STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Parkside Operations LLC
Parkside Retirement Community
2902 I St NE
Auburn, WA 98002

RE: Parkside Retirement Community License # 2638

Dear Administrator:

This letter addresses Compliance Determination(s) 36473 (Completion Date 02/07/2024) and 33548 (Completion Date 12/15/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/07/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2484-2, WAC 388-78A-2700-1-c, WAC 388-78A-2700-1-g, WAC 388-78A-2700-1-g-i, WAC 388-78A-2700-1-g-ii, WAC 388-78A-2700-1-g-iii, WAC 388-78A-2700-1-g-iv, WAC 388-78A-2700-1-g-v, WAC 388-78A-2700-1-g-vi, WAC 388-78A-2620-2-a, WAC 388-78A-2620-2-b, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-3, WAC 388-78A-2140-7, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-2610-1, WAC 388-78A-2610-2-d, WAC 388-78A-2665, WAC 388-78A-2665-1, WAC 388-78A-2665-2, WAC 388-78A-2665-3, WAC 388-78A-2665-4, WAC 388-78A-2665-5, WAC 388-78A-2665-6

The Department staff who did the on-site verification:
Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for the unannounced on-site full inspection on 12/05/2023 and 12/12/2023 of:
Parkside Retirement Community
2902 I St NE
Auburn, WA 98002

The following sample was selected for review during the unannounced on-site visit: 11 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Laurie Anderson 12/23/2023

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) 12.29.23 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:

(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 4 of 7 staff (Staff B, Staff C, Staff D, and Staff E) were screened for Tuberculosis (TB) as required. This failure placed all the residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Note: WAC 388-78A-2480 (1) Tuberculosis-Testing-Required stated the assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Review of facility's personnel records showed the facility employed Staff B, Director of Nursing, on 08/16/2023; Staff C, Housekeeper, on 05/17/2023; Staff D, Caregiver, on 03/06/2023; and Staff E, Caregiver, on 02/02/2023.

Review of the facility's staff schedule showed that from 08/16/2023 through 12/08/2023, Staff B worked at the facility providing oversight of staff who provided care and services for residents. Review of Staff B's personnel records showed no documentation that Staff B completed any testing to be screened for TB.

Review of the facility's staff schedule showed that from 05/17/2023 through 12/08/2023, Staff C worked at the facility providing care and services for residents. Review of Staff C's personnel records showed that on 05/17/2023, Staff C completed one-step of the two-step TB skin test. There was no documentation that showed Staff C completed a second test within one to three weeks after the first test.

Review of the facility's staff schedule showed that from 03/06/2023 through 12/08/2023, Staff D worked at the facility providing care and services for residents. Review of Staff D's personnel records only showed documentation that Staff D completed a chest x-ray on 04/18/2022. There was no documentation that showed Staff D completed any other testing to be screened for TB.

Review of the facility's staff schedule showed that from 02/02/2023 through 12/08/2023, Staff E worked at the facility providing care and services for residents. Review of Staff E's personnel records showed that Staff E completed a one-step TB skin test on 04/23/2023, 90 days after the date of employment. There was no documentation that showed Staff E completed a second test within one to three weeks after the first test.

During an interview on 12/12/2023 at 10:00 AM, Staff A, Executive Director, confirmed that when Staff B, Staff D and Staff E were hired, they were not screened for TB. Staff A stated that they were unaware that TB testing was required for all facility staff within three days of employment. Staff A confirmed that Staff B, Staff D, and Staff E were not screened for tuberculosis within three days of employment as required. Staff A stated that Staff C completed the first TB skin test on the date of employment. Staff A stated there was no documentation that showed Staff C completed a second test within one to three weeks after the first test.

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, Parkside Retirement Community is or will be in compliance with this law and / or regulation on (Date) ~~2/9/24~~ 1/29/24.

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

Tom Gallon 12/29/23

Administrator (or Representative) Date

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

(1) The assisted living facility must:

(c) Provide, and tell staff persons of a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms;

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain an emergency and disaster plan that provided information, operating procedures for internal and external disasters and essential supplies needed to provide care and services for 68 of 68 residents (Resident 1 to Resident 68) in the event of an emergency. This failure placed the facility residents at risk for illness, injury, and potential loss of life in the event of an emergency or disaster.

Findings included .

Review of the labeled and dated black three ring binder, identified as the facility's "Disaster Manual", found: no information that instructed staff of their responsibilities in an emergency; no instructions on how to contact emergency personnel; no instructions on the procedure for evacuation of residents; no details that outline alternative resident accommodations, when needed; and no instructions that outlined the facility's emergency communication plan. The facility stored the binder on a shelf in Staff A, Executive Director's, office.

During an interview on 12/12/2023 at 10:15 AM, Staff A confirmed that the only copy of the emergency binder was kept in the Administrator's Office. Staff A stated that the office was kept locked unless Staff A was present at the facility. Staff A stated that staff only had access to the binder when Staff A worked. Staff A stated that he was unaware the manual omitted important information and instructions for staff to follow in the event of an emergency or disaster.

Plan/Attestation Statement

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

Jon Gallen 12/29/23

Administrator (or Representative) Date

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

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

(a) Have regular examinations and immunizations, appropriate for the species, by a

veterinarian licensed in Washington state;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain current veterinarian pet records for 4 of 5 pets (Pet 2, cat; Pet 3, dog; Pet 4, dog; and Pet 5, cat) that resided in the facility. This failure placed the residents at risk of contracting illnesses from unvaccinated or unhealthy pets living in the facility.

Findings included...

Review of the facility's Disclosure of Services showed the facility permitted pets with the condition stated in their pet policy. Review of the facility's undated policy, titled "Pet policy", showed that pets must maintain regular veterinary examinations and immunizations. The policy showed that pets must be free of diseases transmittable to humans.

Review of the facility's pet binder showed there were five pets that lived in the facility: two cats and three dogs. Review of the records showed no documentation that Pet 2, Pet 3, Pet 4, and Pet 5 received a veterinarian certificate that verified they were free of diseases transmittable to humans. Review of the records showed that Pet 2, Pet 3, Pet 4, and Pet 5 were due for a health examination. Review of the records showed that Pet 2's vaccines expired on 01/02/2022; Pet 3's rabies vaccine was due on 01/02/2023; and Pet 5's rabies vaccine expired on 07/17/2023.

During an interview on 12/12/2023 at 11:40 AM, Staff A, Executive Director, stated that they were unaware of the pets who needed updated records.

Plan/Attestation Statement

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1/29/24 tg.

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

Administrator (or Representative)

12/29/23
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to

address and support each resident's assessed capabilities, needs and preferences, including the following:

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

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

(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in 3 of 11 sampled residents (Resident 1, Resident 2, and Resident 10) Negotiated Service Agreements (NSA), the care needs and interventions for physician ordered medical treatments. This failure placed the residents at risk for unmet care needs and worsening of medically diagnosed conditions.

Findings included...

RESIDENT 1
Review of Resident 1's October 2023, November 2023, and December 2023 Medication Administration Records (MAR) showed a physician's order that Resident 1 received 81 mg of Enteric Coated Aspirin (a coating around the tablet to allow the medication to pass through the stomach to the small intestine before dissolving) daily, by mouth for a diagnosis of [redacted]

Review of Resident 1's Nursing Service Plan, dated 07/23/2023, showed no guidance for the staff about the possible side effects from the use of EC aspirin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed for any side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse.

During an interview on 12/12/2023 at 11:04 AM, Staff B, Director of Nursing, confirmed that Resident's 1's service plan did not have a safety plan for taking a blood thinner medication.

RESIDENT 2
Record review of Resident 2's October 2023, November 2023, and December 2023 MARs

showed Resident 2 was diagnosed with [redacted]. The MARs showed a physician order that Resident 2 received Warfarin (a medication to help prevent blood clots).

Note: The medication, Warfarin, requires regularly scheduled laboratory monitoring, which requires testing of an individuals' blood to determine the time necessary for the blood to clot. The physician's order did not show how often Resident 2 required laboratory blood testing. The physician order did not show the values or parameters for the laboratory test results which would require the facility to notify the physician.

Review of Resident 2's Nursing Service Plan, dated 02/02/2023, showed Resident 2 had a prescribed medication with a blood thinning effect. Review of Resident 2's service plan showed no guidance for the staff about the possible side effects from the use of warfarin, such as an increased risk of bruising and bleeding. The service plan showed no instructions for staff about what actions were needed for such side effects. There were no instructions about when to report any signs and symptoms of side effects to the nurse. The service plan did not show when the laboratory testing needed to be completed. The service plan did not show if Resident 2 would receive laboratory testing at the facility or if Resident 2 would receive transportation assistance to an off-site facility.

During an interview on 12/12/2023 at 11:05 AM, Staff B, Director of Nursing, confirmed that Resident's 2's service plan did not have a safety plan for taking a blood thinner medicine.

RESIDENT 10
Review of Resident 10's October 2023, November 2023, and December 2023 MARs showed a physician's order that Resident 10 received five milligrams (mg) Eliquis (anticoagulant, a medication that is used to treat and prevent blood clots and to prevent stroke), one tablet daily, by mouth for a history of transient ischemic attack (stroke) and cerebral infarction (bleeding within the brain).

Review of Resident 10's October 2023, November 2023, and December 2023 MARs showed a physician's order that Resident 10 received seventy-five milligrams (mg) Plavix (anticoagulant medication used to treat and prevent blood clots and to prevent stroke), one tablet daily, by mouth for a history of transient ischemic attack (stroke)and cerebral infarction (bleeding within the brain).

Review of Resident 10's Nursing Service Plan, dated 02/08/2023, showed no documentation that Resident 10 received Eliquis daily. Review of the service plan showed no documentation that Resident 10 received Plavix daily.

During an interview on 12/12/2023 at 11:06 AM, Staff B confirmed that Resident's 10's service plan did not have a safety plan for taking a blood thinner medicine.

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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, Parkside Retirement Community is or will be in compliance with this law and / or regulation on (Date) 2/9/24. 1/29/24 4.

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

Lon Hallin 12/29/23

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;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 68 of 68 residents (Resident 1 through Resident 68) in the facility with cognitive impairment, mental health diagnosis, or psychosocial behavior concerns, did not have access to hazardous cleaning supplies. This failure placed all 68 residents at risk of harm and injury had they accessed and ingested the hazardous chemicals.

Findings included .

Observation on 12/05/2023 at 12:46 PM showed an unattended housekeeping cart in the hallway outside Apartment 57. Observation of the cart showed an open storage compartment which contained cleaning chemicals that included: a one-quart (qt) bottle of Comet with bleach, a one-pint (pt) bottle of Windex cleaner, a bottle of Citrus Neutral Cleaner All-Purpose cleaner, a 19-ounce (oz) bottle of Lysol Disinfectant Spray, a one qt bottle of Betco GE fight bac RTU disinfectant 390, and a 155-wipe bottle of Clorox/Hydrogen Peroxide Cleaner Disinfectant wipes. The Lysol Disinfectant Spray warning label showed, "Hazards to humans and domestic animals". The Betco GE fight bac RTU disinfectant warning label showed, "hazards to humans and domestic animals. Moderate eye irritation". The Clorox/Hydrogen Peroxide Cleaner Disinfectant wipes label showed, "causes moderate eye irritation. Hazards to humans and domestic animals".

Observation on 12/08/2023 at 10:28 AM in hallway outside Apartment 26 showed an unattended housekeeping cart. Observation showed the cart contained an open storage

compartment of the same chemicals observed on 12/05/2023.

During an interview on 12/05/2023 at 12:46 PM, Staff H, Environmental Services Director, stated that the cleaning carts used by the housekeeping staff did not have lockable storage cabinets for cleaning chemicals. Staff H stated that they were unaware of the precautions needed to prevent residents from accessing potentially hazardous chemicals.

During an interview on 12/05/2023 at 10:50 AM, Staff A, Executive Director and Staff B, Director of Nursing, both stated that all facility residents had mental health, cognitive impairment, or behavioral/psychosocial diagnosis. Staff A and Staff B stated that there were residents in the facility who were assessed to have suicidal ideation (thought about or planning suicide).

Plan/Attestation Statement

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

Lori Gallini — 12/29/23

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:

(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 interview and record review, the facility failed to implement infection control policies and requirements to protect 68 of 68 residents (Resident 1 through Resident 68) in the facility from an infectious illness. This failure placed all 68 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

The Centers for Disease Control and Prevention (CDC), the national public health agency

for the United States, developed guidelines for infection prevention and control practices in healthcare settings including assisted living facilities. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current infection control standards to prevent and control the spread of respiratory infections, such as coronavirus disease 2019 (COVID-19), in healthcare settings.

Review of the CDC website "Transmission-Based Precautions" at (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html), showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission including a fit-tested National Institute for Occupational Safety and Health (NIOSH)-approved N95 or higher-level respirator for healthcare personnel.

Review of the DOH publication, "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings" dated October 31, 2022, showed specific guidelines for a Respiratory Protection Program (RPP) that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and annual fit tests for any employee identified as potentially being exposed to respiratory hazard. The publication showed that facilities were required to provide each employee with the properly fit-tested respirator identified during the fit-test process.

Review of the DSHS Dear Provider Letter, "Provider Responsibilities for Provision of Personal Protective Equipment (PPE), Respiratory Protection Program (RPP), and changes to Department of Health RPP Resources" dated 09/14/2023, showed the guidelines for long-term care facilities (LTCF) and employer responsibilities for respiratory protection and RPP. The letter showed that LTCF providers were required to supply PPE to staff who provided care to residents with known or suspected communicable disease. The letter also showed that employers were responsible to identify respiratory hazards in the workplace, provide appropriate PPE and follow regulations pertaining to respiratory protection.

Review of the facility's policy titled, "Respiratory Protection Program", dated January 2022, showed that the administrator's duties included overseeing the RPP to ensure it was carried out at the workplace. The policy showed that the categories of employees required to use respirators included: Certified Nurse Assistants (CNA's), Registered Nurses (RN's), Health care assistants/caregivers, maintenance staff, housekeeping staff, and administrative staff. The policy showed that the administrator or designee was responsible for respirator use training, medical evaluation, and fit testing of the N95 respirator. The policy showed that the purpose of the facility RPP was to protect against transmission of the COVID-19 virus and other airborne diseases. The policy showed that medical evaluation was performed before employees were allowed to use N95 respirators. The policy showed that employees designated to wear the N95 respirator would be fit-tested before using their respirator and on an annual basis.

Review of the facility's Employee Roster showed that the facility hired Staff A (Executive Director) on 03/28/2022, Staff B (Director of Nursing) on 08/20/2023, Staff C (Caregiver)

on 05/17/2023, Staff D (Caregiver) on 03/02/2023, Staff E (Caregiver) on 01/29/2023, Staff F (Wellness Director) on 02/02/2001, and Staff G (CNA) on 02/09/2011.

Review of the facility's respirator fit testing documentation showed that Staff A, Staff B, Staff C, Staff D, and Staff E did not complete any medical evaluation or fit testing. Review of the documentation showed that Staff F was last medically evaluated on 10/12/2020. There was no documentation that showed when Staff F was due for their annual fit test. Review of the documentation showed that Staff G was last medically evaluated on 01/07/2020. There was no documentation that showed when Staff G was due for their annual fit test.

During an interview on 12/07/2023 at 10:15 AM, Staff B stated that they were the RPP Administrator. Staff A stated that Staff F was the facility staff that performed the fit test for facility employees. Staff A stated that all staff were fit-tested for respirators. Staff A stated that they were aware not all staff required to be fit-tested completed their medical evaluation or fit tests.

Plan/Attestation Statement

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

Tom Gallini 12/29/23

Administrator (or Representative) Date

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

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

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

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This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure that 68 of 68 residents (Resident 1 through Resident 68) were given a copy of the facility's policy regarding Medicaid as a payment source with a signed and dated acknowledgement by the resident. This failure placed all residents at risk of being discharged and unable to reside in the facility.

Findings included ..

Record review of the facility's Disclosure of Services document, showed that the facility accepted Medicaid as a payment source. The document showed the facility Medicaid apartments were limited based on internal designation as well as resident care level and age criteria.

Review of the facility's admission records showed that the facility did not have a separate Medicaid policy, as required, that explained their policy on accepting Medicaid as a payment source with a corresponding signature and date line for the resident to acknowledge receipt.

During an interview on 12/05/2023 at 10:50 AM, Staff A, Executive Director, stated that the facility held several Medicaid contracts that allowed the facility to accept residents that used Medicaid as a payment source. Staff A stated that they were unaware if the facility's admission paperwork contained a separate document regarding the facility's Medicaid policy.

During an interview on 12/12/2023 at 11:30 AM, Staff A stated that the facility had no separate document for the required Medicaid policy. Staff A stated that they were unaware of any current residents' records containing this type of documentation.

Plan/Attestation Statement

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

Tom Gallin

Administrator (or Representative)

12/29/23

Date