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

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

The department completed data collection for the unannounced on-site full inspection on 12/16/2025 and 12/19/2025 of:

Channel Point Village
907 K St
Hoquiam, WA 98550

The following sample was selected for review during the unannounced on-site visit: 9 of 76 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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.

Administrator (or Representative) _____ Date _____

WAC 388-78A-2950 Water supply. The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the facility's hot water temperature did not go above 120 degrees Fahrenheit (F) in 5 of 5 areas (Memory Care Unit dining room, Resident 1, 2, and 11's sink and Memory Care Unit public shower/bathroom). This failure placed all memory care residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included…

Record review of the facility's policy titled, "Resident Hot Water Temperature Log", undated, documented the regulation was for nursing homes and the facility must ensure the hot water system maintained hot water temperatures at 110 degrees F, plus or minus ten degrees F at fixtures used by residents and staff. The hot water temperature should not exceed 120 degrees F. Eight apartments per floor per month were to be checked.

On 12/16/2025 at 10:47 AM, in the memory care unit's dining room public sink, the hot water temperature was 120.7 degrees F that was hot to touch.

On 12/16/2025 at 11:31 AM, in Resident 1 (R1)'s apartment bathroom, the hot water temperature was 120.7 degrees F.

On 12/16/2025 at 11:33 AM, Resident 2 (R2)'s hot water temperature in their bathroom was 120.6 degrees F. When the thermometer was placed inside of the water, steam had been observed to come off the device. Collateral Contact 1, R2's Power of Attorney, stated "the water is hotter than hot."

On 12/16/2025 at 11:31 AM, in Resident 11 (R11)'s apartment bathroom, the hot water temperature was 120.5 degrees F. While the hot water was running there was steam observed to rise and it was hot to touch.

On 12/16/2025 at 11:38 AM, in the memory care unit's television room public bathroom and shower room sink, the hot water temperature was 121.0 degrees F.

On 12/16/2025 at 12:00 PM, Staff A, Executive Director, was notified that five areas in the memory care unit were with hot water temperatures over 120 degrees F and requested a safety plan to protect the memory care residents from injuries. Staff A stated they would notify the home office to get guidance as the maintenance director was out of the facility that day.

In an interview on 12/16/2025 at 12:36 PM, Staff A stated Staff N, Regional Maintenance, would turn the hot water tanks down in the memory care unit.

On 12/16/2025 at 2:02 PM, in the memory care unit's dining room sink, the hot water temperature was 122.6 degrees F.

In an interview on 12/16/2025 at 2:16 PM, Staff A stated Staff G would check the hot water temperatures in the memory care unit tomorrow morning, 12/17/2025, and that Staff N had just turned the hot water temperatures down five minutes prior.

In an interview on 12/16/2025 at 2:22 PM, Staff J, Assistant Executive Director, was requested how the facility was ensuring memory care residents were out of danger of being burned until the hot water temperatures were checked 12/17/2025 in the morning and stated they would have to talk with Staff A and get back with a plan.

On 12/17/2025 at 11:34 AM, Staff G stated they had worked for the facility for a few months. Staff G stated that 12/17/2025 was the first time they checked hot water temperatures for the facility since they were hired. Staff G did not know the accurate water temperature range that was required for the facility. Staff G stated they could not provide any water temperature logs to review since they started employment for the facility.

On 12/18/2025 at 1:09 PM, Staff A stated when they were first hired, they provided Staff G the facility hot water temperature policy and water temperature log. Staff H, Vice President of Operations, stated Staff G had been aware it was their responsibility to

check hot water temperatures within 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, Channel Point Village 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-2070 Timing of preadmission assessment.

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

(2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

(3) For the purposes of this section, "emergency" means any circumstances when the prospective resident would otherwise need to remain in an unsafe setting or be without adequate and safe housing.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete and document a preadmission assessment for 1 of 5 sampled residents (Resident 3 [R3]). This failure placed R3 at risk for improper placement in the facility and unmet care needs by untrained staff.

Findings included…

Record review of the facility's policy titled, "Assessment/NSA[negotiated service agreement]" dated 02/01/2018, documented the community would encourage resident wellness, health promotion and disease prevention through an initial admission assessment and regular wellness visits by the director of nursing or designee. A completed resident assessment was to be obtained up to 14 days prior to move-in or per state regulation.

Record review of the facility documented titled, “Face Sheet”, undated, documented R3’s date of current readmission was on [redacted]/2025.

On 12/16/2025 at 1:09 PM, all R3’s assessments including their pre-admission were requested to review.

On 12/17/2025 at 11:52 AM, Staff J, Assistant Executive Director, stated R3 was a readmission to the facility. Staff J stated R3 moved out of the facility in [redacted] 2025 with their son and then moved back into the facility on [redacted]/2025. Staff J confirmed that R3 was taken off the facility’s census as a resident when they moved out in [redacted]. Staff A, Executive Director, stated there were no changes to the care and services R3 required and prior assessment was reinstated.

On 12/18/2025 at 11:38 AM, R3’s pre-admission assessment was requested to review.

On 12/19/2025 at 3:07 PM, Staff A stated the director of nursing was responsible for completing all assessments for newly admitted residents that included the pre-admission assessments.

As of 12/23/2025 at 5:30 PM, R3’s pre-admission assessment was not provided.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

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

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

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas within the building (Kitchen, second floor ledge and Resident 10's room), failed to keep exterior grounds in good repair, equipment and furnishings clean for 1 of 1 facility reviewed. These failures caused direct impact to Resident 10 and placed all 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 provided document titled, "Disclosure of Services Required by Revised Code of Washington (RCW) 18.20.300", dated "01/2023," showed all assisted living facilities must maintain your life living quarters and other areas you may use in a safe, clean, and comfortable condition.

Record review of the facility document, "Employee Listing", dated 12/16/2025, showed Staff G, Maintenance, was hired at the facility on 07/09/2025, Staff M, Maintenance, was hired at the facility on 08/17/2016 and Staff I, Kitchen Manager, was hired 02/18/2011.

Kitchen

On 12/16/2025 at 2:00 PM, inside the kitchen, next to the handwashing sink, there were two white five-gallon buckets that contained water inside of them. Above one of the buckets the white ceiling was discolored orange where the water dripped.

On 12/16/2025 at 2:37 PM, Staff I, Kitchen Manager, stated leaks in the kitchen were an ongoing problem for the last five years. Staff I stated that the rain hitting the vents caused water to drip from the ceiling onto the floor. Staff I pointed to the orange discoloration on the ceiling and confirmed the location as a point where water dripped.

On 12/17/2025 at 11:16 AM, Staff K, Cook, stated that when it rained the ceiling leaked. Staff K stated that the water did not come out of the pipe above the five-gallon bucket and confirmed water dripped from the ceiling next to the light fixture. Staff K pointed to the orange discoloration on the ceiling and indicated that was where the water leaked. Staff L, Server, was present and stated that the rain filled the buckets up halfway. Staff L stated that facility staff had to dump both buckets out two times the day prior.

On 12/18/2025 at 4:31 PM, observed two white five-gallon buckets inside the kitchen.

The buckets contained water.

Second Floor Ledge

On 12/16/2025 at 10:32 AM, observed a bright orange five-gallon bucket on the second-floor window ledge next to the library. The bucket sat under the fire sprinkler.

On 12/17/2025 at 11:01 AM, observed the same bright orange five-gallon bucket on the second-floor window ledge next to the library. The bucket sat under the fire sprinkler. The bucket contained water. The white ceiling near the fire sprinkler appeared a different shade than the surrounding ceiling.

On 12/18/2025 at 1:30 PM, observed it was rain outside the facility. The same orange five-gallon bucket remained on the second-floor ledge. The bucket contained water. Water dripped from the fire sprinkler into the bucket.

R10

Record review of the facility document, “607 [Resident 10] Bad Weather”, dated 12/10/2025, showed Staff G created a reactive medium priority work order for Resident 10 (R10). Staff G wrote there was a drip in the attic during heavy rain that blead through R10’s light in their ceiling. Staff G wrote it’s been waterproofed and buckets were in the attic that they needed to check back in on. Staff G wrote the work order was pending nice weather for any further repair. Staff G wrote they needed to check drip buckets periodically when it heavily rained. The work order showed Staff G completed the work order 12/15/2025.

In an observation and interview on 12/18/2025 at 3:08 PM, in R10’s apartment, their mattress and box spring had been removed from their bed frame. The bed frame was in the middle of the room and at the foot of the bed was a rectangle trash can with a black trash bag inside that was positioned under the light on the ceiling. inside and on the black trash bag were beads of water. R10 stated there was a water leak from their light on the ceiling that had been there two weeks, and the staff had to move their mattress off the frame to keep the water from dripping on their mattresses. During the interview, there was a splash noise and upon looking at the trash can a bead of water dripped from the far-right corner of the light on the ceiling into the trash can that splashed on the black bag.

On 12/17/2025 at 11:34 AM, Staff G stated the roof above the kitchen was flat and when it rained the roof was compromised which caused leaks. Staff G said they had not repaired any kitchen leaks since they started working for the facility. Staff G stated that R10’s room had an active leak that caused water to drip. Staff G said from the looks of the damage the leak was years old. Staff G stated inside of the attic were multiple old drip buckets. Staff G said they would have to wait for better weather to complete any

patch work on the roof.

On 12/18/2025 at 2:41 PM, Staff M stated Staff G had to add multiple buckets in the attic to catch dripping water from roof leaks. Staff M stated they were aware R10 had a leak inside of their room. Staff M stated Staff G added a bucket in the attic above R10's room to prevent water dripping. Staff M stated Staff G had to wait for better weather to repair roof leaks. Staff M stated they used to work in the kitchen and confirmed when the weather was bad and it rained outside the kitchen ceiling leaked. Staff M stated currently the leak looked worse than what it used to. Staff M escorted the Department upstairs and confirmed next to the library on a ledge a Home Depot bucket sat under the fire suppression system that leaked.

On 12/18/2025 at 4:48 PM, Staff H acknowledged they saw the bucket on the second-floor ledge next to the library the other day when they were at the facility. Staff A stated they were unaware of R10's leak in their apartment that caused the need to move R10's bed off the frame for over two weeks. Staff A acknowledged that there were concerns there could be additional roof leaks which could cause mold (a fungus that can be green, black or white that thrived in damp conditions which spores could negatively impact a person's health).

On 12/29/2025 at 4:40 PM, the Department requested all work orders related to the kitchen ceiling leak and the second-floor window ledge sprinkler head leak for the last six months.

On 12/31/2025 at 10:46 PM, Staff A stated the facility did not have any work orders regarding the kitchen and second floor window ledge sprinkler head leak available 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.

_____ _____

Administrator (or Representative) Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the resident or their responsible party signed the resident assessment (facility's version of the negotiated service agreement [NSA]) for 1 of 9 sampled residents (Resident 4). This failure placed R4 and their responsible party at risk of 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 titled, "Resident Assessments Policy", undated, showed the policy did not address that the NSA needed to be signed by the resident, resident representative, and a representative from the facility.

Record review of R4's, "Face Sheet", undated, showed R4 moved into the facility on [redacted]/2025.

Record review of R4's, "[Facility Name] New Assessment", dated 09/25/2025 showed it was the only NSA provided to review for R4. The NSA was not signed by the resident, the residents responsible party, or any of the facility staff members.

On 12/23/2025 at 10:06 AM, the Department requested if the facility had any signed NSA's to provide to review for R4.

Record review of an email sent to the Department on 12/23/2025 at 2:34 PM, Staff A, Executive Director, stated they could not provide a copy of R4's signed NSA to review.

On 01/07/2026 at 10:00 AM, Staff H, Vice President Operations, stated assessments were to be signed initially and annually by the resident or their representative.

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, Channel Point Village 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-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 resident assessment (facility's version of the Negotiated Service Agreement [NSA]) within 30 days following admission to the facility for 3 of 5 sampled newly admitted residents (Resident 4, 8 and 9). This failure placed all three residents and other new residents at risk of unmet care needs and decreased quality of life.

Findings included…

Record review of the facility's policy titled, "Resident Assessments Policy", undated, showed the policy did not address that the facility needed to complete an NSA within 30 days of the resident moving in.

Record review of the facility's policy titled, "Assessment/NSA [negotiated service agreement]" dated 02/01/2018, documented a completed resident assessment was to be obtained up to 14 days prior to move-in or per state regulation, with any change of condition, six months and annually from admission date. There was nothing in the policy about needing to complete an assessment/NSA within 30 days of admission.

On 12/16/2025 at 1:09 PM, Resident 4 (R4), Resident 8 (R8) and Resident 9 (R9)'s all service agreements from admission were requested to review.

In an interview on 12/18/2025 at 1:09 PM, Staff H, Vice President of Operations, stated

the residents' documents titled, "[Facility Name] New Assessment", was the same document that they use for the negotiated service agreement.

R4

Record review of R4's, "Face Sheet", undated, showed R4 moved into the facility on [redacted] 2025.

Record review of R4's, "[Facility Name] New Assessment", dated 09/25/2025, showed it was an initial assessment, and it was the only NSA provided to review for R4.

R8

Record review of R8's, "Face Sheet", undated showed R8 moved into the facility on [redacted]/2025.

Record review of R8's, "[Facility Name] New Assessment", dated 12/08/2025, showed R8 moved into the facility on [redacted]/2025 and it was the 30-day assessment.

On 12/18/2025 at 11:38 AM, the Department requested R4 and R8's 30-day NSA be provided to review.

On 12/18/2025 at 4:24 PM, Staff A, Executive Director, stated they could not provide R4's 30-day NSA to review.

R9

Record review of R9's "Face Sheet", undated, documented R9 moved into the facility on [redacted]/2025.

On 12/17/2025 at 9:59 AM, only one assessment was received for R9 that was titled, "[Facility Name] New Assessment", dated 10/14/2025, documented it was an initial assessment.

On 12/23/2025 at 10:06 AM, the Department requested all R9's assessments that were completed 10/14/2025 through 12/17/2025. At 2:34 PM, the Department received an email from Staff A, that documented, if any document requested was not attached, the facility did not have the document to provide. There were no additional assessments for R9 provided.

As of 12/24/2025 at 5:30 PM, there were no other assessments provided to the Department that were completed for R9.

In an interview on 12/18/2025 at 3:12 PM, R8 stated they recalled participating in an assessment prior to their admission into the facility. R8 stated that since they moved into the facility they had not participated in a 30-day assessment related to their health and their care needs.

On 12/19/2025 at 3:07 PM, Staff A stated the director of nursing was responsible for completed 30-day NSA's for newly admitted residents.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

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

(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 the resident assessment within 14 days following admission to the facility for 4 of 5 sampled newly admitted residents (Resident 4, 6, 8 and 9). This failure placed all four resident and newly admitted residents at risk of unmet care needs and staff not having the most updated and accurate care and services the residents required.

Findings included…

Record review of the facility's policy titled, "Resident Assessments Policy", undated, showed the policy did not address that the facility needed to complete an assessment within 14 days of the resident moving in.

Record review of the facility's policy titled, "Assessment/NSA [negotiated service agreement]" dated 02/01/2018, documented a completed resident assessment was to be obtained up to 14 days prior to move-in or per state regulation, with any change of condition, six months and annually from admission date. There was nothing in the policy about needing to complete an assessment/NSA within 14 days of admission.

On 12/16/2025 at 1:09 PM, all assessments for Resident 4 (R4), Resident 8 (R8),

Resident 6 (R6) and Resident 9 (R9)'s from admission were requested to review.

R4

Record review of R4's, "Face Sheet", undated, showed R4 moved into the facility on [redacted]/2025.

The facility did not provide a 14-day assessment for R4 to review.

R8

Record review of R8's, "Face Sheet", undated showed R8 moved into the facility on [redacted]/2025.

The facility did not provide a 14-day assessment for R8 to review.

In an interview on 12/18/2025 at 3:12 PM, R8 stated they recalled participating in an assessment prior to their admission into the facility. R8 stated that since they moved into the facility they had not participated in a 14-day assessment related to their health and their care needs.

On 12/18/2025 at 11:38 AM, the Department requested R4 and R8's 14-day assessment be provided to review.

On 12/18/2025 at 4:24 PM, Staff A, Executive Director, stated they could not provide R4 and R8's 14-day assessment to review.

R6

Record review of R6's document titled, "Face Sheet", undated, documented they moved into the facility on [redacted]/2025.

On 12/17/2025 at 9:59 AM, the only facility assessments for R6 received were dated 09/30/2025 and 11/04/2025. There was no 14-day assessment provided for R6 to review.

R9

Record review of R9's "Face Sheet", undated, documented R9 moved into the facility on [redacted]/2025.

On 12/17/2025 at 9:59 AM, only one assessment was received for R9 that was titled, "[Facility Name] New Assessment", dated 10/14/2025, documented it was an initial assessment.

On 12/23/2025 at 10:06 AM, the Department requested all R9's assessments that were completed 10/14/2025 through 12/17/2025. At 2:34 PM, the Department received an email from Staff A, that documented, if any document requested was not attached, the facility did not have the document to provide. There were no additional assessments for R9 provided.

On 12/19/2025 at 3:07 PM, Staff A stated the director of nursing was responsible for completed 14-day assessments for newly admitted residents.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) 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 3 of 4 sampled

residents (Resident 5, 7 and 12). This failure placed the residents at risk for unmet care needs and/or abuse, neglect, and exploitation.

Findings included…

On 12/23/2025 at 10:06 AM, the facility's policy on resident incident reports and investigations was requested.

Record review of the facility's policy, "Unusual Occurrence Report Policy," undated, documented if a resident had a fall then a full report on the UOR (unusual occurrence Report) form would be completed. The facility staff member who witnessed the event completed the UOR form. The staff member completed all information and would make appropriate contacts. All resident occurrences should be reported to the physician and family as soon as possible and documented in the appropriate place on the UOR form. The resident would be placed on alert charting for 72 hours. The care coordinator or designated employee must review the incident within 24 business hours and investigate further. If the investigator was not a licensed nurse then a licensed nurse must sign the incident investigation within 72 hours.

Resident 5 (R5)

Record review of R5's document titled, "Face Sheet", undated, documented they moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted] and [redacted] and [redacted].

Record review of R5's Medication Administration Record (MAR), dated 12/01/2025 through 12/16/2025, documented that R5 was on alert monitoring for an unwitnessed fall in their apartment that started on 12/04/2025 and a fall in their apartment on 12/10/2025.

On 12/18/2025 at 11:38 AM, R5's incident report and investigation findings for falls 12/04/2025 and 12/10/2025 were requested.

In an interview on 12/18/2025 at 4:24 PM, Staff A, Executive Director, stated they did not have all the documents that were requested that included the incident reports and investigation for R5's falls on 12/04/2025 and 12/10/2025.

Resident 7 (R7)

Record review of R7's, "Face Sheet", undated, showed R7 moved into the facility on

[redacted]/2023. R7 had multiple medical diagnoses of [redacted] and [redacted] and [redacted].

Record review of R7's, "Temporary Service Plan", dated 08/05/2025, showed R7 had a non-injury fall.

On 12/18/2025 at 11:38 AM, the Department requested R7's event incident investigation form to review from their non injury fall on 08/05/2025.

On 12/18/2025 at 4:24 PM, Staff A, Executive Director stated they could not provide R7's event incident investigation form to review from their non injury fall on 08/05/2025.

Resident 12 (R12)

Record review of R12 document titled, "Face Sheet", undated, documented they moved into the facility on [redacted]/2021. R12 had a medical diagnosis of [redacted].

Record review of the facility's document titled, "Event/Incident Investigation Form", dated 11/03/2025, documented R12 had an unwitnessed fall in their apartment on 11/03/2025 at 11:00 PM. R12's statement documented that they turned after getting ice cream when they lost their balance and fell. There was nothing documented for findings actions taken, individuals interviewed, investigation conclusions, or signatures of whom reviewed it.

On 01/05/2026 at 8:45 AM, Collateral Contact 3, R12's Representative, stated they were never notified of R12's fall that took place on 11/03/2025.

On 12/19/2025 at 12:47 PM, Staff Q, Medication Technician, stated facility staff completed the incident part of resident investigations and the investigation portion of the document was completed by Staff A or the director of nursing.

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

(1) The residents' characteristics and needs;

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

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to secure potentially hazardous supplies and equipment for 6 of 6 locations (bath and shower room, Resident 1's bathroom, Resident 14's bathroom, Resident 15's bathroom, dining room, and the activities room) in the memory care unit. This failure placed all memory care residents at risk of ingesting potentially toxic materials.

Findings included…

Record review of the facility's, "Memory Care Transition Handbook", undated, documented prohibited or restricted items are evaluated based on guiding principles to include is there a warning label, is it a danger to any resident, storage location and that some personal care items that needed to be secured in a locked cabinet included shampoo, conditioner, and hand sanitizer.

In an observation on 12/17/2025 at 10:52 AM, inside Resident 15's unlocked apartment room bathroom, in the shower was a bottle of Head and Shoulder's (brand name) shampoo.

In an observation on 12/17/2025 at 10:53 AM, in the memory care television room with the resident accessible unlocked shower and bathroom on top of the silver paper towel dispenser were two bottles. One bottle labeled “Rusk Sensories”, was a bottle of anti-frizz shampoo that had a warning label to not apply near eyes or on irritated skin and if the eyes came in contact with the shampoo, the eye would need to be flushed thoroughly with water. The product was only for external use and needed to be kept out of reach of children. The bottle had numerous ingredients that included alcohol and magnesium nitrate (an inorganic salt that was essential for plant growth and required careful handling due to its oxidizing properties). The second bottled labeled “JOICO” was moisturizing shampoo. There was black ink that crossed off shampoo and “conditioner” was handwritten above that did not say what brand of conditioner.

In an observation on 12/19/2025 at 11:35 AM, in the memory care television room with the resident accessible unlocked shower and bathroom on top of the silver paper towel dispenser were the same two bottles of shampoo as observed on 12/17/2025.

In an observation on 12/19/2025 at 11:37 AM, in Resident 1’s bathroom on the countertop unlocked was a spray bottle of cleanse total body cleanser, a tube of active prevention toothpaste, 18 fluid ounce bottle that was three quarters full of blue liquid with label “dawn” dish soap.

In an observation on 12/19/2025 at 11:45 AM, in the memory care dining room, in the unlocked cabinets above the sink there was a 12 fluid ounce bottle of Purell (brand name) hand sanitizer that was half full of clear gel liquid. There were five residents, that included Resident 13 that wandered and was unattended in the dining room.

On 12/18/2025 at 3:04 PM, Staff R, Housekeeper, stated all chemicals and hazardous supplies in the memory care unit should be secured.

On 12/19/2025 at 11:59 AM, Staff O, Medication Technician, stated all shampoos, chemicals, and conditioners were to be locked up if they were toxic in the memory care unit. Staff O was unsure if shampoo and conditioners were allowed to be left out if they were nontoxic and stated that all bottles of hand sanitizer were to be locked up.

In an observation on 12/19/2025 at 12:42 PM, inside Resident 14’s unlocked apartment room bathroom, were five bottles of various shampoos unlocked in their shower stall that included one labeled “Jhrimack silver brightening ageless shampoo.”

On 12/19/2025 at 12:45 PM, Staff P, Medication Technician, stated all shampoos were to be locked in the lockable drawers in the residents’ rooms and not be left out unlocked and accessible to any memory care residents.

On 12/19/2025 at 12:47 PM, Staff Q, Medication Technician, stated memory care residents were ok to have shampoo and conditioner in their rooms, but unable to have denture cleaner or other beauty supplies. Staff Q stated every memory care resident has a lockable drawer in their room that the supplies were to be locked in. Staff Q stated there was a list of chemical supplies that were allowed to be left out that they were unable to provide to the Department or locate in the wellness office of the memory care unit.

On 12/19/2025 at 3:08 PM, Staff A, Executive Director, stated items such as shampoo, conditioner, hand sanitizer, toothpaste, and peri cleanser were all supposed to be locked up and not accessible within the memory care unit.

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:

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

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

(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 assess and determine residents required nurse delegated tasks for 2 of 2 residents (Resident 5 and Resident 16), failed to notify the nurse delegator when a resident received a new insulin order for 1 of 1 residents (Resident 2), and failed to ensure staff had the required nurse delegation training and documentation for 1 of 3 staff (Staff E). These failures resulted in all residents receiving medication administration services by staff who were not

specifically delegated to perform the tasks and at risk for unmet care and medical needs.

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.
(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by Revised Code Washington (RCW) 18.79.260 (3)(e)(ii).
(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.
(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.
(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.
(8) Verify that the nursing assistant or home care aide:
(a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;
(b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;
(c) Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training;
(d) Has a certificate of completion issued by the department of social and health services indicating completion of diabetes training when providing insulin injections to a diabetic client; and
(e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.
(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.
(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 thirty 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.
(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 un-expected 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 ninety 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.
(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 occurs at least every ninety 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 ninety days.

Record review of the facility's policy titled, "Nurse Delegation", dated 02/01/2018, documented the registered nurse would delegate tasks of nursing care when the nurse determines that it was in the best interests of the resident for non-licensed staff to provide the task. The delegating nurse would ensure competency of staff by checking that all staff have completed approved training and nurse delegation training by viewing their certificates. Documentation of the task completion would be done on the medication administration record (MAR) by the caregiver. Any unusual condition or response to the task would be written in the resident care notes as well as contact with the delegating nurse.

Record review of the facility's document titled, "Employee Listing," undated, documented Staff E, Medication Technician, started employment at the facility on 12/07/2022.

Record review of the facility's document titled, "Nurse Delegation: Credentials and Training Verification," dated 10/01/2025, documented that Staff E had their Home Care Assistant certification and their nine-hour nurse delegation core certification. There was no documentation that showed Staff E had completed their three-hour special focus diabetes certificate.

Record review of R2's document titled, "Nurse Delegation: Instructions for Nursing Task", dated 06/13/2025, documented Staff E was not delegated for insulin administration.

Record review of R2's document titled, "Nurse Delegation: Instructions for Nursing Task", dated 07/26/2025, documented R2 had blood sugar checks three times daily and insulin administration up to three times day that were both delegated tasks.

R2

Record review of R2's document titled, "Nurse Delegation: Nursing Visit", dated 11/28/2025, documented R2 required nurse delegation for medication administration

related to their inability to self-administer medication due to dementia (a progressive brain disorder that affects a persons memory, judgement, and ability to care out activities of daily living needs). Staff E had been observed or demonstrated, given verbal description, and able to record properly of R2's delegated tasks by the nurse delegator that included medication administration.

Record review of R2's document titled, "Nurse Delegation: Nursing Visit", dated 06/13/2025, documented R2 required nurse delegation for medication administration related to their inability to self-administer medication due to dementia. Staff E had been observed or demonstrated, given verbal description, and able to record properly of R2's delegated tasks by the nurse delegator except for insulin injections.

Record review of R2's MAR, dated 10/01/2025 through 10/31/2025, documented R2 had orders for Xultophy insulin (prescribed injected medication to help regulate and lower high blood sugar levels) administered daily every morning that Staff E administered the insulin two times and an order to have their blood sugar checked and then administer Fiasp insulin (prescribed injected medication to help reduce high blood sugars quickly) three times a day based upon their blood sugar reading that Staff E administered two times.

Record review of R2's MAR, dated 11/01/2025 through 11/30/2025, documented R2 had orders for Xultophy insulin administered daily that Staff E had administered three of 20 administrations, to have their blood sugar checked and Fiasp insulin and administered three times a day based upon their blood sugar reading number that Staff E administered 12 times, and a new order for Tresiba insulin (prescribed injected medication to help keep high blood sugars down over a long period of time) to be administered daily that Staff E administered two of 11 administrations.

Record review of R2's MAR, dated 12/01/2025 through 12/18/2025, documented R2 was to have their blood sugar checked and Fiasp insulin and administered three times a day based upon their blood sugar reading that Staff E administered two times, and for Tresiba to be administered daily that Staff E administered one time.

Review of R2's nurse delegation binder on 12/19/2025 at 2:00 PM, showed there was no documentation that the delegated staff had been updated and reviewed by the nurse delegator to administer the new medication order Ozempic.

R5

Record review of R5's document titled, "Face Sheet", undated, documented they moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

On 12/17/2025 at 2:11 PM, R5 stated the facility staff brought their medication to them, inject their insulin, and poke their finger for their blood sugars every day.

On 12/17/2025 at 1:25 PM, Staff T, Registered Nurse Delegator, stated they do not recall R5 being nurse delegated for any tasks.

On 12/18/2025 at 4:28 PM, Staff O, Medication Technician, stated they administered insulin injections to R2, that just got a new order for Ozempic, and R5. Staff O stated at times R5 could do it themself but there were times they had to poke their finger to check their blood sugar and inject their insulin.

On 12/19/2025 at 10:08 AM, Staff S, Medication Technician, stated R5 has asked us to inject their insulin and poke their finger for the blood sugar check at times and have done it. Staff S stated the nurse delegator was to be called every time there was a change in the delegated resident, when a resident needed to be delegated, to come out and complete an assessment to determine if delegation was needed, and with any medication changes with the delegated residents. At 10:27 AM, Staff S stated Resident 16 (R16) had a difficult time following direction and was a little confused poking their finger with their nail and not the device with the needle inside, that required Staff S to help R16 poke their finger for their blood sugar reading that was low at 74.

On 12/19/2025 at 12:00 PM, Staff O entered R5's room to provide them with their insulin and check their blood sugar. Upon Staff O handing R5 the alcohol wipe to clean their finger and the device to poke their finger for the blood sugar, R5 stated "oh now I have to do it!" Staff O stated, "you have to do it". R5 asked Staff O since when did they have to check their own blood sugar and administer their own insulin with Staff O stated "always". At 12:07 PM, Staff O stated there were at times R5 could not poke their finger that required them to poke their finger for their blood sugar check. Staff O stated they had to read the directions and get help from another medication technician on how to dial up R2's new insulin order for Ozempic as the dosing is not the same as other insulin R2 takes.

Review of the nurse delegation binder on 12/19/2025 at 2:00 PM, showed there was no documentation that R5 had been assessed, evaluated if delegation was required, or delegated staff were educated and documented to administer R5's blood sugar check or insulin injection administrations.

On 12/18/2025 at 4:47 PM, Staff H, Vice President of Operations, acknowledge that not all residents that required delegated tasks were nurse delegated that included Staff E not having their nurse delegation focus on diabetes certificate and still administering insulin injections and checking residents blood sugars. Staff H stated the facility nurse was not communicating to the nurse delegator when residents required nurse delegation.

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-2210 Medication services.

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

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

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

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

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

This requirement was not met as evidenced by:

Based on observation interview and record review, the facility failed to ensure residents were administered their medications as ordered by their physician for 3 of 3 residents (Resident 9, 5 and 4). The facility failed to ensure medications were administered in a safe manner by 1 of 1 medication technicians (Staff O) observed. These failures resulted in Resident 4 delay in physical therapy as ordered and Resident 9 and Resident 5 receiving medications not as prescribed by their physician orders and placed all three residents at risk for medical complications.

Findings included…

Record review of the facility's document titled, "Employee Procedures For Medication Assistance," undated, documented when a resident was assisted with their routine medication administration the trained staff were to read the electronic medication administration record (eMAR), check the residents name, medication name, date, route of administration, frequency, reason being taken, time of administration, strength and

number of tablets/capsules/or dose. The trained staff member would then read the label on the medication container to ensure it matches the order on the eMAR and then read and check the eMAR to the medication label to ensure they match before the medication was prepared and if there were concerns then contact the director of nursing.

Resident 9 (R9)

Record review of R9's "Face Sheet," undated, documented R9 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Record review of R9's document titled, "[Facility Name] New Assessment", dated 10/14/2025, documented they wore tubigrips (tight socks that are applied to the legs to help with fluid retention and swelling) for compression that required assistance from staff to put them on and take them off at night on their legs. R9 required the facility's wellness staff to assist with ordering, storing, monitoring and administering their medication at proper doses and times and take R9 vital signs and report to the physician.

Record review of R9's Medication Administration Record (MAR), dated 10/01/2025 through 10/31/2025, documented an order for amiodarone (medication to life threatening heart rhythm problems) with instructions to hold the medication if the residents heart rate is less than 60 and to notify the physician. Review of the administrations documented on 10/27/2025 the medication was administered, but there was no documented heart rate.

Record review of R9's Medication Administration Record (MAR), dated 10/01/2025 through 10/31/2025, documented an order for metoprolol succinate extended release (a prescribed medication to help treat high blood pressure and heart failure) to be given daily with instructions to hold for a heart rate less than 60, systolic blood pressure (top number of a blood pressure reading) less than 90 or diastolic blood pressure (bottom number of the blood pressure reading) was less than 50 and to notify the physician. Review of medication administrations documented on 10/25/2025, 10/26/2025 and 10/27/2025, the medication was administered but there was no documented heart rate of blood pressure readings to ensure they were safe to administer, and the physician did not need to be notified.

Record review of R9's Medication Administration Record (MAR), dated 10/01/2025 through 10/31/2025, documented an order for azithromax (a prescribed antibiotic medication to treat bacterial infection) to administer daily for four days and R9 only received the medication for two days.

Record review of R9's Medication Administration Record (MAR), dated 10/01/2025 through 10/31/2025, documented an order for Augmentin (prescribed antibiotic medication to help treat bacterial infection) two times a day for five days that started on [redacted]/2025 at 8:00 PM, R9 only received five of the ten doses ordered.

Record review of R9's document titled, "Client Coordination Note Report," dated 11/06/2025, documented they were to have weekly weights completed for their congestive heart failure and were to notify the physician if R9 had a five pound or more weight gain.

On 12/23/2025 at 10:06 AM, all R9's weights for 11/01/2025 through 12/17/2025 were requested to review.

Review of R9's monthly weights and vitals with effective date 11/05/2025, documented they only had one weight completed on 12/07/2025.

Record review of R9's document titled, "Fax Cover Sheet", dated 11/04/2025, documented that R9's physician orders them to wear size "F" tubigrip, with directions to place them on in the morning and off in the evening.

Record review of R9's Medication Administration Record, dated 11/01/2025 through 11/30/2025, documented there was no order for the medication technician to apply the tubigrips in the morning and take off in the evening to R9's lower legs.

Record review of R9's Medication Administration Record, dated 12/01/2025 through 12/17/2025, documented there was no order for the medication technician to apply the tubigrips in the morning and take off in the evening to R9's lower legs. R9 has an order for amiodarone take daily and to hold if the heart rate was less than 60. R9 had an order for metoprolol succinate extended release to administer daily and to hold for a heart rate less than 60, systolic blood pressure less than 90 or diastolic blood pressure was less than 50 and notify the physician. Review of the administrations documented on 12/14/2025, R9's amiodarone and metoprolol succinate extended release was administered with a heart rate of 59.

On 12/23/2025 at 10:06 AM, the facility was requested to send documentation to show R9's physician was notified that their heart rate was 59 on 12/14/2025.

On 12/23/2025 at 2:34 PM, the facility sent an email to the Department with attached documents. The facility documented that it what was requested was not attached, then the facility does not have it to provide. Upon reviewing the documents that were attached, there was no physician notification for R9's pulse being 59 on 12/14/2025 and their medications were held per orders.

On 12/19/2025 at 12:47 PM, Staff Q, Medication Technician, stated they were to follow the physician orders that were documented on the MAR to ensure that there were administered properly if they had parameters to hold a medication.

On 12/19/2025 at 10:08 AM, Staff S, Medication Technician, stated that any orders for resident that have parameters to follow were on the MAR and if the vital sign was out of parameter the medication technicians would mark “not given out of parameter”, on the eMAR.

Resident 5 (R5)

Record review of R5’s document titled, “Face Sheet,” undated, documented R5 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Record review of R5’s document titled, “[Facility Name] New Assessment”, dated 06/11/2025, documented the medication would be administered in accordance with policies and procedures, monitored for desired and potential adverse effects.

Record review of R5’s MAR, dated 10/01/2025 through 10/31/2025, documented they had an order for novolog insulin (prescribed medication injection to help reduce high blood sugars quickly) to inject five units three times a day with no parameters to hold the medications. Review of the administrations documented on 10/27/2025 at 7:00 AM, R5’s novolog injection was not administered. Review of the medication notes documented R5’s novolog was not administered as it was outside of parameters.

On 12/19/2025 at 11:59 AM, the wellness door of the assisted living side of the facility was opened by Staff O, Medication Technician with their bare hands. Staff O stated they were filling out a fax communication form. Staff O approached the medication cart that was in the wellness office and opened the top drawer and grabbed out a clear plastic bag with insulin pens inside, a black bag with blood sugar machine inside, alcohol wipe squares, and blue gloves. Staff O left the wellness room and was not observed review any type of MAR to verify they got out the correct insulin. Staff O entered R5’s room and announced they were here to check their blood sugar and administer insulin with R5 in agreement. R5’s blood sugar reading was 171. Staff O dialed up five units of the insulin and handed it to R5 to inject. At 12:05 PM, Staff O returned to the wellness office and went to a computer that was on the counter and pulled up the eMAR and documented the medication they provided to R5. Staff O stated they went by the order on the insulin pen and stated that there were no parameters to the order to hold and that R5 would get the insulin dose regardless what his blood sugar reading was.

On 12/19/2025 at 3:08 PM, Staff H, Vice President of Operations, stated the medication technicians were to have the computer on with the eMAR open and check the

medication order on the medication to the eMAR to ensure that it was correct and follow their right checks prior to administering the medication to the resident.

Resident 4 (R4)

Record review of R4's, "Face Sheet", undated, showed R4 moved into the facility on [redacted]/2025. R4 had a medical diagnosis of [redacted].

Record review of R4's, "[Facility Name] New Assessment", dated 09/25/2025, documented R4 required oral medication management. The memory care staff were to manage all orders and deliveries of new medications and refill medications. R4 were to begin outpatient physical therapy upon move in.

Record review of R4's, "Referral Form", dated 11/06/2025, showed R4 were to have a physical therapy evaluation and treatment for their weakness and unsteady gait. The referral start date and when the physician signed the document was 10/31/2025.

Record review of R4's, "Outsider Provider Note", dated 12/02/2025, documented R4 had an evaluation and R4 participated. The document was signed by the outside provider on 12/18/2025.

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, Channel Point Village 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-24642 Background checks National fingerprint background check.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a national fingerprint background check for 1 of 4 sampled staff (Staff A). This failure placed all residents at risk of being cared for by a staff member with a potentially disqualifying history.

Findings included…

Record review of the facility's document titled, "Employee Listings," undated, documented Staff A, Executive Director, started employment at the facility on 06/30/2025.

On 12/17/2025 at 10:29 AM and at 12:28 PM, the Department requested documentation of Staff A's national fingerprint background check.

During a record review of provided staff records on 12/17/2025, no record of Staff A's national fingerprint background check was available for review.

On 12/17/2025 at 3:00 PM, Staff A stated the facility provided all staff documents requested and if any were missing, the facility did not have the requested document. Staff A stated they did not have a national fingerprint background check completed and this is the reason there is no results available to provide.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

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

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

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

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

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

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

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

(a) Exclusively for the individual resident; or

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document, in the resident's assessment (facility's version of the Negotiated Service Agreement [NSA]), the plan to provide assistance with activities of daily living, to provide necessary health support services from outside providers, the plan to provide intermittent nursing services, and the residents preferences on how servicers would be provided for 9 of 10 sampled residents (Resident 7, 4, 8, 2, 1, 3, 5, 9, and 12). These failures placed the residents at risk for unmet care needs and care and services not being provided per the NSA.

Findings included…

Record review of the facility's policy titled, "Resident Assessments Policy," undated, documented the community would encourage resident wellness, health promotion and disease prevention through an initial admission assessment and regular wellness visits by the director of nursing. The policy did not address the plan on how facility staff would provide assistance with resident's activities of daily living, intermittent nursing services, necessary health support, how residents preferences would be incorporated into the services provided, and the time of when services would be provided.

Record review of the facility's policy titled, "Nurse Delegation," dated 02/01/2018, documented the registered nurse would delegate tasks of nursing care when the nurse determines that it was in the best interests of the resident for non-licensed staff to provide the task. Documentation of the task completion would be done on the medication administration record (MAR) by the caregiver. The registered nurse would design a clear delegation plan for each task and would be referred to in the resident's

service plan and also notation on the MAR which identified the task provision.

On 12/18/2025 at 1:09 PM, Staff H, Vice President of Operations, stated the residents assessments were the residents negotiated service agreements and were one document.

Resident 7 (R7)

Record review of R7's, "Face Sheet", undated, showed R7 moved into the facility on [redacted]/2023. R7 had multiple medical diagnoses of [redacted] and [redacted] and [redacted]

Record review of R7's, "[Facility Name] New Assessment," dated 07/03/2025, documented R7 received in house bathing services one to two times a week. The NSA did not document when R7 bathed or their preferences on what time they wanted to be bathed. The dietary section showed R7 received a regular menu and did not require a special diet. The NSA documented conflicting information that R7 required a low sodium diet (diet that restricted salt intake). The NSA did not incorporate hospice notes that indicated R7 required a mechanical soft diet (foods that were easy to chew and swallow) for ease of chewing and R7 were to be provided child portions. R7 had a history of falls. R7's documented falls included R7 had three falls on 09/07/2023, and their recent falls were on 01/29/2024, 02/15/2024, and 03/03/2024. R7's NSA did not incorporate R7's falls that took place on 03/29/2025, 05/04/2025, 06/04/2025, and 08/05/2025. The NSA documented that R7 used their power chair to get to the dining room and activities. The NSA had conflicting information as it documented that R7 required a routine escort from facility staff via wheelchair to get to the dining room and activities. The medication section documented staff gave R7 their medications with a full cup of water. The NSA did not incorporate that R7 had some of their medications crushed (a pill broken down into a fine powder). The linen section documented R7 required additional linen services but did not indicate what days or times R7's laundry was to be completed.

Record review of R7's "Temporary Service Plan", dated 03/29/2025, documented R7 had an unwitnessed non-injury fall.

Record review of R7's "Temporary Service Plan", dated 05/04/2025, documented R7 had an unwitnessed non-injury fall.

Record review of R7's "Temporary Service Plan", dated 06/04/2025, documented R7 had an injury fall where they bruised their right knee, and they possibly bruised their left knee.

Record review of R7's "Temporary Service Plan", dated 08/05/2025, documented R7 had a non-injury fall.

Record review of R7's "[Company Name] Hospice", dated 07/15/2025, showed R7's diet was changed to mechanical soft for ease of chewing and R7 was to be provided child portions.

Record review of R7's "[Company Name] Hospice", dated 10/01/2025, showed two of R7's medications were able to be given crushed.

Record review of R7's "[Company Name] Hospice", dated 10/06/2025, showed one of R7's medications were able to be given crushed.

On 12/19/2025 at 9:35 AM, R7 stated they were not supposed to get up and ambulate independently inside of their apartment. R7 stated they were supposed to push their pendant when they needed to get up and wait for facility staff to assist them. R7 stated they no longer used their power chair. R7 stated the facility staff escorted them back and forth to all their meals. R7 stated they were not supposed to have nuts or chewy foods in their diet.

On 12/19/2025 at 3:07 PM, Staff J, Assistant Executive Director, stated R7 used to use their power chair but they no longer did so.

Resident 4 (R4)

Record review of R4's, "Face Sheet", undated, showed R4 moved into the facility on [redacted]/2025. R4 had a medical diagnosis of [redacted].

Record review of R4's, "[Facility Name] New Assessment", dated 09/25/2025, showed R4 was independent with bathing but required reminders to follow their personal bathing schedule. The NSA did not document R4 preferences on when and what days they bathed and when the facility staff were to remind R4 to bathe. R4 required home health coordination and R4 was supposed to begin outpatient physical therapy upon move in. The NSA did not document any details that pertained to R4's outpatient physical therapy. The NSA documented resident used a non-community pharmacy which contradicted that R4 used the in-house pharmacy.

Record review of R4's, "Referral Form", dated 11/06/2025, documented an order for physical therapy to evaluate and treat R4.

Record review of R4's, "Progress Notes for (R4)", dated 12/03/2025, Staff P, Medication

Technician, documented a late entry for 10/31/2025 when R4's primary care provider sent a referral for R4 to start physical therapy.

Resident 8 (R8)

Record review of R8's, "Face Sheet", undated showed R8 moved into the facility on [redacted]/2025. R8 had a diagnosis of [redacted]. R8 had a general low sodium diet (diet that restricted salt intake) with no concentrated sweets (foods that have a large amount of sugar which spiked blood sugar).

Record review of R8's, "[Facility Name] New Assessment", dated 12/08/2025, documented R8 moved into the facility on [redacted]/2025 which contradicted the information on R8's face sheet. R8 received in house bathing services three to four times a week. The NSA did not document when R8 bathed or their preferences on what days they wanted to be bathed. R8 received a regular menu, and no special diet was required which contradicted what was documented on R8's face sheet. R8 was hearing impaired and required staff assistance to replace and change hearing aid filters every three to five days. The NSA did not document what days the facility staff were to help R8 with their hearing aids.

Record review of R8's, [Facility Name] Resident Orders, dated 09/29/2025, documented R8 had a no concentrated sweets and no added salt diet. R8's medical doctor signed the document on 09/29/2025.

Resident 2 (R2)

Record review of R2's, "Face Sheet", undated, showed R2 moved into the facility on [redacted]/2023. R2 had a medical diagnosis of [redacted]. R2 had a general diabetic diet (healthy eating that focused on fruits, vegetables, whole grains, lean proteins and healthy fats and sodium), no concentrated sweets, and no lactose diet (reduced or eliminated milk sugar).

Record review of R2's, "[Facility Name] New Assessment", dated 05/30/2025, documented R2 was independent with bathing but required facility staff to remind them of their personal bathing schedule. The NSA did not document R2's preferences as to what days and times facility staff were to remind R2 to bathe. The NSA documented R2 received a regular menu and no special diet was required which contradicted that R2 had a no concentrated sweets and no lactose diet. The NSA does not include R2 was nurse delegated for their inability to self-administer all their medications. The oral medication section documented that R2 took their medications with a full cup of water. The NSA did not include that some of R2's medications were crushed.

Record review of R2's, "Nurse Delegation Nursing Visit", dated 11/28/2025, documented R2 was delegated related to their inability to self-administer all their medications due to dementia.

Record review of R2's, "After Visit Summary", dated 08/19/2024, documented multiple of R2's medications were able to be crushed.

Resident 1 (R1)

Record review of R1's, "Face Sheet", undated, documented R1 moved into the facility on [redacted]/2023.

Record review of R1's, "[Facility Name] New Assessment", dated 11/06/2025, documented R1 had multiple medical diagnoses that included [redacted]. R1 was potential for falls related to slow beating heart rate that requires staff to observed them for safety needs, walks with a four wheeled walker and was independent with transfers. Residents safety indicated that R1 was a high fall risk and on blood thinning medications with a history of falls and not reporting them after they occur that has affected their knees and mobility. R1 walked independently with a cane.

On 12/19/2025 at 12:47 PM, Staff Q, Medication Technician, stated R1 required stand by assist from the facility staff for all transfers.

Resident 3 (R3)

Record review of R3's, "Face Sheet", undated, documented R3 moved into the facility on [redacted]/2024.

Record review of R3's, "[Facility Name] New Assessment", dated 12/16/2025, documented they were independent with eating a regular diet with no special diet required and no food allergies.

Record review of an email sent to the Department on 12/23/2025 at 2:34 PM, had R3's document titled, "Dietary Communication Form", undated, documented R1 was to not have lactose.

On 12/19/2025 at 9:20 AM, Collateral Contact 2, Power of Attorney, stated R3 had been hospitalized in the last few months for stomach pain, unable to have bowel movements, and had loose stools when they identified that R3 was lactose intolerant.

Resident 5 (R5)

Record review of R5's, "Face Sheet", undated, documented R5 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R5's, "[Facility Name] New Assessment", dated 06/11/2025, documented they were currently receiving physical therapy services and always used a wheelchair. R5 used a walker only with physical therapy per evaluation on 03/30/2025. R5 had experienced an increase in falls with physical therapy and occupational therapy recommendation to use a wheelchair and not a walk especially a four-wheel walker. R5 was to ask for assistance every shift and was independent with transfers. R5 did not require escorts and could walk to dining room and all activities inside and outside of residence independently.

On 12/17/2025 at 1:57 PM, R5 stated the facility staff help escort them to the dining room for meals, does not sleep in their bed and sleeps on the ground, and when they have used their bed the bed cane that was on the left side of the bed helped with bed mobility. R5 stated they used a manual wheelchair all the time as their balance was off and had a lot of falls since living at the facility.

Resident 9 (R9)

Record review of R9's "Face Sheet", undated, documented R9 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Record review of R9's document titled, "[Facility Name] New Assessment", dated 10/14/2025, documented they ate independently, did not have much of an appetite, did not require tray services, and ate in the dining room. R9 did not have any food allergies and there was no documentation that R9 required any alterations to their diet.

Record review of R9's document titled, "Client Coordination Note Report", dated 11/06/2025, documented that a new dysphagia appropriate diet of minced and moist was ordered by the resident's physician.

Resident 12 (R12)

Record review of R12 document titled, "Face Sheet", undated, documented they moved into the facility on [redacted]/2021. R12 had a medical diagnosis of [redacted].

Record review of R12's, "[Facility Name] New Assessment', dated 07/01/2025,

documented resident received in house bathing and required complete assistance with showering and bathing needs 1 to 2 times a week. The NSA did not document R12's preferences as to what days facility staff were to provide R12 assistance in the shower. R12 had bowl incontinence (inability to control bowel movements) and needed assistance to clean up and maintain acceptable hygiene standards. R12 required a schedule for toileting and was taken to and from the bathroom as R12 needed assistance with incontinence supplies, cleansing after voiding, and assistance with changing linen. The NSA contradicted itself as it then documented R12 did not need a toileting schedule at this time.

Record review of R12's, "Skin Check Shower Sheet", dated 11/26/2025, documented R12 had a shower completed. This was the only documented shower in the month of November that was completed.

Record review of R12's "Skin Check Shower Sheet", dated 11/29/2025, documented R12 was out of the facility and their shower was not completed.

Record review of R12's "Skin Check Shower Sheet", dated 12/06/2025, documented R12 had a shower completed.

Record review of R12's "Skin Check Shower Sheet", dated 12/13/2025, documented R12 had a shower completed.

On 01/05/2026 at 8:45 AM, Collateral Contact 3 (CC3), R12's Representative, stated R12 had bowl incontinence and the facility staff were supposed to help R12 shower. CC3 stated they were concerned that R12 was not getting showered as often as they were supposed to per R12's NSA. CC3 stated frustration that R12 was required to pay for a service they did not regularly receive.

On 12/19/2025 at 3:08 PM, Staff A, Executive Director, stated the director of nursing updates the residents' assessments when there were changes needed to be made.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 9 residents (Resident 4, 8, and 2) medications were available to be administered. This failure resulted in the residents not receiving medications as ordered and placed all residents at risk for unmet care needs and medical complications associated with not receiving medications as ordered.

Findings included…

Record review of the facility's, "Medication Policies Handbook", undated, documented new medication orders would be processed in a timely manner to facilitate the safe delivery of the medication to the residents. When new orders were received the order would be faxed to the pharmacy, if needed, within 24 hours the facility staff would transcribe the order. A notation would be made on the original order that included actions taken, date, and initials of the staff member who processed the order. The resident would be placed on alert charting according to the type of medication which usually was for 72 hours. The medication unavailable section documented facility staff were to identify the medication that was needed. Staff were to notify the director of nursing or the licensed professional on call. Staff were to fax and call the pharmacy and notify the family to discuss the delivery plan each time the medication was to be given even if several times a day until delivered. Staff were to alert the medical doctor of medications unavailable and request an order to hold until the next routine delivery. Staff were to mark as a no pass on the medication administration record (MAR) which indicated medication was unavailable and write steps taken to make the medication available. The resident should be placed on alert charting to alert staff that the medication was coming and to observe the resident for changes in condition related to the ordered medication.

Resident 4 (R4)

Record review of R4's, "Face Sheet," undated, showed R4 moved into the facility on [redacted]/2025. R4 had a medical diagnosis of [redacted].

Record review of R4's, "[Facility Name] New Assessment," dated 09/25/2025, documented R4 required oral medication management. The memory care staff were to manage all orders and deliveries of new medications and refill medications.

Record review of R4's MAR, dated 10/01/2025 through 10/31/2025, documented R4 had an order for levothyroxine sodium (medication used to supplement the thyroid hormone) and missed three doses from 10/04/2025 through 10/06/2025 because the medication was not yet received from the pharmacy. R4 had an order for donepezil (medication used to treat symptoms of Alzheimer's disease) and missed two doses on 10/04/2025 because the medication was not yet received from the pharmacy. R4 had an order for memantine (medication used to treat symptoms of Alzheimer's disease) and missed two doses on 10/04/2025 because the medication was not yet received from the pharmacy. R4 had an order for midodrine (medication used to treat low blood pressure when standing up) and missed two doses on 10/04/2025 because the medication was not yet received from the pharmacy. There were no documented steps taken to make the medication available to review. R4's MAR showed they were not placed on alert due to missed medications from 10/04/2025 through 10/06/2025.

Record review on 12/19/2025 at 1:58 PM, R4's hard medical chart showed there were no progress notes, alert charting notes, or any fax correspondence with R4's medical doctor related to missed medications from 10/04/2025 through 10/06/2025.

On 12/16/2025 at 1:09 PM, the Department requested R4's 10/01/2025 through 12/16/2025 progress notes and alert charting notes to review.

Record review of R4's "Progress Notes for (R4)," documented no notes to review related to when R4 missed multiple of their medications from 10/04/2025 through 10/06/2025.

No alert charting notes were provided to review for R4.

On 12/23/2025 at 10:06 AM, the Department requested all correspondence of when R4's medical doctor was notified when R4 missed their medications in October.

On 12/23/2025 at 2:35 PM, Staff A, Executive Director, stated they could not provide any documentation to review that R4's medical doctor was notified when R4 missed

their medications in October.

Resident 8 (R8)

Record review of R8's, "Face Sheet", undated showed R8 moved into the facility on [redacted]/2025. R8 had a diagnosis of [redacted].

Record review of R8's, "[Facility Name] New Assessment", dated 12/08/2025, documented R8 required oral medication management. R8 was unable to recall medication names, dose or when to take. The facility staff were to administer medications according to their medical doctors' orders. R8 used the community pharmacy.

Record review of R8's, MAR, dated 10/01/2025 through 10/31/2025, documented R8 had an order for losartan (medication used to treat high blood pressure) and missed five doses from 10/04/2025 through 10/08/2025 because the medication was not yet received from the pharmacy. R8 had an order for guaifenesin (medication used to relieve chest congestion) and missed six doses from 10/08/2025 through 10/10/2025 because the medication was not available with a dash that documented "family". R8 had an order for vitamin c (builds collagen, boosts immunity, and helps absorb iron) and missed one dose on 10/08/2025 because the medication was not available with a dash that documented "family". R8 had an order for vitamin d (helps build bones to keep them healthy) and missed three doses 10/08/2025 through 10/10/2025 because the medication was not available with a dash that documented "family". R8 had an order for prednisone (medication used to reduce inflammation and suppress the immune system) and missed eight doses from 10/14/2025 through 10/21/2025 because the medication was not available with a dash that documented "family". R8's MAR showed R8 was placed on alert for multiple reasons but was not placed on alert due to their missed medications from 10/04/2025 through 10/21/2025.

Record review of R8's, MAR, dated 12/01/2025 through 12/16/2025, documented R8 had an order for guaifenesin and missed five doses of their medication through 12/15/2025 through 12/17/2025 because the medication was not yet received from the pharmacy and because the medication was not available with a dash that documented "family". R8's MAR showed they were not placed on alert due to their missed medications from 12/15/2025 through 12/17/2025.

Record review on 12/19/2025 at 2:00 PM, R8's hard medical chart showed there were no progress notes, alert charting notes, or any fax correspondence with R8's medical provider related to their missed medication in October and December.

On 12/16/2025 at 1:09 PM, the Department requested R8's, progress notes and alert charting notes to review from 10/01/2025 through 12/16/2025.

Record review of R8's, "Progress Notes for (R8)", documented no notes to review related to when R8 missed multiple of their medications from 10/04/2025 through 10/21/2025 and from 12/15/2025 through 12/17/2025.

No alert charting notes were provided to review for R8.

On 12/23/2025 at 10:06 AM, the Department requested all correspondence of when R8's medical doctor was notified when R8 missed their medications in October and December.

On 12/23/2025 at 2:35 PM, Staff A stated they could not provide any documentation to review that R8's medical doctor was notified when R8 missed their medications in October and December 2025.

Resident 2 (R2)

Record review of R2's, "Face Sheet", undated, showed R2 moved into the facility on [redacted]/2023. R2 had a medical diagnosis of [redacted].

Record review of R2's, "[Facility Name] New Assessment", dated 05/30/2025, documented R2 required oral medication management. R2's medications would be administered in accordance with policies and procedures and would be monitored for desired and potential adverse effects.

Record review of R2's, MAR, dated 10/01/2025 through 10/31/2025, documented R2 had an order for ipratropium brom spray (nasal spray used to relieve runny nose) and missed eight doses from 10/15/2025 through 10/18/2025 because the medication was not yet received from the pharmacy. R2's MAR showed they were not placed on alert due to their missed medications from 10/15/2025 through 10/18/2025.

Record review of R2's, MAR, dated 11/01/2025 through 11/30/2025, documented R2 had an order for ipratropium brom spray and missed 13 doses from 11/10/2025 through 11/14/2025 because the medication was not yet received from the pharmacy. R2 had an order for Fiasp 100-U/ML (units per milliliter) pen (prefilled disposable device that contained fast acting insulin used to control high blood sugar) and missed two of three dosages on 10/27/2025 because the medication was not yet received from the pharmacy. R2's MAR showed they were not placed on alert when they missed their ipratropium brom spray from 11/10/2025 through 11/14/2025.

Record review of R2's, MAR, dated 12/01/2025 through 12/16/2025, documented R2 had an order for ipratropium brom spray and missed three doses because the

medication was not yet received from the pharmacy. R2's MAR showed they were not placed on alert when they missed their ipratropium brom spray.

On 12/16/2025 at 1:09 PM, the Department requested R2's, progress notes and alert charting notes to review from 10/01/2025 through 12/16/2025.

No progress notes or alert charting notes were provided to review for R2.

On 12/23/2025 at 10:06 AM, the Department requested all correspondence of when R2's medical doctor was notified when R2 missed their medications in October, November and December 2025.

On 12/23/2025 at 2:35 PM, Staff A stated they could not provide documentation to show that R2's medical doctor was notified when R2 missed their medications in October, November and December 2025.

On 12/19/2025 at 10:09 AM, Collateral Contact 1 (CC1), R2's Power of Attorney, stated to their knowledge R2 had only ever missed one dose of insulin due to the medication not being available. CC1 had been under the impression R2 received all their medications as ordered from their medical doctor.

On 12/19/2025 at 10:08 AM, Staff S, Medication Technician, stated they were to get the medication as soon as possible, call the nurse, call the residents physician, and notify the family that the resident did not get their medication.

On 12/19/2025 at 12:47 PM, Staff Q, Medication Technician, stated if a resident missed their medication, then the protocol would be to notify the residents power of attorney, notify the residents medical doctor via fax, and to place the resident on alert charting. Staff Q stated if a resident's medication was not available they would fax the resident's medical doctor and fax the pharmacy to inquire when the medication would be available.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Channel Point Village 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-2230 Medication refusal.

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

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

(i) Conducts an evaluation; and

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the physician when 2 of 9 sampled residents (Resident 4 and Resident 9) refused their medication. This failure placed Resident 4 and Resident 9 at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included…

Record review of the facility's "Medication Policies Handbook," undated, documented if a resident refused a medication, facility staff were to offer it again after an appropriate amount of time had passed. When a medication was refused for any reason press "No Pass" and select the appropriate reason in the eMAR (electronic medication administration record). The director of nursing would be notified the first time a resident refused their medication. The director of nursing or the delegated facility staff would notify the residents physician of the refusal. If ordered, instructions on how to proceed if a resident refused medication should be noted in the eMAR. If no parameters are

written in the eMAR then facility staff should contact the director of nursing each time the resident refused the medication. If a resident refused their medication on a consistent basis, then consult with the resident about why they refused the medication and if appropriate contact the resident's physician to see if there are any alternatives to the current order. If the residents consistently choose not to follow their physician orders and refusals could result in serious negative consequences, then it should be addressed in the resident's negotiated services agreement and discussed with the resident and family to minimize negative consequences.

Resident 4 (R4)

Record review of R4's "Face Sheet," undated, showed R4 moved into the facility on [redacted]/2025. R4 had a medical diagnosis of [redacted].

Record review of R4's "[Facility Name] New Assessment," dated 09/25/2025, documented R4 required oral medication management. The memory care staff were to manage all orders and deliveries of new medications and refill medications. The assessment did not address that R4 often refused their medications.

Record review of R4's MAR, dated 10/01/2025 through 10/31/2025, documented R4 had an order for diclofenac sodium 1% gel (a topical anti-inflammatory used for temporary relief of minor arthritis pain) and they refused their medication 26 of 27 days. R4 had an order for ipratropium brom spray (nasal spray used to relieve runny nose) and they refused their medication 2 of 27 days.

Record review of R4's MAR, dated 11/01/2025 through 11/30/2025, documented R4 had an order for ipratropium brom spray and they refused their medication 3 of 30 days. R4 had an order for midodrine (medication used to treat low blood pressure when standing up) and they refused their medication 2 of 30 days. R4 had an order for donepezil (medication used to treat symptoms of Alzheimer's disease) and refused their medication 2 of 30 days. R4 had an order for memantine (medication used to treat symptoms of Alzheimer's disease) 2 of 30 days. R4 had an order for diclofenac sodium 1% gel and refused their medication 28 of 30 days.

Record review of R4's, MAR, dated 12/01/2025 through 12/16/2025, documented R4 had an order for diclofenac sodium 1% gel and refused their medication 8 of 16 days. R4 had an order for ipratropium brom spray and refused their medication 1 of 16 days.

On 12/23/2025 at 10:06 AM, the Department requested all correspondence of when R4's medical doctor was notified when R4 refused their medications in October through December.

Record review of R4's, Fax, dated 12/05/2025, documented that R4 refused their

diclofenac gel and requested they moved it to an as needed medication.

There was no other documentation provided that showed the facility staff notified R4's physician they refused multiple of their medications in October, November, and December.

Resident 9 (R9)

Record review of R9's "Face Sheet," undated, documented R9 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

On 12/17/2025 at 9:59 AM, only one assessment was received for R9 that was titled, "[Facility Name] New Assessment," dated 10/14/2025, documented they had good safety awareness and able to make needs know. R9 requires wellness staff assistance with ordering, storing, monitoring and administering their medications at proper doses and times. R9 has Duoneb (prescribed medication that is inhaled in a mist treatment that helps open the airways in lungs and decrease inflammation in the lungs to help with breathing) breathing treatments for their chronic obstructive pulmonary disease. R9 requires staff assistance with taking and reporting their vital signs to their physician.

Record review of R9's MAR, dated 10/01/2025 through 10/31/2025, documented they had an order for Duoneb to be administered two times daily and refused their Duoneb on 10/25/2025 and 10/31/2025 at 8:00 AM and 8:00 PM.

Record review of R9's MAR, dated 11/01/2025 through 11/30/2025, documented they had an order for Duoneb to be administered two times daily and refused their Duoneb six time at 8:00 AM and 19 times at 8:00 PM. R9 had an order for lidocaine four percent patch to be applied in the morning and taken off at night to their shoulder and R9 refused to have the lidocaine patch applied 12 times. On 11/09/2025 R9 refused their docusate sodium (medication to help soft bowel movement), Eliquis (prescribed medication to help thin the blood), furosemide (prescribed medication to help reduce swelling, fluid retention, and treat heart failure), and gabapentin (prescribed medication to help treat nerve pain).

Record review of R9's MAR, dated 12/01/2025 through 12/16/2025, documented R9 they had an order for Duoneb to be administered two times daily. Review of the administrations documented R9 refused their Duoneb 15 times at 8:00 AM and 17 times at 8:00 PM. R9 had an order for lidocaine four percent patch to be applied in the morning and taken off at night to their shoulder and R9 refused to have the lidocaine patch applied seven times. On 12/01/2025 R9 refused their docusate sodium, Eliquis, furosemide, and gabapentin.

On 12/23/2025 at 10:06 AM, all of R9's physician notifications for all of the refused medications for 10/01/2025 through 12/16/2025 were requested to review.

On 12/19/2025 at 12:47 PM, Staff Q, Medication Technician, stated if a resident refused their medications after three consecutive days the resident would be placed on alert charting and the facility staff notified the residents physician. Staff Q stated their guidance was provided by the previous director of nursing.

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, Channel Point Village 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-2610 Infection control.

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

(2) The assisted living facility must:

(c) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of infections by:

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide necessary handwashing supplies in 8 of 9 sampled assisted living residents (Resident 7, 8, 2, 14, 1, 11, 5 and 9) rooms, and failed to ensure staff washed their hands, per the recommended guidance, for 5 of 5 staff members (Staff U, V, W, F and O) observed. These failures resulted in a break in hand hygiene practices, staff not having access to hand hygiene supplies, and placed all residents, staff, and visitors at risk for spread of infectious disease.

Findings included…

Record review of the facility's policy, "Infection Control Policy," dated 02/01/2018, documented the community would institute appropriate infection control practices to prevent and limit the spread of infections. Universal precautions would be followed during nursing and housekeeping tasks under the assumption each resident was considered potentially infectious. All employees must routinely use appropriate barriers to protect themselves against the spread of germs and infections. Good handwashing and use of gloves would guard against the spread of germs and infection. Gloves must be worn when touching blood or bodily fluids, touching the resident when delivering hands on care which contact with blood or bodily fluids was possible, touching the non-intact skin of residents, and handling items or surfaces with blood or bodily fluids. Hands and skin surfaces must be washed immediately and thoroughly if contaminated with blood or bodily fluids. Hands must be washed immediately after removing gloves or providing resident care. Good handwashing and wearing gloves were the best barriers to prevent the spread of germs from one resident to another. The facility staff were to follow these procedures to ensure proper hand washing. Facility staff were to completely wet their hands and wrists, apply soap, hold their hands lower than their elbows while washing, work up a good lather, spread it over the entire area of hands and wrists, get soap under your nails and between your fingers. Facility staff were to clean for 30 seconds by rubbing vigorously, rub one hand against the other hand and wrist, rub between their fingers by interlacing them, rub up and down to reach all skin surfaces on their hands and in-between their fingers, and rub the tips of their fingers against the palms to clean with friction around the nail bed. The facility staff were to wash two inches above the wrists, rinse well, dry thoroughly with paper towels, and turn off the faucet with a paper towel.

On 12/16/2025 at 11:12 AM, during the general tour of the facility there were no publicly accessible bathrooms observed on the second flood. Staff J, Assistant Executive Director, confirmed there were no public bathrooms accessible on the second floor.

Hand Washing Supplies in Resident Apartment

Resident 7 (R7)

Record review of R7's, "Face Sheet", undated, showed R7 moved into the facility on [redacted]/2023. R7 had a medical diagnosis of [redacted].

Record review of R7's "[Facility Name] New Assessment," dated 07/03/2025, documented R7 required a toileting schedule and was taken to and from the bathroom. R7 needed assistance with incontinence supplies and cleansing after voiding. R7 wore adult briefs.

On 12/19/2025 at 9:25 AM, R7 stated if they needed to use the bathroom the facility

staff would help them. R7 stated after they used the bathroom the facility staff used wipes on them. Inside of R7's bathroom there was no soap receptacle that hung on the wall. R7's bathroom had la maison Provence lemon soap and reusable hand towels. R7's apartment kitchen had peppermint wizard hand soap and a roll of paper towels. R7 stated that the facility staff asked them to wash their hands inside of their apartment.

Resident 8 (R8)

Record review of R8's "Face Sheet", undated, showed R8 moved into the facility on [redacted]/2025. R8 had a diagnosis of [redacted].

Record review of R8's "[Facility Name] New Assessment," dated 12/08/2025, documented R8 required nightly set up of bedside commode/urinal (portable toilet) and removal cleaning every morning. R8 required assistance in changing their catheter bag (a container that collects urine from a catheter) from bedside bag to leg bag in the morning and from leg bag to bedside bag in the evening. R8 required assistance with cleaning their catheter bags.

On 12/18/2025 at 3:12 PM, inside of R8's bathroom, it was observed that there was no soap receptacle that hung on the wall. R8's bathroom had myers clean hand soap and reusable hand towels. R8's apartment kitchen had myers hand soap, in a clear container orange soap, and a roll of paper towels. R8 said the facility did not provide their soap and paper towels and that they bought them themselves.

Resident 2 (R2)

Record review of R2's "Face Sheet," undated, showed R2 moved into the facility on [redacted]/2023. R2 had a medical diagnosis of [redacted].

Record review of R2's "[Facility Name] New Assessment," dated 05/30/2025, documented R2 was occasionally incontinent of urine and stool.

On 12/16/2025 at 11:33 AM, R2's bathroom was not observed to have paper towels in the paper towel receptacle.

Resident 14 (R14)

On 12/19/2025 at 12:41 PM, R14's bathroom was not observed to have paper towels in the paper towel receptacle.

Resident 1 (R1)

Record review of R1's, "Face Sheet", undated, documented R1 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R1's, "[Facility Name] New Assessment", dated 11/06/2025, documented they required staff's assistance to get in and out of the shower, wash hard to reach areas, assist with drying, stand-by assistance with dressing and ensuring their clothes were changed daily and soiled clothes were placed in dirty clothes basket to be washed, and was on a routine toileting schedule as they often experience urinary incontinence and needed assistance with changing briefs, incontinent laundry, and supplies.

On 12/16/2025 at 11:31 AM, inside R1's bathroom, the soap dispenser that was hung up on the wall, when motioned to have soap dispensed no soap was dispensed.

Resident 11 (R11)

On 12/16/2025 at 11:34 AM, inside R11's bathroom, the soap dispenser that was hung up on the mirror, when motioned to have soap dispensed no soap was dispensed.

Resident 9 (R9)

Record review of R9's "Face Sheet," undated, documented R9 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Record review of R9's document titled, "[Facility Name] New Assessment," dated 10/14/2025, documented they required one person stand-by assistance with getting in and out of the shower, staff to wash hard to reach areas and required moderate assistance with toileting, cleaning, and dressing from staff.

On 12/18/2025 at 3:41PM, inside R9's bathroom, at the sink, it was observed that there were no paper towels for the staff to use.

Resident 5 (R5)

On 12/17/2025 at 2:11 PM, inside R5's bathroom at the sink there were no paper towels available for use and there was a bar soap. R5 stated their son brought in the soap and paper towels for them to use and that the facility did not provide any hand washing supplies for the staff to use in their care area.

On 12/18/2025 at 3:04 PM, Staff R, Housekeeper, stated the facility staff provided all of the memory care residents soap and paper towels inside of their resident bathrooms. Staff R stated not all of the assisted living residents were provided a soap receptacle inside of their bathroom. Staff R stated some of the assisted living residents bought their own supply of soap. Staff R stated they did not distribute paper towels to the assisted living residents rooms. Staff R stated if their hands became soiled inside of a resident room and they wore gloves they would dispose of their gloves. Staff R stated if their hands became soiled and they were not wearing gloves they would leave the resident room and wash their hands in the communal bathroom.

On 12/19/2025 at 12:56 PM, Staff Q, Medication Technician, stated the facility did not supply soap and paper towels for staff to use in assisted living side of the facility and the handwashing supplies were the residents personal supplies. Staff Q stated that if their hands were soiled in the assisted living residents rooms, they would use whatever supply of soap and paper towels were available to wash their hands. Staff Q stated they were taught to use water and soap, scrub for 30 seconds, then rinse, dry hands with paper towels, then grab new paper towels to turn off the water.

Hand Hygiene Dining Room

On 12/16/2025 at 2:17 PM, Staff I, Kitchen Manager, stated facility staff members were to wash their hands before they started a new task, in between tasks, and between glove changes. Staff I stated they wore gloves when they served residents their food.

On 12/19/2025 at 12:00 PM, Staff U, Server, had been observed to stand at a table with multiple residents and confirmed the residents' orders on a piece of paper that they held in their bare hands. Staff U touched a pen and marked something off on the slip of paper. Without performing hand hygiene Staff U went to the kitchen's serving window with counter and picked up multiple plates and distributed them to the residents at 12:08 PM. Staff U returned to the kitchen window, picked up more plates, and distributed them to the residents. Staff U had been observed to enter the kitchen, they touched a pen and paper, picked up a plate, put the plate down on the counter, and then started to put fruit cups of pineapple onto trays and distributed plates to residents. At 12:18 PM, Staff U went to the kitchen's serving window and placed both of their hands palm down onto the counter. Staff U picked up residents plates and distributed them. At 12:19 PM, Staff U returned to the kitchen counter and was observed to look at paper slips and at 12:21 PM, placed their hands onto the counter. Staff U picked up a spoon and distributed a resident the spoon and plate of food. At 12:24 PM, Staff U had been observed to perform hand hygiene inside of the kitchen. At 12:26 PM, Staff U exited the kitchen and rolled out a dessert cart. At 12:28 PM, Staff U approached a resident table and inquired with residents what they wanted to eat. Staff U had been observed to pick up and visibly show the residents which dessert plate they could choose. Staff U picked

up a plate and then set down a plate that contained banana bread, pudding, pecan bar, and blue berry pie. Staff U had been observed to pick up the dessert plates multiple times at one table before they moved onto the next table.

On 12/19/2025 at 12:03 PM, Staff V, Kitchen Staff, were observed in the kitchen through the kitchen's serving window and wore disposable gloves while they held a clipboard and pen. Staff V put down the clipboard and pen and started to plate lunch for the residents. At 12:15 PM, Staff V doffed (took off) their gloves and without performing hand hygiene they put on another pair of disposable gloves. Staff V had been observed to plate more food items for the residents. At 12:24 PM, Staff V doffed their gloves and did not perform hand hygiene before they left the kitchen and went into the dining room. Staff V had been observed to pick up a pen. Staff V stood at the kitchen's windows counter and touched paper slips and placed their hands on top of the counter.

On 12/19/2025 at 12:12 PM, Staff W, Kitchen Staff, were observed to talk with a resident who sat at the dining table. Staff W went to the kitchen's serving window with counter and got a piece of paper. At 12:19 PM Staff W had been observed to touch the counter with both of their hands, they touched saran wrap on the counter, they then retrieved silverware from a cup on the counter, and picked up and distributed two plates of food to the residents.

Hand Hygiene Resident Care

On 12/19/2025 at 12:39 PM, the Department knocked on R2's apartments closed door. Through the door a facility staff member stated resident care. Staff F, Caregiver, opened R2's bedroom from inside the room. Staff F had been observed to wear disposable blue gloves on each of their hands.

Hand Hygiene Medication Pass

R5

On 12/19/2025 at 11:59 AM, the wellness door of the assisted living side of the facility was opened by Staff O, Medication Technician, with their bare hands. Staff O stated they were filling out a fax communication form. Staff O approached the medication cart that was in the wellness office and opened the top drawer and grabbed out a clear plastic bag with insulin pens inside, a black bag with blood sugar machine inside, alcohol wipe squares, and blue disposable gloves. Staff O left the wellness room and was not observed to wash their hands or use hand sanitizer prior to getting the supplies or during the duration of the observation. Staff O knocked on R5's door, entered the room and announced they were here to check their blood sugar and administer insulin. Staff O handed R5 an alcohol wipe square and then put on the blue disposable gloves without performing hand hygiene. Staff O assisted R5 to put the blood on the strip of the blood sugar machine strip, then assisted to put a needle on the tip of the insulin pen and handed it to R5. Staff O took the used insulin pen, opened the closet cabinet with

their same gloved hands and disposed the needle into a red sharps container. At 12:04 PM, Staff O removed their gloves, threw them in the trash, and exited R5's room. Staff O was not observed to perform hand hygiene after removing their gloves or exiting R5's room. At 12:05 PM, Staff O opened the wellness room door, put the insulin pens and blood sugar back into the top drawer of the medication cart without still without performing hand hygiene. Staff O stated they were to wash their hands or perform hand hygiene before and after each residents interaction and that they did not carry hand sanitizer on them to use. Staff O stated the hand sanitizer was always available on the medication cart for them to use and that not all residents had hand hygiene supplies in their rooms for staff to use.

On 12/19/2025 at 3:08 PM, Staff H, Vice President of Operations, stated staff were to wash their hands with soap, water, and dry with paper towels between each tasks, after the use of a bathroom, after breaks, after removing disposable gloves. Staff H stated the acceptable way for the staff to wash their hands were with soap and water and agreed that not all assisted living residents care areas had soap and paper towels available for staff to wash their hands with.

This is a recurring deficiency previously cited under subsection (1) on 10/09/2024.

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, Channel Point Village 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-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 interview and record review, the facility failed to monitor a change in resident condition that required intervention for 7 of 9 residents (Resident 2, 3, 5, 6, 7, 8 and 9). This failure placed these residents at risk of their care needs not being met and potential negative outcomes.

Findings included…

On 12/18/2025 at 4:24 PM, Staff A, Executive Director, stated the facility's alert charting policy was the facility document titled, "Change of Resident Condition", dated 02/01/2018.

Record review of the facility's policy, "Change of Resident Condition", dated 02/01/2018, documented any change of a resident's condition that was observed by a care manager must be reported on the "Care Manager's Change of Condition Report" be completed and placed in the designated mailbox by the end of the same shift in which the change was first noted. The health and wellness director would ensure appropriate assessment and follow-up took place. Condition changes included length of time or amount of assistance needed for ADL (activities daily living) care, changes in willingness or ability to take medications, medication side effects, signs and symptoms of health condition either observed or reported by the resident, decline in cognitive condition, emotional and behavioral changes. The change of condition report would be used by the care team daily to discuss care changes and resident re-assessments. Any changes in the service plan would be noted by the director of nursing and shared with appropriate staff members no later than the next day. There was no guidance for medication technicians or care staff if and when they were to chart on a resident and where related to them being put on alert monitoring.

Resident 2 (R2)

Record review of R2's, "Face Sheet", undated, showed R2 moved into the facility on [redacted]/2023. R2 had a medical diagnosis of [redacted].

Record review of R2's MAR, dated 10/01/2025 through 10/31/2025, documented R2 was placed on alert monitoring from 10/02/2025 through 10/05/2026 related to R2's non-injury fall.

Record review of R2's MAR, dated 11/01/2025 through 11/30/2025, documented R2 was placed on alert monitoring from 11/21/2025 through 11/24/2025 related to R2's injury fall when they fell in the shower and had a skin tear on their right forearm. R2 was placed on alert monitoring from 11/27/2025 through 11/30/2025 related to when they were out of their fiasp insulin medication (rapid acting used to manage blood sugar levels).

Record review of R2's MAR, dated 12/01/2025 through 12/17/2025, documented R2 was placed on behavior monitoring from 12/03/2025 through 12/10/2025. R2 was placed on alert monitoring from 12/12/2025 through 12/13/2025 related to R2's new Ozempic medication (medication used to help control blood sugar levels). R2 was placed on alert monitoring that started 12/17/2025 related to R2's oral surgery and new medication azithromycin (used to treat a variety of bacterial infections) and tramadol (used to treat moderate to severe pain). R2 was placed on alert observations from 12/12/2025 through 12/15/2025 related to R2's resident to resident altercation.

On 12/16/2025 at 1:09 PM, the Department requested R2's, progress notes and alert charting notes to review from 10/01/2025 through 12/16/2025.

No progress notes or alert charting notes were provided to review for R2.

Resident 8 (R8)

Record review of R8's "Face Sheet", undated showed R8 moved into the facility on [redacted]/2025. R8 had a diagnosis of [redacted].

Record review of R8's MAR, dated 10/01/2025 through 10/31/2025, documented R8 was placed on alert monitoring from 10/26/2025 through 10/30/2025 related to R8's return from the emergency department from their urinary retention and urinary tract infection. R8 was placed on alert monitoring from 10/19/2025 through 10/22/2025 related to R8 injury fall off their scooter outside onto the grass which resulted in a skin abrasion on their left elbow and right upper forearm. R8 was placed on alert monitoring from [redacted]/2025 through 10/07/2025 related to them being a new resident.

Record review of R8's "Temporary Service Plan", dated [redacted]/2025, documented R8 was a new admit. The monitoring and reporting section showed initiate alert charting, monitor for vitals, invite R8 to activities, escort R8 to activities and meals, talk or visit with R8, and compare R8's needs to their care plan. Ten facility staff members signed that they read and understood the document.

Record review of R8's "Temporary Service Plan", dated 10/27/2025, documented R8

returned from the emergency department for urinary retention and a urinary tract infection. The monitoring and reporting section showed initiate alert charting, monitor for vitals, invite R8 to activities, escort R8 to activities and meals, talk or visit with R8, and compare R8's needs to their care plan. 13 facility staff members signed that they read and understood the document.

Record review of R8's MAR, dated 11/01/2025 through 11/30/2025, documented, R8 was placed on alert monitoring from 11/20/2025 through 11/23/2025 related to their medication change to losartan (used to treat high blood pressure). R8 was placed on alert monitoring from 11/21/2025 through 11/23/2025 related to their new medication for nitrofurantoin (antibiotic used to prevent and treat urinary tract infections). R8 was placed on alert monitoring from 11/25/2025 through 11/28/2025 related to their new medication nitrofurantoin monomcr (antibiotic used to prevent and treat urinary tract infections).

On 12/16/2025 at 1:09 PM, the Department requested R8's, progress notes and alert charting notes to review from 10/01/2025 through 12/16/2025.

Record review of R8's "Progress Notes for (R8)", dated 12/03/2025, Staff P, Medication Technician, documented a late entry from 11/21/2025 that R8 returned from the emergency room after going to be seen for their leaking catheter. R8 was prescribed new medication.

No alert charting notes were provided to review for R8.

R7

Record review of R7's "Face Sheet", undated, showed R7 moved into the facility on [redacted]/2023. R7 had multiple medical diagnoses of [redacted] and [redacted] and [redacted].

Record review of R7's MAR, dated 10/01/2025 through 10/31/2025, documented, R7 was placed on alert monitoring from 10/02/2025 through 10/05/2025 related to their new medication oxycodone (medication used to treat moderate to severe pain). R7 was placed on alert monitoring from 10/07/2025 through 10/13/2025 related to R7's new medication senna lax (medication used to treat constipation).

Record review of R7's "Temporary Service Plan", dated 10/02/2025, documented R7 had new medication of oxycodone and acetaminophen. The what to chart section showed any side effects of new medication including faintness, dizziness, nausea, vomiting, diarrhea, changes in level of consciousness, etc. needed to immediately be reported to the registered nurse. The facility staff were to document daily temperature, blood pressure, pulse, and respirations. The facility staff were to document all

complaints from the resident. Ten facility staff members signed their names that they read and understood the information.

Record review of R7's "Temporary Service Plan", dated 10/07/2025, documented R7 had new medication of senna lax and milk of magnesium (used to treat constipation) were to be given if R7 did not have a bowel movement for three days. The what to chart section showed any side effects of new medication including faintness, dizziness, nausea, vomiting, diarrhea, changes in level of consciousness, etc. needed to immediately be reported to the registered nurse. The facility staff were to document daily temperature, blood pressure, pulse, and respirations. The facility staff were to document all complaints from R7. Eight facility staff members signed their names that they read and understood the information.

Record review of R7's MAR, dated 11/01/2025 through 11/30/2025, documented, R7 was placed on alert monitoring from 11/22/2025 through 11/26/2025 related to their new medication sulfa/trimeth (medication used to treat bacterial infections).

On 12/16/2025 at 1:09 PM, the Department requested R7's, progress notes and alert charting notes to review from 10/01/2025 through 12/16/2025.

Record review of R7's "Progress Notes for (R7)", dated 10/03/2025, Staff X, Former Director of Nursing, documented they called and spoke to R7's power of attorney about their new prescription of oxycodone. There were no other progress notes provided to review related to R7's new medications.

No alert charting notes were provided to review for R7.

Resident 5 (R5)

Record review of R5's "Face Sheet", undated, documented R5 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R5's MAR, dated 10/01/2025 through 10/31/2025, documented they were put on alert monitoring for a non injury fall on 10/30/2025 on night shift that continued through 11/02/2025 night shift.

Record review of R5's MAR, dated 11/01/2025 through 11/30/2025, documented they were put on alert monitoring for an unwitnessed fall in their apartment with existing injury to right shoulder on 11/27/2025 on night shift through 11/30/2025 at night shift.

Record review of R5's MAR, dated 12/01/2025 through 12/16/2025, documented they

were put on alert for an unwitnessed fall in their apartment on 12/03/2025 in the evening through 12/06/2025 night shift. R5 was put on alert for a fall in their apartment on 12/19/2025 in the evening through 12/12/2025 night shift.

On 12/16/2025 at 1:09 PM R5's progress notes, alert notes, and any charting notes for 10/01/2025 through 12/16/2025 were requested to review.

Record review of R5's progress notes, undated, documented there were two notes. One note was on 10/15/2025 about R5 being seen by physical therapy for an reassessment, and the other noted was dated 10/24/2025 that was a late chart note for 09/25/2025 at 1:15 PM, when R5 had an un-witnessed non injury fall in there room. There was no further documentation to show that R5 was monitored after each occurrences that were documented on their MAR's for dates 10/01/2025 through 12/16/2025.

Resident 3 (R3)

Record review of R3's document titled "Face Sheet", undated, documented their readmission date was on [redacted]/2025.

On 12/17/2025 at 11:52 AM Staff J, Assistant Executive Director, stated R3 was a readmission resident to the facility. Staff J stated R3 moved out of the facility in [redacted] 2025 with their son and then moved back into the facility on [redacted]/2025. Staff J confirmed that R3 was taken off the facility's census as a resident when they moved out in [redacted].

On 12/16/2025 at 1:09 PM R3's progress notes, alert notes, and any charting notes for 10/01/2025 through 12/16/2025 were requested to review.

Record review of R3's progress note, dated 11/20/2025 showed it was a late entry for [redacted]/2025 at 10:00 AM, documented R3 was out of the facility at home since [redacted]/2025. R3 returned back to the facility and moved into the memory care unit. There was no further documentation on how R3 was adjusting since moving back into the facility.

Resident 6 (R6)

Record review of R6's document titled, "Face Sheet", undated, documented they admitted into the facility [redacted]/2025.

On 12/16/2025 at 1:09 PM R6's progress notes, alert notes, and any charting notes for 10/01/2025 through 12/16/2025 were requested to review.

Record review of R6's progress notes, undated, documented there were two progress notes. One progress dated 10/20/2025 at 4:36 PM, that was a late entry for 10/17/2025 related to receiving a call from a physician concerning a referral and the recommendation that R6 ate soft food to avoid and there was a note dated 10/23/2025 at 11:50 PM, that was about the physician calling with the results of the procedure R6 had recently undergone. There was no other documentation or documentation about how R6 adjusted to moving into the facility on [redacted]/2025.

Resident 9 (R9)

Record review of R9's "Face Sheet", undated, documented R9 moved into the facility on [redacted]/2025.

Record review of R9's MAR, dated 10/01/2025 through 10/31/2025, documented they were put on alert monitoring for a fall that started on 10/30/2025 at bedtime and continued through 11/02/2025 at night shift. R9 was put on alert monitoring for missed medication amoxicillin trihydrate and potassium clavulanate (a prescribed medication with two antibiotics to help treat bacterial infections) and azithromycin (prescribed medication antibiotic to help treat infections) that started on 10/28/2025 at bedtime. R6 was put on alert monitoring for a new medication debrox (a medicated ear wax remover solution) ear drops in right ear before bed for five days that started on 10/30/2025 on night shift and continued through 11/02/2025 at night shift.

Record review of R9's MAR, dated 11/01/2025 through 11/30/2025, documented they were put on alert monitoring for returning back to the facility from the hospital after a choking episode that started on 11/02/2025 at night and continued through 11/05/2025 at night. R9 had an order for oxygen check and if oxygen saturation reading was below 93 as needed oxygen was to be applied. Review of the R9's reading documented on 11//11/2025 and 11/12/2025 there were no oxygen saturation readings documented, on 11/14/2025 R9's oxygen saturation was 84, on 11/22/2025 their oxygen saturations were 90 and on 11/26/2025 their oxygen saturations were 86. There was no documentation that indicated that as needed oxygen was applied to R9. R9 was put on alert monitoring for new medication miconazole (prescribed medication to treat fungal and yeast infections) that started 11/15/2025 at night and continued through 11/19/2025 at night.

On 12/16/2025 at 1:09 PM R9's progress notes, alert notes, and any charting notes for 10/01/2025 through 12/16/2025 were requested to review.

Record review of R9's progress notes, undated, documented there was one note dated 12/11/2025 at 1:26 PM, about a new medication order for fluconazole (prescribed medication to help treat fungal infections) from R9's physician. There were no other progress notes about the alerts that were put in place on R9's MAR, when their oxygen saturations were in the 80's, after returning back to the facility from going to the hospital after a choking episode or when they moved into the facility on [redacted]/2025.

On 12/18/2025 at 1:09 PM Staff H, Vice President of Operations, stated the residents alert monitoring was documented in the facilities electronic record system in the progress notes and that a temporary service plan (TSP) would be implemented for what the alert was and kept in the wellness center. Staff H stated the medication technicians were to just document the residents vital signs on the MAR for the alert monitoring and then document in the progress notes further details on the resident related to the reason why they were on alert monitoring.

On 12/19/2025 at 10:08 AM Staff S, Medication Technician, stated a resident was put on alert for any changes that were different from their typical behavior. The staff would alert the facility nurse of the changes and Staff A, Executive Director and then document on the MAR the resident was on alert with the reason. The staff would complete a TSP and then notify the residents physician. Staff S stated they documented the resident alert monitoring on the resident MAR. Staff S showed on the MAR the section “med pass notes”, and stated this was where they documented their notes for any resident on alert monitoring.

On 12/19/2025 at 12:56 PM, Staff Q, Medication Technician, stated only the lead medication technicians put residents on alert and document. The non lead medication technicians would fill out the TSP and any other paperwork for any resident that had a new medications, fall, any injury, or any changes with the resident. Staff Q stated they were not a lead medication technician and was unsure where the facility documented the residents alert charting.

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-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(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

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 4 sampled new staff (Staff B, C, D, and G) had completed their facility orientation upon hire, failed to ensure 2 of 2 sampled Staff (Staff E and F) completed their annual continuing education units (CEU), and failed to ensure 1 of 4 staff (Staff C) completed their first aid and Cardiopulmonary resuscitation (CPR) certification. These failures placed all residents at risk for staff not being trained on updated medical information and staff being unaware of facility protocols and expectations upon hire.

Findings included…

Facility Orientation

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

Record review of the facility’s “Employee Listing”, undated, documented Staff B, Caregiver, started employment at the facility on 08/12/2025. Staff C, Caregiver, started employment at the facility on 09/22/2025. Staff D, Medication Technician, started employment at the facility on 08/26/2025. Staff G, Maintenance, started employment at the facility on 07/09/2025.

On 12/17/2025 at 10:29 AM, the Department requested Staff B, Staff C, and Staff D’s facility orientation to review. At 12:58 PM, the Department re-requested Staff B, Staff C, and Staff D’s facility orientation and requested Staff G’s facility orientation to review. There was no facility orientation provided to review for Staff B, Staff C, Staff D, and Staff G.

On 12/17/2025 at 11:34 AM, Staff G stated when they were on-boarded at the facility the previous director of maintenance did not leave them any details that pertained to how they were supposed to complete their job.

On 12/19/2025 at 12:47 PM, Anonymous 1, facility staff, stated they were hired at the facility within the last year and did not complete the facility orientation.

On 12/18/2025 at 1:00 PM, Staff H, Vice President Operations, stated when new employees were hired at the facility, they did a walkthrough of the facility but could not provide any facility orientation documentation to show the employees facility orientation was completed.

Continued Education Units

WAC 388-112A-0611 “(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:(i) A certified home care aide;(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);(iii) A certified nursing assistant;(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in RCW 28A.300.010; and(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0060.(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.(c) The continuing education requirements of this section do not apply to a registered nurse, a licensed practical nurse, and an advanced registered nurse practitioner licensed under chapter 18.79 or 18.80 RCW, even if voluntarily certified as a home care aide under chapter 18.88B RCW.(d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete and provide documentation of 12 hours of continuing education within 45 calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; and(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or(ii) If the 45 calendar day time period allows the long-term care worker to complete continuing education in January or February of the following year, the credit hours earned will be applied to the calendar year in which the long-term care worker was hired.(e) If the birthday following initial certification as a home care aide or nursing assistant (NA-C) is less than a full year from the date of initial certification, no continuing education will be due for the first renewal period.(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.”

WAC 388-110-220 Enhanced adult residential care service standards. “(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:(d) Ensure that each staff who works directly with residents has at least six hours of continuing

education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112-0205. Appropriate topics include, but are not limited to:(i) Agitation: Caregiving strategies;(ii) Challenging behaviors: Strategies for managing aggression and sexual behavior;(iii) Delusions and hallucinations;(iv) Using problem-solving strategies in dementia care;(v) Depression and dementia;(vi) Fall prevention for people with dementia;(vii) Personal care as meaningful activity;(viii) Promoting adequate food and fluid consumption;(ix) Promoting pleasant and purposeful activity;(x) Resistance to care: Caregiving strategies; and(xi) Recognizing and assessing pain in people with dementia…"

Record review of the Department system showed the facility had a specialized dementia care contract that was active and started on 07/01/2025 and was good through 06/30/2027.

Staff E

Record review of the facility's "Employee Listing", undated, documented Staff E, Medication Technician, started employment at the facility on 12/07/2022 and their birthday was October 3rd.

Record review of CEU's provided for Staff E, documented 4 of 12 hours completed and 1 of 6 hours completed related to dementia during the dates of 10/03/2024 through 10/03/2025.

Staff F

Record review of the facility's "Employee Listing", undated, documented Staff F, Caregiver, started employment at the facility on 09/27/2023 and their birthday was March 16th.

Record review of CEU's provided for Staff F, documented one of 12 hours completed and zero of six hours completed related to dementia during the dates of 03/16/2024 through 03/16/2025.

On 12/19/2025 at 2:45 PM, Staff A, Executive Director, acknowledged that Staff E and Staff F did not have all 12 of 12 required CEU's and that Staff E and Staff F did not have six of 12 CEU's that were related to dementia.

First Aid and CPR

WAC 388-112A-0720- "What are the CPR and first-aid training requirements? (2)

Assisted living facilities. (a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire. (c) The form of the first-aid or CPR card or certificate may be electronic or printed.

Record review of the facility's document titled, "Employee Listings", undated, documented Staff C, Caregiver, started employment at the facility on 09/22/2025.

On 12/17/2025 at 10:29 AM, Staff C's CPR and first aid card was requested to review.

On 12/17/2025 at 11:45 AM, Staff J, Assistant Executive Director, stated Staff C had not completed the CPR and first aid training.

On 12/17/2025 at 3:00 PM, Staff A stated Staff J, Assistant Executive Director, was the person responsible for the upkeep of the facility staff employee files.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete reference checks for 1 of 2 employees (Staff C). This failure placed all residents at risk of receiving care and services from unqualified and/or unsuitable staff.

Findings included…

Record review of the facility's document titled, "Employee Listings", undated, documented Staff C, Caregiver, started employment at the facility on 09/22/2025.

On 12/17/2025 at 12:58PM and 2:58 PM, the Department requested Staff C's reference checks for review.

Record review of facility staff documents as of 12/17/2025 at 5:30 PM, revealed no documentation that the facility conducted Staff C's reference checks.

On 12/19/2025 at 3:08 PM Staff A, Executive Director, stated Staff J, Assistant Executive Director, or their designee, was responsible to audit and ensure that all staff had received and completed all required documents that included staff reference checks.

This is a recurring deficiency previously cited on 02/08/2024.

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Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

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

(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 4 of 4 sampled Staff (Staff A, C, D and B) received all required Tuberculosis (infectious bacterial disease of the lungs) testing within the required time frame. This failure resulted in the facility failing to test staff for Tuberculosis (TB) and placed all residents and staff at risk for exposure to highly communicable disease.

Findings included…

On 12/17/2025 at 2:33 PM, Staff J, Assistant Executive Director, stated the document titled, “Mantoux (PPD) TB Skin Test”, dated 12/11/2025, was the facility’s policy and had highlighted the areas that the facility follows when they would need to administer a TB test to an employee.

Record review of the facility’s document titled, “Mantoux (PPD) TB Skin Test,” dated 12/11/2025, documented the areas highlighted was test one, test two that was to be completed seven to 14 days from the date of the initial TB injection, that the TB skin test must be read by a registered nurse between 48-72 hours of administration, any unread tests would result in a repeat TB test and any positive test (induration of five millimeters or greater) would result in referral to an outside agency or their primary healthcare practitioner for follow up and testing by chest x-ray.

Record review of the facility’s document titled, “Employee Listings,” undated, documented, Staff A, Executive Director, started employment on 06/30/2025.

Staff A

Record review of Staff A’s TB test, undated, documented they received an initial TB test on 04/21/2021 and a second TB test on 04/28/2021.

Record review of Staff A’s TB skin testing, dated 06/10/2025, documented they received their initial TB test on 07/02/2025. There was no documented second test.

Staff D

Record review of the facility’s document titled, “Employee Listings”, undated, documented Staff D, Caregiver, started employment on 08/26/2025.

Record review of Staff D’s TB skin testing, dated 01/23/2019, documented they received their initial TB skin test on 01/23/2019 and a second TB skin test on 02/11/2019.

Record review of Staff D’s untitled document, dated 08/11/2022, documented that Staff D had a quantiferon TB gold (a test that detects latent TB immune response) blood test that had a negative result. There were no other TB skin tests provided for Staff D to review.

Staff B

Record review of the facility's document titled, "Employee Listings", undated, documented Staff B, Caregiver, started employment on 08/12/2025.

Record review of Staff B's TB skin testing, dated 08/09/2025, documented they had an initial TB test completed on 08/19/2025 that did not have any results documented. There was no second TB test documented as completed and no other TB test results were provided to review for Staff B.

Staff C

Record review of the facility's document titled, "Employee Listings", undated, documented Staff C, Caregiver, started employment on 09/22/2025.

On 12/17/2025 at 10:29 AM, 12:58 PM and 2:58 PM, the Department requested Staff C's TB test results for review.

On 12/17/2025 at 3:00 PM, Staff A stated the prior director of nursing was provided the TB test form to complete for Staff C. Staff C's TB testing was not completed.

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Administrator (or Representative) Date