes – All time, dated 05/26/2023 through 05/30/2023, showed no notes prior to 05/26/2023 to review regarding R1's loose stool concerns, if their physician prescribed them medication, and when and if the loose stool resolved.

Resident 3 (R3)

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on [REDACTED]/2018. The primary diagnosis section showed R3 had a diagnosis of [REDACTED]

Record review of R3's Needs and Services Plan, undated, activities of daily living (ADL's) section showed resident was total assistance for bathing, grooming, dressing, meals, and toileting. If resident refused assistance allow time to complete later as appropriate. Do not rush or argue with the resident during ADL's. "Resident needs [their] food cut, prompting throughout meal to stay in dining room and how to eat daily. Finger foods work best for [R3] because [R3] is forgetting how to use the silverware at times... The following services will be provided for this directed care resident: monitor weight, ensure resident safety strategies are in place, insure resident consuming meals and snack daily, communication with family and representative."

In an observation on 07/24/2023 at 3:00 PM, R3 came into the dining room to sit at a table with the Licenser. R3 was asked if it was ok to sit next to them. R3 was observed to speak multiple words that didn't complete a sentence. R3 was observed to become upset. R3 stood up, raised their hands, and continued to say words that didn't make sense. Resident 20 (R20) stated that R3 typically sat at that table. R20 stated R3 frequently got upset with any changes to their table.

In an interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated R3 shouldn't live at the facility. R7 stated R3 often would scream at other residents. R7 stated other resident would then tell R3 to "shut up". R7 stated R3 should be in a dementia unit. R7 stated R3 often wanders throughout the facility. R7 stated there wasn't enough staff support and assistance to provide to R3 as they required. R7 stated they had observed R3 yell and scream at Resident 38 (R38).

In an interview on 07/26/2023 at 2:38 PM, Staff R, Caregiver, stated R3 had dementia. Staff R stated R3 would often get angry and frustrated with staff when care was attempted to be provided.

In an interview on 07/26/2023 at 3:07 PM, Staff P, Cook, stated R3 had dementia. Staff P stated they have observed R3 to wander away from the dining room tables during meals. Staff P stated R3 required small portions or R3 would get angry and not eat.

In an interview on 07/27/2023 at 12:41 PM, Staff I, Medication Technician, stated they had observed R20 to yell at R3. Staff I stated R20 had told R3 to "shut the F**k up". Staff I stated R3 has dementia. Staff I stated R3 and R38 hang out with each other. Staff I stated R38 gets frustrated with R3. Staff I stated they had observed R3 and R38 yell at each other.

In an interview on 07/25/2023 at 1:37 PM, Staff B, Resident Care Director/Registered Nurse, stated R3 did not have any charting notes or narrative notes the facility were able to provide for review. Staff A, Executive Director, stated there should be charting notes from caregivers and medication technicians that the facility could provide to review.

There were never any charting notes or narrative charting notes provided to review regarding R3.

In an interview on 08/08/2023 at 10:20 AM, Collateral Contact 3 (CC3), R3's Power of Attorney, stated the facility staff only ever contacted them when it regarded notifying them R3's billing statement was going to get raised. CC3 stated the communication they received from the facility was nonexistent. CC3 stated they were unsure if R3 had experienced any kind of change of condition. CC3 stated they did not visit R3 often and they felt the facility interpreted this as not needing to communicate with them regarding R3's care needs.

Resident 8 (R8)

Record review of R8's Face Sheet, undated, showed R8 admitted into the facility on [REDACTED]/2022.

The primary diagnosis section showed R8 had diagnoses of [REDACTED] and [REDACTED]

Record review of R8's Needs and Services Plan, undated, activity's goal showed encourage involvement and participation as R8 desired. Interventions showed assist R8 to choose and attend desired activities and R8 would receive one on one services as needed.

Record review of R8's Charting Notes – All time, dated 06/27/2023 through 07/14/2023, showed no notes to review prior to 06/27/2023 regarding R8's admission into the facility that took place on [REDACTED]/2023.

Record review of the facility's Resident/Family Concern/Grievance Form, dated 05/29/2023, showed R8 expressed concern that after bingo they had gotten into a verbal argument with R15. R8 stated R15 cursed at them and R8 reported they called R15 names back. R8 stated they tried to explain what happened to Staff L, Activities, and that Staff L walked away while shaking their head. R8 wrote "I guess that will end my bingo".

In an interview on 07/26/2023 at 3:54 PM, R8, stated R15 yelled at them, and they got in a verbal altercation. R8 stated Staff L had been present during the altercation. R8 stated Staff L and R15 went into the office together. R8 stated they could not participate in activities in the facility because R15 would curse at them. R8 stated that in the past R15 had destroyed their artwork on their room door by drawing over it.

In an interview on 07/27/2023 at 12:10 PM, Staff A stated they were aware R8 and R15 had gotten into a resident to resident altercation. Staff A stated R8 stated R15 ripped up their drawings. Staff A stated R15 stated they did not rip up R8's drawings. Staff A stated they did not have proof of what happened. Staff A stated both R8 and R15 were upset about the incident. Staff A stated they were not aware R8 showcased fear around R15. Staff A stated they were not aware that R8 stopped participating in activities because of the incident. Staff A stated the residents did not report their concerns to them.

Record review of R8's Charting Notes – All time, dated 06/27/2023 through 07/14/2023, showed no notes to review regarding how R8 was doing after their resident to resident altercations with R15.

Record review of R8's Charting Notes – All time, dated 06/27/2023 at 6:44 PM, Staff V, Medication Technician, wrote R8's leg was severely swollen. Staff V instructed staff to make sure R8's legs were elevated. R8 regularly took their furosemide (medication to help treat fluid retention and swelling caused by congestive heart failure). R8 did not have chest pain or trouble breathing.

Record review of R8's Charting Notes – All time, dated 06/27/2023 through 07/14/2023, showed there were no further charting notes to review regarding R8's swollen leg that occurred on 06/27/2023.

In an interview on 07/27/2023 at 12:18 PM, Staff A stated residents would need to be placed on alert when they experienced a change of condition. Staff A stated if a resident had a fall, if they returned from the hospital, if they were a newly admitted resident, and if the resident had a new medication were all examples of when residents needed to be placed on alert charting for a minimum of 48 hours.

This is a recurring deficiency previously cited on 04/26/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) <u>10/6/2023</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Debbie Smathers</u> Administrator (or Representative)	<u>9/11/2023</u> Date

WAC 388-78A-2450 Staff.

- (1) Each assisted living facility must provide sufficient, trained staff persons to:
- (a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;
- (2) The assisted living facility must:
- (b) Verify staff persons' work references prior to hiring;
 - (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;
 - (vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and
 - (i) Develop and implement a process to ensure caregivers:
 - (i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;
 - (j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility to ensure all staff were properly trained on how to report allegations of abuse and neglect as a mandated reporter for 4 of 4 sampled Staff (Staff L, Staff N, Staff F, and Staff I). The facility failed to ensure staff work reference checks were completed before they were hired for 1 of 6 sampled staff (Staff A). The facility failed to ensure all employees were trained on how to provide the care and services for all residents based on their Needs and Services Plans (facility's version of

the Negotiated Service Agreements) for 4 of 5 sampled staff (Staff F, Staff R, Staff G, and Staff O). These failures placed all 52 of 52 residents at risk of staff not identifying and reporting potential abuse and neglect to help protect the residents. There failures placed all residents at risk of receiving care and services from unqualified and or unsuitable staff.

Findings included...

Record review of the facility's policy, titled, "Elder Abuse, Neglect, and Exploitation", dated 12/15/2021, showed resident abuse, neglect, and exploitation were prohibited. Should any resident experience abuse by staff, residents, family, or others or when any form of abuse was suspected, staff and volunteers were required to immediately provide notification to persons/agencies as described in this policy. All resident care assistants would receive in-service training on elder abuse definitions and descriptions (term abuse as used in this policy also includes, but not is not limited to, neglect, abandonment, and financial exploitation), signs and symptoms of abuse, and reporting requirements during initial orientation. The training would be repeated annually.

RCW 74.34.020 Definitions: "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

Record review of the "Assisted Living Facility Guidebook, Partners in Protection", dated February 2018, under the section, "when to make a report", showed when an individual mandated reporter had reason to suspect sexual or physical assault had occurred, they must report immediately as soon as the resident victim was protected from further harm. An individual was to report when there was reasonable cause to believe abandonment, abuse, neglect, or financial exploitation had occurred, the report would be made immediately.

Record review of the facility's policy, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, showed a copy of the negotiated service agreement was kept in the resident's record. A copy of the residents negotiated service agreement would be kept in the NSA binder that was readily available to the care staff.

Abuse and Neglect

In an interview on 07/26/2023 at 11:52 AM, Staff L, Activities, stated if they suspected a resident was being abused or neglected, they would inform Staff A, Executive Director. Staff L stated Staff A would probably notify Staff L, Resident Care Director. Staff L stated depending on the circumstance and who was accused would determine the next steps. Staff L stated the incident would need to be reported to the state.

In an interview on 07/26/2023 at 1:42 PM, Staff N, Housekeeping, stated if they suspected a resident was being abused or neglected, they would inform Staff A. Staff N stated they would go through the chain of command. Staff N stated they know they were a mandated reporter, and they would call the concern in to the state if they needed to.

In an interview on 07/26/2023 at 1:43 PM, Staff F, Caregiver, stated they would call the Department's Complaint Resolution Unit (CRU) hotline number, only for physical abuse or neglect. Staff F stated they were never trained about the yellow CRU Hotline posters that were hung around the facility. Staff F stated they hadn't had any training since they were hired at the facility about being a mandated reporter or abuse/neglect reporting and identification. Staff F stated they had observed Resident 16 (R16) and Resident 17 (R17) had yelled at each other often and accused each other of stealing their personal belongings. Staff F stated they reported it to Staff A, Executive Director, and kept R16 and R17 on their own side of the room they shared.

In an interview on 07/27/2023 at 12:52 PM, Staff I, Medication Technician, stated a mandated reporter was someone that saw something physically happen. Staff I stated they hadn't participated in a training by the facility about abuse, neglect, or mandated reporting for this year 2023.

In an interview on 07/26/2023 at 12:39 PM, Staff A stated they didn't know how often the facility provided education and training to the facility's staff about abuse, neglect, and mandated reporting to protect the residents.

Work References

Record review of the Department of Health and Social Services data base showed the facility started to be managed by the current management company as of 06/01/2022. The Departments databased showed the owner Brookdale Ocean Shores transferred ownership to another owner on 05/31/2022.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff A, Executive Director, was hired at the facility on 06/01/2022.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff B, Resident Care Director Registered Nurse, was hired at the facility on 07/10/2023.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff L, Activities, was hired at the facility on 12/22/2022.

Record review of Staff A's Green Lake Senior Living Ocean Shores Professional Reference, dated 07/24/2023, showed Staff B conducted the reference check for the facility Brookdale

Ocean Shores. The form showed the company contacted was blank.

Record review of Staff A's Green Lake Senior Living Ocean Shores Personal Reference, undated, showed Staff B conducted the reference check for the facility Brookdale Ocean Shores. Staff L, Activities, was the person contacted. The reference check showed nine of ten questions on the form were documented as N/A (not applicable).

Record review of Staff A's Green Lake Senior Living Ocean Shores Professional Reference, dated 07/24/2023, showed Staff B conducted the reference check for the facility Brookdale Ocean Shores. The company's name that was contacted was "Flooring Company".

In an interview on 07/26/2023 at 3:56 PM, Staff M, Business Office Manager, stated new employee reference checks were to be completed before the employee was hired. The facility's business office manager was responsible for completed reference checks.

Care and Services for the Residents

Record review on 07/25/2023 at 1:35 PM of Resident 7's medical file showed there was no Needs and Services Plan available to review.

In an interview on 07/26/2023 at 1:43 PM, Staff F, Caregiver, stated they didn't know where to look or was shown where the Needs and Services Plans were to review what the care and services the residents required. Staff F stated they learned what the residents needed by working with and assisting the residents.

In an interview on 07/26/2023 at 2:38 PM, Staff R, Caregiver, stated they were not aware the resident's needs and care services plan were located to review for specific care and services the residents required. Staff R stated they only knew what care and services residents required by the person that trained them and just getting to know the residents.

In an interview on 07/31/2023 at 11:00 AM, Staff G, Maintenance, stated they also worked as a caregiver for the facility. Staff G stated they never received training from the facility regarding how to access the residents' hard charts and locate their needs and services plans. Staff G stated they had to follow up with facility staff and inquired about how to access the resident's information.

In an interview on 07/31/2023 at 11:00 AM, Staff O, Caregiver, stated they never received training from the facility regarding how to access the residents' hard charts and locate their needs and services plans. Staff G stated they followed up with facility staff and inquired about how to access the resident's information.

In an interview on 07/27/2023 at 12:45 PM, Staff I, Medication Technician, stated the

facility had service plan binder that would have a copy for all the residents in the facility inside for staff to review. Staff I stated they weren't up-to-date.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete the Negotiated Service Agreement (NSA) within 30 days following admission to the facility for 1 of 2 sampled residents (Resident 8). This failure placed Resident 8 at risk of unmet care needs and decreased quality of life.

Findings included...

Record review of the facility's policy, "Resident Assessment and Negotiated Service Agreement", dated 08/10/2021, under the section service agreement planning, showed the assisted living facility must develop an initial resident service plan, based on discussions with the resident and resident's representative if the resident has one and the preadmission assessment upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority. Identifies the resident's immediate needs and provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences. Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in.

Record review of R8's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2022 with multiple medical diagnoses including [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] and [REDACTED]

Record review of R8's Washington Resident Assessment, dated 03/20/2023, showed R8 had a history of domestic violence (violent or aggressive behavior), history of substance abuse (excessive use of a drug that is harmful to self and others), and was identified to have safety considerations of hoarding. R8 administered their own medications. R8 required assistance from a nurse. R8's prescribed medications and over the counter (medications that could be bought in a store) were to be obtained by the facility staff.

Record review on 07/27/2023 of R8's medical chart showed there was a document titled, "Care Plan Master", dated 12/29/2022 for review.

In an interview on 07/27/2023 at 11:47 AM, Staff D stated the facility nurse was responsible to complete all the resident's assessments.

In an interview on 08/08/2023 at 3:26 PM, Staff D, Western WA Clinical Services Director Registered Nurse Delegator, stated R8's document Care Plan Master was the facility version of preadmission assessment. Staff D stated R8 had a Needs and Services Plan (facility version of the NSA), completed on 06/12/2023. There were no other assessments that were completed between the dates 12/29/2022 through 06/11/2023 for review.

This is a recurring deficiency previously cited on 07/06/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023.

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the residents physician and/or residents responsible party for 7 of 7 sampled residents (Resident 16, Resident 6, Resident 14, Resident 7, Resident 4, Resident 5, and Resident 10) when the residents had an incident or change in condition. This failure resulted in the resident's physician and or representative not being able to make an informed decision about the resident's care and placed residents at risk of unmet care needs.

Findings included...

Resident 4 (R4)

Record review of R4's Face Sheet, undated, showed R4 moved into the facility on [REDACTED]/2020.

Record review of R4's Home and Community Services Assessment Current Annual, dated 07/12/2023, showed Collateral Contact 10 (CC10), family of R4, was R4's durable power of attorney of healthcare and financial and emergency contact.

Record review of R4's Internal Incident Report, dated 03/04/2023 at 8:30 PM, showed R4 yelled at staff demanding their medication in an aggressive manner. The report showed the incident was the second occurrence that R4 yelled at facility staff that day. Under the section, "notifications" showed there was no date, time or name of the physician that was notified. There was no documented date, time or name of the family member/responsible party that was notified.

Record review of R4's internal Incident Report, dated 05/03/2023, showed R4 hit their head from a fall. Under the section, "notifications", showed there was no documented date, time or name of the family member/responsible party that was notified.

Record review of R4's internal Incident Report, dated 05/15/2023 at 3:17 PM, showed R4 tried to close a window and fell. Under the section, "notifications", showed there was no documented date, time or name of the family member/responsible party that was notified. Staff J, Medication Technician, documented that R4 was their own power of attorney.

Record review of R4's internal Incident Report, dated 05/20/2023 at 11:00 PM, showed R4 attempted to open a drawer and fell. Under the section, "notifications", showed there was no documented date, time or name of the family member/responsible party that was notified.

Resident 10 (R10)

Record review of R10's Home and Community Services Assessment details, dated 10/08/2021, showed Collateral Contact 13 (CC13), child of R10, was R10's informal decision maker.

Record review of R10's Internal Incident Report, dated 07/08/2023 with no time documented, showed R10 had injured their leg that developed swelling. R10 stated it had happened five days ago when they got on the bus. Under the section, "notifications", showed the physician was notified. There was no documented date or time when the physician was notified. There was no documented date, time, or name of the family member/responsible party that was notified.

Resident 16 (R16)

Record review of R16's Medication Administration Record, dated 07/16/01/2023 through 07/24/2023, showed R16 refused their stool softening medication related to their loose stools on 07/01/2023 and 07/17/2023. R16 refused their stool softening medication on 07/20/2023 and 07/24/2023 with the reason documented that R16 wanted the medication as needed.

In an interview on 07/27/2023 at 1:55 PM, R16 stated the medication technicians continued to administer them stool softening medications that caused them to have loose stools. R16 stated they had accidents from the loose stools. R16 stated they had requested the medication technicians to change the medication to as needed. R16 stated the facility didn't contact their physician for the change.

In an interview on 07/27/2023 at 1:13 PM, Staff I, Medication Technician, stated if a resident had consistent loose stools, they would contact their physician. Staff I stated that R16 had complained of loose stools. Staff I stated that R16 took a stool softener. Staff I stated they hadn't contacted the physician.

In an interview on 07/27/2023 at 4:20 PM, Staff J, Medication Technician, stated R16 had complained of loose stools in the last 30 days. Staff J stated R16 had complained of loose stools. Staff J stated they were unable to give R16 any medications to help stop the loose stools as R16 didn't have any orders for any of that medication. Staff J stated R16 requested that her stool softening medications be changed to as needed rather than daily. Staff J stated that he had faxed the physician two times. Staff J stated the faxes should be in R16 medical chart. Staff J stated all fax communications to the physicians were filed in the residents hard medical chart until a response was returned.

In an observation and interview on 07/27/2023 at 4:15 PM, Staff J looked through R16 medical hard chart for the two physician faxes. Staff J was unable to show either fax communication. Staff J stated it would have been filed in the front of the chart or the or under the physician tab. Staff J stated they were unsure where the physician fax was at for review. Staff J stated that was the only place they file all physician fax's for R16.

Resident 6 (R6)

Record review of R6's Face Sheet, undated, showed R6 moved into the facility on [REDACTED]/2022. Collateral Contact 2 (CC2), daughter of R6, was R6's Power of Attorney and responsible party.

Record review of R6's Internal Incident Report, dated 06/04/2023 at 9:00 PM, showed R6 had gotten lightheaded when they got up to lock their door. R6 fell and hit their head. Under the section, "notifications", showed R6's family was notified by another resident, as R6 had instructed another resident to call CC2.

In an interview on 07/25/2023 at 10:17 AM, R6 stated they had a fall that resulted in them hitting their head. R6 stated they were able to open their door and another resident at the facility heard them calling out for help. R6 stated they instructed the resident to call CC2 and notify them of what happened.

In an interview on 07/26/2023 at 12:15 PM, CC2 stated R6 had a fall on 06/04/2023. CC2 expressed frustration that another resident at the facility called and notified CC2 that R6 had a fall. CC2 stated the facility staff never did call and explain or report that R6 had fallen.

Resident 14 (R14)

Record review of R14's Face Sheet, undated, showed R14 moved into the facility on [REDACTED]/2020.

Record review of R14's Home and Community Services Assessment Current Annual, dated 04/13/2023, showed Collateral Contact 10, daughter of R14, was R14's emergency contact and informal decision maker.

Record review of R14's Internal Incident Report, dated 07/20/2023 at 1:45 PM, showed R14 was lightheaded and staggered backwards and fell. Under the section, "notifications" showed R14's "daughter" was contacted. There was no documented date, time, or name of the family member/responsible party that was notified.

Resident 7 (R7)

Record review of R7's Face Sheet, undated, showed R7 moved into the facility on [REDACTED]/2023.

Record review of R7's Home and Community Services Assessment details, dated 05/26/2023, showed Collateral Contact 6 (CC6) daughter of R7, was the emergency contact and representative/protective payee for R7.

Record review of R7's Internal Incident Report, dated 07/18/2023 at 1:00 PM, showed R7 was found lying on the floor in their room. R7 reported that they fell. Under the section, "notifications" showed family member/responsible party was not notified. There was a note documented that R7 would notify CC6. There was not applicable documented for date and who notified the family member/responsible party.

Resident 5 (R5)

Record review of R5's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2022. Collateral Contact 12 (CC12), son of R5, was listed as the responsible party for R5.

Record review of R5's Internal Incident Report, dated 06/27/2023 at 3:30 PM, showed R5 stood up to fast and fell to the ground. Under the section, "notifications" showed family member/responsible party was not notified. There was a note documented that R5 stated CC12 was out of the county.

This is a recurring deficiency previously cited on 12/22/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide requested documents to the department for review for 3 of 3 documents requested (disclosure of services, employee files, and call light reports). This failure resulted in the department not having necessary information to assess facility systems.

Findings included..

Record review of the Department record Assisted Living Facility Request for Documentation, dated 07/24/2023, Attachment B showed Disclosure of Services (Attachment L) was due to the licenser within two hours of entry of the facility.

Requested the facility's disclosure of services on 07/24/2023 at 12:35 PM.

Record review of the facility's disclosure of services, undated, provided on 07/24/2023 at 2:43 PM, showed the document did not have any documented services that showed what services the facility provided.

Requested the facility's disclosure of services on 07/25/2023.

Record review of the facility's disclosure of services, undated, provided on 07/25/2023 at 2:15 PM, showed the document did not have any documented services that showed what services the facility provided.

In an interview on 07/26/2023 at 12:33 PM, Staff A, Executive Director, stated the facility did have a disclosure of services and it was in the front nurse's office.

In an interview on 07/26/2023 at 1:01 PM, Staff D, Western WA Clinical Services Director/Registered Nurse Delegator, stated Staff A would have the facility's disclosure of Services. Staff D stated Staff A was responsible for the disclosure of services and not the nursing department.

In an interview on 07/26/2023 at 1:03 PM, Staff A stated that Staff F, Health Services Director, had kept the disclosure of services form for the facility.

As of 07/31/2023 the department had not received a completed disclosure of services for

the facility to review.

Employee Record Requests

On 07/25/2023 at 8:50 AM, all components of the employee files were requested to be provided no later than 07/25/2023 by 12:00 PM for the sampled staff which included Staff A, Executive Director, Staff E, Cook, Staff F, Caregiver, Staff G Maintenance, Staff H, Medication Technician, and Staff K, Caregiver's.

On 07/25/2023 at 12:24 PM, Staff A brought in paperclipped staff records to review.

In an interview on 07/25/2023 at 3:20 PM, Staff A was re-requested to provide the sampled staff employee files with all components. The Department explained the sampled staff records did not include facility orientation, reference checks, and food handlers' cards. The documents were requested to be provided no later than 07/26/2023 by 8:00AM. Staff A acknowledged this was the second time the records were being requested.

On 07/26/2023 at 8:00 AM the employee files were not provided to review as requested.

In an interview on 07/26/2023 at 11:14 AM, Staff A stated the facility had employee files for their staff.

As of 08/17/2023 no further documentation was provided for review.

Call Light Report Requests

On 07/25/2023 at 3:20 PM, the call light report for Resident 7 (R7) on 07/19/2023 was requested to be provided no later than 07/26/2023 by 8:00 AM.

In an interview on 07/25/2023 at 3:20 PM, Staff A, Executive Director, stated they would have to follow up with how to gain access to the facility's call light system. Staff A stated Staff C, Resident Care Coordinator, was the staff member who knew how to obtain access to the call light system. Staff A stated Staff C was not available.

As of 07/26/2023 at 8:00 AM R7's call light report was not provided to review.

In an interview on 07/26/2023 at 2:56 PM, Staff B, Resident Care Director/Registered Nurse, stated they were told the person that had the password for the call light computer system was on medical leave. Staff B stated the staff member had not yet to return the call. Staff B said that they do not know how to access the call light system since it was now

Greenlake Management.

Plan/Attestation Statement

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Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

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

- (a) Orientation and safety;
- (d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 6 sampled staff (Staff F, Staff H, and Staff G) had the required CPR (cardiopulmonary resuscitation) and/or First Aid training and failed to ensure 7 of 7 sampled Staff (Staff A, Staff F, Staff G, Staff E, Staff R, Staff K, and Staff O) had completed their facility orientation training. These failures placed 52 of 52 residents at risk for staff not being trained on life saving measures and staff being unaware of the facility's expectations.

Findings included...

Record review of the provider letter number 2022-032 sent by the Department of Social and Health Services, dated 09/09/2022 amended date 10/07/2022, showed CPR and first aid training no longer had emergency rules in place. All facilities were to be back in compliance by 10/27/2022.

Record review of the facility's policy, titled, "Staffing, cardiopulmonary resuscitation (CPR), first aid, and emergency training", dated 08/10/2021, showed staff shall have orientation and training or certification pertinent to the duties including, but not limited to CPR and first aid.

CPR/1st AID

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff F, Caregiver, was hired at the facility on 05/22/2023.

Record review on 07/25/2023 of Staff F's employee documents that were provided by the facility, showed there was no CPR or First AID card to review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff H, Medication Technician, was hired at the facility on 05/19/2023.

Record review on 07/25/2023 of Staff H's employee documents that were provided by the facility, showed there was no CPR or First AID card to review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff G, Maintenance, was hired at the facility on 05/22/2023.

Record review on 07/25/2023 of Staff G's employee documents that were provided by the facility, showed there was no CPR or First AID card to review.

Facility Orientation

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff A, Executive Director, was hired at the facility on 06/01/2022.

Record review on 07/25/2023 of Staff A's employee documents that were provided by the facility, showed there was no facility orientation training document for review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff F, Caregiver, was hired at the facility on 05/22/2023.

Record review on 07/25/2023 of Staff F's employee documents that were provided by the facility, showed there was no facility orientation training document for review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff E, Cook, was hired at the facility on 06/01/2022.

Record review on 07/25/2023 of Staff E's employee documents that were provided by the facility, showed there was no facility orientation training document for review.

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Record review of the facility provided employee roster, dated 07/24/2023, showed Staff G, Maintenance, was hired at the facility on 05/22/2023.

Record review on 07/25/2023 of Staff G's employee documents that were provided by the facility, showed there was no facility orientation training document for review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff K, Caregiver, was hired at the facility on 06/01/2022.

Record review on 07/25/2023 of Staff K's employee documents provided by the facility, showed Staff K showed there was no facility orientation training document for review.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff R, Caregiver, was hired at the facility on 07/12/2023.

Record review of the facility provided employee roster, dated 07/24/2023, showed Staff O, Caregiver, was hired at the facility on 06/02/2023.

In an interview on 07/26/2023 at 1:43 PM, Staff F, Caregiver, stated they did not have a facility orientation provided to them upon hire. Staff F stated they were shown around the facility when they trained with another caregiver.

In an interview on 07/26/2023 at 2:38 PM, Staff R stated they had not participated or completed a facility orientation training since they were hired. Staff R stated they learned the layout of the facility when they walked around.

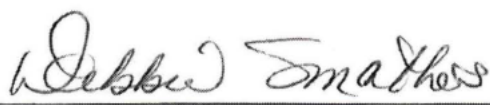
In an interview on 07/31/2023 at 11:00 AM, Staff G stated they had not participated or completed a facility orientation training when they were hired.

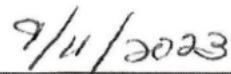
In an interview on 07/31/2023 at 11:00 AM, Staff O stated they had not participated or completed a facility orientation training when they were hired.

Plan/Attestation Statement

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


Administrator (or Representative)


Date

WAC 388-78A-2390 Resident records. The assisted living facility must maintain adequate records concerning residents to enable the assisted living facility:

- (1) To effectively provide the care and services agreed upon with the resident; and
- (2) To respond appropriately in emergency situations.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have a resident physical chart for 2 of 6 sampled residents (Resident 7 [R7] and Resident 36 [R36]). The facility failed to have a completed resident identifying information sheet for 4 of 4 sampled residents (R36, R7, Resident 16 [R16], and Resident 8 [R8]). These failures placed these residents at risk to not have medical information available to staff and medical responders to appropriately care for the resident in a medical emergency.

Findings included...

Record review of the facility's policy, "The Resident Record", dated 08/10/2021, showed each resident's record was maintained in an orderly fashion and audited every six months by the wellness director. Under the section, "Procedure", showed a three-ring binder was used for the resident's physical chart. All care documents would be maintained in the chart. Under the section, "Content of Resident Records", showed active residents records must include on the resident identifying information a current name, address, and telephone number of the residents primary health care provider, residents representative, if the resident has one, individual(s) to contact in care of an emergency, illness or death, and family members or others, if any, the resident requests to be involved in the development or delivery of services for the resident.

Physical Chart

In an observation and interview on 07/25/2023 at 1:30 PM, Staff D, Western WA Clinical Services Director Registered Nurse Delegator, stated they were unable to provide a resident record chart for R7. Staff D stated the documents they had for R7 were placed in an orange file folder for review.

In an observation and interview on 07/27/2023 at 1:17 PM, Staff D, stated R36 did not currently have a chart for the department to review. Staff D stated they were working on following up on R36's medication administration records and their resident record chart. Staff D showed the Department an orange file folder and stated that the file folder was R36's. The orange file folder showed there were documents inside for R7.

In an interview on 08/22/2023 at 12:15 PM, Staff B, Resident Care Director/Registered Nurse, stated they were responsible to create resident charts for residents who admitted

into the facility. Staff B stated historically the facility Resident Care Coordinator had been responsible for creating charts for the residents who admitted into the facility.

Resident Identifying Information

Resident 36

Record review of the facility's, Resident Characteristic Roster and Sample Selection, undated, showed R36 moved into the facility on [REDACTED]/2023.

In an interview on 07/27/2023 at 1:17 PM, Staff D, stated R36 did not currently have a face sheet (facility's version of resident identifying information sheet) for the department to review.

Resident 7

Record review of R7's Face Sheet in the physical chart, printed on 06/07/2023, showed they moved into the facility on [REDACTED]/2023. The face sheet showed there was no physician's name, address, or phone number documented for review. There was no pharmacy's name, address, or phone number listed for R7. There was no documented responsible party and/or alternative contact for R7 for review.

Record review of R7's Home and Community Services Assessment details, dated 05/26/2023, showed Collateral Contact 6 (CC6) daughter of R7, was the emergency contact and representative/protective payee for R7.

Resident 16

Record review of R16's Face Sheet, printed on 01/31/2023, showed R16 moved into the facility on [REDACTED]/2023. The face sheet showed there were no responsible party or alternative contact documented for review.

Record review of R16's Home and Community Services Assessment details, dated 08/03/2023, showed Collateral Contact 5 (CC5) daughter of R16, was documented as R16's emergency contact.

Resident 8

Record review of R8's Face Sheet, printed on 07/27/2023, showed R8 moved into the facility on [REDACTED]/2022. The face sheet showed there was no physician's name, address, or phone number documented for review. There was no documented pharmacy name, address, or phone number for review. The face sheet showed there was no documented responsible party or alternative contact for review.

In an interview on 07/25/2023 at 1:30 PM, Staff D, stated the nursing department was responsible to update and make a face sheet for all of the residents that were resided at the facility.

Statement of Deficiencies

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In an interview on 08/22/2023 at 12:15 PM, Staff B stated the facility Resident Care Coordinator had been responsible for updating residents face sheets and generating face sheets for newly admitted residents.

Plan/Attestation Statement

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Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

- (1) Notify construction review services:
 - (a) In writing;
 - (b) Thirty days or more before the intended change in use;
 - (c) Describe the current and proposed use of the room; and
 - (d) Provide all additional documentation as requested by construction review services;
- (2) Obtain the written approval of construction review services for the new use of the room; and
- (3) Ensure the facility functional program and room list are updated to reflect the change.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to house residents in the approved capacity designated rooms. This failure placed 4 of 4 sampled residents (Resident 16 [R16], Resident 17 [R17], Resident 18 [R18], and Resident 19 [R19]) at risk of residing in a room not adequate per regulations for two people and a decreased in quality of life.

Findings included...

Record review of the facility provided resident list, titled, Management Ocean Shores,

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

undated, showed R16 and R17 lived in the same room. The document showed R18 and R19 lived in the same room.

Record review of the Departments database showed the room that R16 and R17 shared, was only approved to have one resident to occupy the room.

Record review of the Departments database showed the room that R18 and R19 shared, was only approved to have one resident to occupy the room.

In an interview and observation on 07/26/2023 at 1:52 PM, there were two female residents (R16 and R17) that resided in one room. R16 stated they had lived together in the room for over five months. R16 stated they hated each other, but it had been better. R16's side of the room did not have access to a window. R16 had to go through R17's side of the room to exit the room. The bathroom was on the opposite side of the room for R17. R17 would have to enter R16's side of the room to use the bathroom. R16 and R17's beds were up against the wall to have room to get in and out of bed. R16 and R17 were observed to both have a manual wheelchair.

In an interview and observation on 07/27/2023 at 3:18 PM, there was one male and one female (R18 and R19) that was in the same room. The room had one bed inside of the room. R18 and R19 stated they were a couple that shared the room.

In an interview on 07/27/2023 at 4:17 PM, Staff U, Clinical and Compliance Director, stated they were unable to find documentation that showed the two rooms were approved by the Department to have two residents occupy the room.

Plan/Attestation Statement

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Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

WAC 388-78A-2270 Resident controlled medications.

(1) The assisted living facility must ensure all medications are stored in a manner that prevents each resident from gaining access to another resident's medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure medications were stored properly and secured for 2 of 2 sampled resident's (Resident 16 and Resident 7) rooms and 1 of 1 first aid kits. This failure placed 52 of 52 residents at risk to ingest non prescribed medications in error.

Findings included...

Resident 16 (R16)

Record review of R16's face sheet showed R16 moved into the facility on [REDACTED]/2023 with [REDACTED] diagnoses that included [REDACTED]

Record review of R16's Assessment for Medication Self-Management, dated 05/03/2023, showed R16 was identified as not able to self-manage their medications.

Record review of R16's Needs and Services Plan, undated, showed R16 required significant total assisted with their medication by the medication technician.

Record review of R16's Medication Administration Record (MAR), dated 07/01/2023 through 07/24/2023, showed R16 had an order for albuterol hand held inhaler (inhaled medication to help treat wheezing and shortness of breath caused by breathing problems, a rescue inhaler) to inhale one to two puffs every four hours as needed and Flovent hand held inhaler (inhaled steroid medication that is used long term to help prevent shortness of breath) inhale one puff two times daily. Review of the medication orders showed R16 was not ordered to self-administer the medicated inhalers.

In an interview and observation on 07/26/2023 at 1:55 PM, R16 stated "oh I need to take my inhaler". R16 opened her bedside table in the top drawer that was unsecured. R16 pulled out a beige inhaler with a white cap. R16 shook the inhaler and inhaled the medications. R16 stated "oh I took the wrong inhaler, that is ok". R16 then grabbed a red inhaler with a white cap. R16 shook the inhaler and inhaled the medication. R16 stated the facility staff did know that R16 had their inhalers in their room. R16 stated the inhaler, showed the beige inhaler with white cap, was their Flovent prescribed medicated inhaled steroid inhaler. R16 showed the red inhaler with white cap and stated that was their albuterol rescue inhaler. R16 stated the facility staff don't allow them to keep over the counter pain medication in their room. R16 was observed to have an unopened package of a medicated patches to help with pain sitting on top of their bedside table unsecured. R16 stated they put the medicated patch on their back to help aid the pain.

In an interview on 07/27/2023 at 1:09 PM, Staff I, Medication Technician, stated residents that have a physician order to do their own medications were the only residents allowed to have medications in their rooms. Staff I stated R16's physician ordered the facility to administer all of R16's medications. Staff I stated last time R16 had medication in their room, R16 took too much of their medication.

Resident 7 (R7)

Record review of R7's face sheet showed R7 moved into the facility on [REDACTED]/2023.

Record review of R7's Washington Resident Assessment dated 06/12/2023, showed R7 was unable to manage their own treatments, medications, and equipment per the physician's order. R7 had memory issues.

Record review of R7's Assessment for Medication Self-Management, dated 06/05/2023, showed R7 was identified as not able to self-manage their medications.

Record review of R7's charting note, dated 06/04/2023 at 8:00 PM, showed Staff S, Former Health Services Director documented that R7 was changed from self-medication administration to have the facility administer R7 their medications.

Record review of R7's MAR, dated 07/01/2023 through 07/24/2023, showed R7 had a prescribed medication orders for meclizine (prescribed medication to help with motion sickness or vertigo/dizziness) 25 milligrams (mg) take one tablet every eight hours as needed for vertigo. R7 had a prescribed order to take polyeth glycol (alternative name for medication miralax, medication to help soften stool). R7 was to take the medication one to two scoops in six to eight ounces of fluid every day as needed for constipation (difficulty in passing hard bowel movements). R7 had on order for ondansetron (medication to reduce nausea and vomiting), take under the tongue every six hours as needed. The medication orders did not show or indicate that the resident was independent to keep those medications in their room and administer themselves.

In an observation and interview on 07/25/2023 at 10:11 AM, Resident 7 (R7) stated the facility provided their routine medications. Observed on top of the counter in R7's room was a white bottle with purple lid that was unsecured. The side of the bottle showed "miralax". R7 stated they used it to help when they had a hard time having a bowel movement. R7 stated they had their meclizine and ondansetron in their top drawer of their bedside table in case they had a Meniere's attack (an inner ear problem that can cause dizzy spells called vertigo and sometimes hearing loss). Observed that there was no lock on the top drawer that R7 had pulled the two medication bottles out of. Observed the first prescribed medication bottle that showed R7's name and the prescribed medication ondansetron 4mg. Observed the second medication bottle that showed R7's name and the prescribed medication meclizine 25 mgs. R7 stated they had a Meniere's attack, and the medication staff took a long time to respond. R7 stated they were very dizzy and had vomited from the Meniere's attack. R7 stated since that attack, they kept the two medications at their bedside just in case. R7 stated they hadn't mentioned to the staff they had those medications in their room.

First Aid Kit

In an interview on 07/27/2023 at 11:15 AM, Staff A, Executive Director, stated there was a first aid available for use in the activity's room. Staff A stated residents did not have access to the room or went into the room.

In an observation on 07/27/2023 at 2:17 PM, the activity's room had a first aid kit that hung on the wall. Inside of the unlocked first aid kit there was a box of ammonia inhalant respiratory stimulant (a gaseous compound that when inhaled causes irritation to the eyes, nose, and throat).

In an interview on 07/27/2023 at 3:30 PM, Staff D, Western WA Clinical Services Director Registered Nurse Delegator, stated the ammonia inhalant respiratory stimulant should not

have been stored inside the unlocked first aid kit.

Plan/Attestation Statement

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

(1) The assisted living facility must:

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

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

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

(iv) Alternative resident accommodations;

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

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility had developed and maintained a disaster preparedness manual for 1 of 1 facility reviewed. The facility failed to ensure they had sufficient supply of emergency preparedness food and water for 52 of 52 residents. This failure placed all 52 residents and 26 staff not having the resources and direction to assist the residents if a natural or emergency disaster occurred.

Findings included...

Revised Code of Washington (RCW) 18.20.525 "Disaster preparedness plan - (1) Each

assisted living facility shall develop and maintain a comprehensive disaster preparedness plan to be followed in the event of a disaster or emergency, including fires, earthquakes, floods, infectious disease outbreaks, loss of power or water, and other events that may require sheltering in place, evacuations, or other emergency measures to protect the health and safety of residents. The facility shall review the comprehensive disaster preparedness plan annually, update the plan as needed, and train all employees when they begin work in the facility on the comprehensive disaster preparedness plan and related staff procedures.”

Record review on 07/27/2023 at 1:37 PM, of the binder labeled, “Disaster Plan”, showed there were several photographs and descriptions how to shut off the facility water, sprinklers, the water main control valve, and main electrical shut-off. There was a single page document titled, “Emergency Evacuation of the Community (AMF 05 DM)”, undated, that showed, “The extent of a disaster and measures taken to control it will be DETERMINED and DIRECTED BY THE LOCAL FIRE AND EMERGENCY PREPAREDNESS PERSONNEL and carried out by the Executive Director / designee, Supervisor in Charge and all associates. Residents and associates will be moved to the prearranged emergency shelter facility Grays Harbor Health and Rehab” with a contact name. There was driving directions to the rehab center. There was a printed instructions document titled, “building a kit”, dated 05/05/2018. There was a document dated 04/23/2018, that showed three day emergency menu for breakfast, main meal, light meal, HS (bedtime) snack. The document was approved by a registered dietitian. There was no disaster plans of any kind in the binder for review. There were no policy or procedures related to the facility’s emergency preparedness in the binder for review.

Emergency Evacuation

In an interview on 07/25/2023 at 2:32 PM, Staff M, Business Office Manager, stated if the facility needed to be evacuated related to an emergency or natural disaster the staff and residents were to meet in the front of the facility.

In an interview on 07/26/2023 at 1:42 PM, Staff N, Housekeeping, stated they were unsure where they would need to meet if the facility was evacuated. Staff N stated the location would need to be away from the facility.

In an interview on 07/31/2023 at 11:00 AM, Staff O, Caregiver, stated they were never trained the location where they would meet, if the facility needed to be evacuated in an emergency or natural disaster.

Emergency food supplies

In an interview and observation on 07/25/2023 at 7:35 AM, Staff E, Cook, stated the facility’s emergency supply of food for the facility was on a rack that had all canned goods. Staff E stated the emergency supply of dried goods was stored on the same shelves as the other dried goods. The shelf with dried goods had three boxes of brownie mix, four bags of cake mix, four bags of cereal, two big bags of pasta noodles, some packets of powdered

drink mixes, one box of rice, box of saltine crackers, and four loaves of bread.

In an interview on 07/26/2023 at 12:52 PM, Staff A, Executive Director, stated they were unaware of where the emergency food supply for the facility was. Staff E was responsible for managing the food supply.

In an interview on 07/26/2023 at 11:52 AM, Staff L, Activities, stated they thought they needed to meet in the front circular courtyard of the facility. Staff L stated if they evacuated to the back of the facility, staff and residents could get trapped between the building and the ocean.

In an interview and observation on 07/26/2023 at 3:54 PM, Staff M, Business Office Manager, stated the emergency supply of water was stored in the room off of the electrical panel room. In the room was a rack that showed 14 five-gallon jugs that were empty. Staff M stated the staff should not be using that water.

In an interview on 07/27/2023 at 12:04 PM, Staff A stated Staff M was responsible to ensure the facility had up to date emergency supply of water. Staff A stated maintenance was responsible to keep the facility's emergency preparedness binder up to date and available for review.

In an interview on 07/27/2023 at 1:41 PM, Staff A stated the room off the electrical panel room was designated for the emergency supply of water for 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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023.

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

Debbie Smathers
Administrator (or Representative)

9/11/2023
Date

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

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

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

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable

statutes and rules, including, but not limited to:

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

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to have Registered Nurse (RN) Delegation services and documentation in place for 3 of 6 sampled residents (Resident 7, Resident 3, and Resident 38). This failure placed all residents receiving RN delegated services at risk for receiving care and services by untrained staff.

Findings included...

Washington Administrative Code (WAC) 246-840-930- "Criteria for delegation- (1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE.

3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.

(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.

(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.

(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.

(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.

(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j)

The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent.

(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient."

Record review of Department of Social and Health Services document, titled, "Community Nurse Delegation Orientation 2023", undated, showed the Registered Nurse delegator assessment was required to determine the residents clinical and behavioral status was not fluctuating and consistent. The resident was stable and predictable. When the resident was not functionally able and/or not cognitively aware they received medications, the long-term care worker was authorized to so with delegation of the medication by the guidance of the RN delegator. The document showed under the Washington State Law, long-term care workers were delegated by an RN to perform specific nursing tasks that do not include administration of medications by injections except for insulin or non-insulin injections for diabetes and does not require nursing judgement.

Resident 7 (R7)

Record review of R7's Face Sheet, undated, showed R7 moved into the facility on [REDACTED]/2023.

Record review of R7's physician clinic chart summary, dated 06/09/2023, showed R7 had multiple medical diagnoses that included [REDACTED] and [REDACTED]. The summary showed R7 had an order for Ozempic (injectable medication that help reduce blood sugar levels and/or help with weight loss) inject under the skin once a week.

Record review of R7's Resident Care Plan (facility version of pre-admission assessment), dated 05/19/2023, showed R7 took Ozempic (an injected prescribed medication that helps increase insulin release, delay stomach emptying, and reduce desire to eat) injections. There was no documentation that showed R7 was a type 2 diabetic. Under the section titled, "medical additional details", showed R7 was pre-diabetic.

Record Review of R7's Home and Community Services Assessment Details Current Interim,

dated 05/26/2023, showed R7 had multiple medical diagnoses that included [REDACTED]. There was no documentation that R7 had type 2 diabetes.

Record review of R7's physician orders, dated 06/07/2023, showed R7 had a medication order for Ozempic injection. R7 was to inject the medication under the skin once a week.

Resident 3 (R3)

Record review of R3's Face Sheet, undated, showed R3 moved into the facility on [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED]

Record review of R3's Washington Resident Assessment, dated 06/08/2023, showed R3 had multiple medical diagnoses that included [REDACTED]. R3 required staff to administer all their medications. R3 was very confused and did not make sense most of the time.

Record review of R38's Medication Administration Record (MAR), dated 07/01/2023 through 07/24/2023, showed R3 took prescribed medication Olanzapine (medication to help manage mental health conditions) one tablet every day in the evening.

Resident 38 (R38)

Record review of R38's Face Sheet, undated, showed they moved into the facility on [REDACTED]/2015.

Record review of R38's Home and Community Services Assessment Details Current Annual, dated 01/18/2023, showed R38 had multiple medical diagnoses that included [REDACTED]. R38 had short and long term memory problems. Assessment showed R38 was noted to be unable to remember where they were born or recall events in the last 48 hours. R38 had poor decision making and was unaware of the consequences to decisions made. R38 experiences delusions (false belief that persist even though evidence was provided to show it was not false) and hallucinations (false perception of objects, events, or things that involve sight, sound, smell, touch, and taste). Under the section titled, "Medication management", showed R38's medications must be administered. R38 was unaware of dosages and has forgotten to take medications.

Record review of R38's MAR, dated 07/01/2023 through 07/24/2023, showed R38 was prescribed, pravastatin (medication to help lower cholesterol) one tablet daily at bedtime, senna (medication to promote bowel movements) two tablets daily at bedtime, and vitamin d (medication that replaces vitamin d in the body) one capsule daily.

In an observation and interview on 07/24/2023 at 3:00 PM, R3 approached the Licensors at

a dining table. R3 was observed to become upset, shaking hands, and threw their hands up in the air. R3's face had a distorted facial expression. R3 was unable to answer questions and talked incoherently with jumbled words and noises.

In an interview on 07/25/2023 at 10:11 AM, R7 stated the facility administered all their medications that included the injection administration of their prescribed medications Ozempic. R7 stated they took Ozempic for weight loss. R7 stated they were pre-diabetic but had not been diagnosed to have diabetes.

In an interview on 07/26/2023 at 1:49 PM, R38 stated "yes" they received medications. R38 stated "yes" multiple times when R38 was asked who gave their medications to them. R38 stated some words that were unable to be deciphered. R38 stated "yes" to where they lived. R38 was unable to answer questions.

In an interview on 07/27/2023 at 12:41 PM, Staff I, Medication Technician, stated they were delegated to administer R7 Ozempic injection. Staff I stated R7 took the medication for weight loss.

In an interview on 07/27/2023 at 1:01 PM, Staff I stated when they administered R3's medications to them they were able to put them in their mouth. Staff I stated R3 didn't understand that they were taking medications when Staff I handed the medications to R3. Staff I stated R3 was unable to say and form words to talk. Staff I stated R3's medications were not delegated. Staff I stated R3's medications didn't require nurse delegation. Staff I stated nurse delegation only included medicated lotions, creams, powders, insulin, and blood sugar checks.

In an interview on 07/27/2023 at 1:03 PM, Staff I stated R38 sometimes understands they take medications and other times R38 does not. Staff I stated a lot of times R38 will keep their medications inside up against their cheek inside their mouth. Staff I stated R38 is not delegated for their prescribed medications. Staff I stated Staff D, Western WA Clinical Services Director Registered Nurse Delegator, had delegated them to administer R7's Ozempic injection.

In an interview on 07/27/2023 at 3:30 PM, Staff D stated R3 was not nurse delegated for their oral medications. Staff D stated R3 did have dementia and that they weren't aware when they took medications. Staff D stated R38 was not delegated. Staff D stated R38 should have been delegated as they were not aware they took medications despite R38 able to administer the medications in their mouth. Staff D acknowledged that R7's Ozempic injections for weight loss was not appropriate to be a delegated task.

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

Statement of Deficiencies

License #: 2615

Compliance Determination #26995

Plan of Correction

Ocean Shores Assisted Living

Completion Date

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Licensee: Greenlake Management Ocean Shores,

08/22/2023

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/6/2023

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

Debbie Smathers

Administrator (or Representative)

9/11/2023

Date

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