



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

FRED LIND MANOR
FRED LIND MANOR
1802 17TH AVE
SEATTLE, WA 98122

RE: FRED LIND MANOR License # 864

Dear Administrator:

This letter addresses Compliance Determination(s) 52263 (Completion Date 12/26/2024) and 48554 (Completion Date 10/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/26/2024 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-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2950-6, WAC 388-78A-2300-2-a-ii, WAC 388-78A-2300-2-a-iii

The Department staff who did the on-site verification:

Sunny Kent, Licenser
Scottie Sindora, ALF Licenser

If you have any questions, please contact me at (253)312-1446.

Sincerely,


Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

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



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 864	Compliance Determination # 48554
Plan of Correction	FRED LIND MANOR	Completion Date
Page 1 of 5	Licensee: FRED LIND MANOR	10/29/2024

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

The department completed data collection for an unannounced on-site follow-up on 10/10/2024 and 10/10/2024 of:

FRED LIND MANOR
1802 17TH AVE
SEATTLE, WA 98122

This document references the following SOD dated: 10/29/2024

The following sample was selected for review during the unannounced on-site visit: 7 of 35 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Scottie Sindora, ALF Licensors
Sunny Kent, Licensors

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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

11/07/2024
Date

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

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

Statement of Deficiencies

License #: 864

Compliance Determination # 48554

Plan of Correction

FRED LIND MANOR

Completion Date

Page 2 of 5

Licensee: FRED LIND MANOR

10/29/2024



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 Assisted Living Facility (ALF) failed to obtain signatures on the Service Plans (equivalent to Negotiated Service Plan) from 7 of 9 sampled residents (Resident 1, 2, 3, 4, 5, 6 and 7) and/or their representatives. This prevented Residents 1, 2, 3, 4, 5, 6 and 7 and/or their representative from confirming their agreement with, and acceptance of, the contents of the plans and placed them at risk for not receiving care and services.

Findings included..

Record review of a 2024 Resident Characteristic Roster (RCR) showed the ALF admitted Resident 1 on [REDACTED]/2023. Review of Resident 1's Service Plan (SP) showed a completion/review date of 10/07/2024. The SP was not signed by the resident or their representative.

Record review of the RCR showed the ALF admitted Resident 2 on [REDACTED]/2022. Review of the Resident 2's SP showed a completion/review date of 10/07/2024. The SP was not signed by the resident or their representative.

Record review of the RCR showed the ALF admitted Resident 3 on [REDACTED]/2018. Review of the Resident 3's SP showed a completion/review date of 10/07/2024. Further review showed the SP was signed on 10/10/2024, after the Department was already on-site for the Follow-Up Visit from the Full Inspection.

Record review of the RCR showed the ALF admitted Resident 4 on [REDACTED]/2023. Review of the Resident 4's SP showed a completion/review date of 10/07/2024. The SP was not signed by the resident or their representative.

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

Statement of Deficiencies	License #: 864	Compliance Determination # 48554
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Page 3 of 5	Licensee: FRED LIND MANOR	10/29/2024

Record review of the RCR showed the ALF admitted Resident 5 on [REDACTED]/2024. Review of the Resident 5's SP showed a completion/review date of 10/07/2024. The SP was not signed by the resident or their representative.

Record review of the RCR showed the ALF admitted Resident 6 on [REDACTED]/2019. Review of the Resident 6's SP showed a completion/review date of 10/07/2024. The SP was not signed by the resident or their representative.

Record review of the RCR showed the ALF admitted Resident 7 on [REDACTED]/2016. Review of the Resident 7's SP showed a completion/review date of 10/07/2024. Further review showed the SP was signed on 10/10/2024, after the Department was already on-site for the Follow-Up Visit from the Full Inspection.

In an interview, on 10/10/2024 at 11:45 AM, Staff B (Licensed Nurse) stated that they had been scrambling, that morning, to get signatures from residents. Staff B stated that they began emailing and contacting residents and/or representatives "within the past couple of days."

This is an uncorrected deficiency previously cited on 08/22/2024.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 12/13/2024.

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


 Administrator (or Representative)

11/15/2024
 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, and interview, the Assisted Living Facility (ALF) failed to ensure the ALF's hot water boiler maintained a temperature between 105 degrees and 120 degrees Fahrenheit (F). This placed 44 residents at risk for scalding or other burn injuries.

Statement of Deficiencies	License #: 864	Compliance Determination # 48554
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Findings included...

Observation, on 10/10/2024 at 10:05 AM, showed water temperatures readings in the following locations: 2nd floor common laundry room sink was 130.6 degrees F, 3rd floor common laundry room sink was 132.7 degrees F, 4th floor common laundry room sink was 132.3 degrees F, and the men's common restroom sink on the 1st floor was 131.2 degrees F.

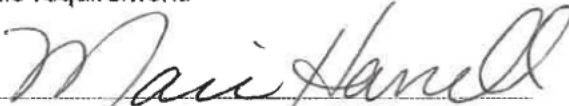
In an interview, on 10/10/2024 at 10:55 AM, Staff A (Executive Director) stated that she would contact the boiler operator to have the water adjusted. Staff A stated that there was no one on site who could adjust the temperature valve, and a company had to be called.

This is an uncorrected deficiency previously cited on 08/22/2024.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 12/13/2024.

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


Administrator (or Representative)

11/15/2024
Date

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

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

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

(ii) Approved by a dietitian; and

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

This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 864	Compliance Determination # 48554
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Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure their dietary manual, and menu items, were approved by a registered dietician and reviewed every five years. This failure placed 44 of 44 residents at risk for not receiving adequate nutrition.

Findings included...

Record review of the ALF's Disclosure of Services form, dated 2017, showed the ALF was required to offer prescribed, specialized, diets to include low sodium, diabetic diets, and mechanical soft diets.

Record Review of the ALF's dietary manual, undated, showed no evidence the manual was approved by a dietician.

In an interview, on 10/10/2024 at 11:15 AM, Staff A (Executive Director) stated that she had contacted the ALF's corporate office, and no one understood the cited WAC.

This is an uncorrected deficiency previously cited on 08/22/2024.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 12/13/2024.

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



Administrator (or Representative)

 11/15/2024

Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License # 864	Compliance Determination # 45272
Plan of Correction	FRED LIND MANOR	Completion Date
Page 1 of 25	Licensee: FRED LIND MANOR	08/22/2024

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

The department completed data collection for the unannounced on-site full inspection on 08/12/2024 and 08/14/2024 of:

FRED LIND MANOR
1802 17TH AVE
SEATTLE, WA 98122

The following sample was selected for review during the unannounced on-site visit: 7 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Sunny Kent, Licenser
Scottie Sindora, ALF Licenser

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

09/03/2024
Date

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

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

Statement of Deficiencies

License #: 864

Compliance Determination #: 45272

Plan of Correction

FRED LIND MANOR

Completion Date

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Licensee: FRED LIND MANOR

08/22/2024

Mari Hamel

Administrator (or Representative)

9/16/2024

Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

- (1) Medical history;
- (2) Necessary and contraindicated medications;
- (3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;
- (4) Significant known behaviors or symptoms that may cause concern or require special care;
- (5) Mental illness diagnosis, except where protected by confidentiality laws;
- (6) Level of personal care needs;
- (7) Activities and service preferences; and
- (8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living facility (ALF) failed to complete a pre-admission assessment for 1 of 7 sample residents (Resident 5). This left the ALF without critical information required to make an informed decision about if the resident was appropriate for their community, and whether the ALF could meet the resident's needs.

Findings included...

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 5 on 2023. Review of a Move-Out Report, dated 08/13/2024, showed diagnoses including [REDACTED] and [REDACTED].

Review of the ALF's electronic medical records system on 08/12/2024 found no pre-admission assessment for Resident 5.

Administrator (or Representative)

Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

- (1) Medical history;
- (2) Necessary and contraindicated medications;
- (3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;
- (4) Significant known behaviors or symptoms that may cause concern or require special care;
- (5) Mental illness diagnosis, except where protected by confidentiality laws;
- (6) Level of personal care needs;
- (7) Activities and service preferences; and
- (8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living facility (ALF) failed to complete a pre-admission assessment for 1 of 7 sample residents (Resident 5). This left the ALF without critical information required to make an informed decision about if the resident was appropriate for their community, and whether the ALF could meet the resident's needs.

Findings included...

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 5 on [REDACTED] /2023. Review of a Move-Out Report, dated 08/13/2024, showed diagnoses including [REDACTED] and [REDACTED]

Review of the ALF's electronic medical records system on 08/12/2024 found no pre-admission assessment for Resident 5.

Statement of Deficiencies	License #: 864	Compliance Determination #: 45272
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Observation, on 08/14/2024 at 2:20 PM, showed Resident 5 moved into their apartment. They answered the door independently and used a cane for ambulation.

In an interview during a preliminary exit conference with Staff F (Executive Director) on 08/14/2024 at 3:30 PM, the Department requested the ALF send Resident 5's pre-admission assessment to the Department if they had one.

As of 08/19/2024 at 5:00 PM, the Department did not receive Resident 5's pre-admission assessment.

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, FRED LIND MANOR is, or will, be in compliance with this law and / or regulation on (Date) 10/6/2024.

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

Mari Hamell
Administrator (or Representative)

9/16/2024
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:

(b) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(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.

This requirement was not met as evidenced by:

Based on observation, interview and record review, The Assisted Living Facility (ALF) failed to ensure that an Assessment, included the use and safety considerations of medical devices for 1 of 7 sampled residents (Resident 2) who used side bed rails (SBR). This placed Resident 2 at risk of injury and the potential for serious physical harm due to side rail entrapment and death.

Findings included...

Observation, on 08/14/2024 at 2:20 PM, showed Resident 5 moved into their apartment. They answered the door independently and used a cane for ambulation.

In an interview during a preliminary exit conference with Staff F (Executive Director) on 08/14/2024 at 3:30 PM, the Department requested the ALF send Resident 5's pre-admission assessment to the Department if they had one.

As of 08/19/2024 at 5:00 PM, the Department did not receive Resident 5's pre-admission assessment.

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, FRED LIND MANOR 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-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:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(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.

This requirement was not met as evidenced by:

Based on observation, interview and record review, The Assisted Living Facility (ALF) failed to ensure that an Assessment, included the use and safety considerations of medical devices for 1 of 7 sampled residents (Resident 2) who used side bed rails (SBR). This placed Resident 2 at risk of injury and the potential for serious physical harm due to side rail entrapment and death.

Findings included...

Statement of Deficiencies

License # 854

Compliance Determination # 45272

Plan of Correction

FRED LIND MANOR

Completion Date

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Licensee: FRED LIND MANOR

08/22/2024

NOTE: Review of the United States Food and Drug Administration (FDA) website, showed the FDA developed a brochure regarding side bed rail use in health care facilities titled, "A Guide to Bed Safety." The brochure outlined the importance of frequent assessment to monitor for resident's physical and mental status, monitoring high risk residents, and ensuring side bed rail safe installation. The document outlined risks of using side rails including strangling, suffocating, bodily injury, or death when a person can get caught, increased fall risk if not used properly, feelings of isolation and unnecessary restriction and prevention of completing activities of daily living.

Record review of a 2024 Characteristics Roster showed the facility admitted Resident 2 on [REDACTED] 2017. Review of an Assisted Living Resident Assessment (ALRA), effective date 01/05/2024, showed Resident 2 had diagnoses including [REDACTED] and [REDACTED].

Observation and interview, on 08/19/2024 at 2:20 PM, showed a hospital bed with bilateral SBRs in Resident 2's apartment. The left SBR (facing the window) was in the "up" position. Observation also showed a caregiver providing hands-on assistance for Resident 2 as they transferred from their bed to their wheelchair to use the restroom. After using the restroom, the caregiver assisted Resident 2 with a transfer from the wheelchair to their recliner chair. Resident 2 stated that they used the SBRs during transfers and repositioning.

Review of the ALRA also showed Resident 2's care and service needs included one person assistance with mobility and transfers, Activities of Daily Living (a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.), and toileting. The Assessment also showed Resident 2 was a high risk for falls and required a wheelchair for ambulation. The Assessment did not indicate Resident 2 used SBRs. The ALF failed to demonstrate and document the risks and benefits of SBR use were explained to Resident 2 and their representatives, so the resident and representatives could make an informed decision about them.

During an interview, on 08/20/2024 at 11:00 AM, Staff F (Executive Director) stated that Resident 2's family opted for the hospital bed and SBRs. Staff F expressed awareness the SBRs required additional documentation. Staff F also stated they looked for the additional documentation but did not find any.

This deficiency was previously cited on 04/12/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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

NOTE: Review of the United States Food and Drug Administration (FDA) website, showed the FDA developed a brochure regarding side bed rail use in health care facilities titled, "A Guide to Bed Safety." The brochure outlined the importance of frequent assessment to monitor for resident's physical and mental status, monitoring high risk residents, and ensuring side bed rail safe installation. The document outlined risks of using side rails including strangling, suffocating, bodily injury, or death when a person can get caught, increased fall risk if not used properly, feelings of isolation and unnecessary restriction and prevention of completing activities of daily living.

Record review of a 2024 Characteristics Roster showed the facility admitted Resident 2 on [REDACTED] 2017. Review of an Assisted Living Resident Assessment (ALRA), effective date 01/05/2024, showed Resident 2 had diagnoses including [REDACTED] and [REDACTED].

Observation and interview, on 08/19/2024 at 2:20 PM, showed a hospital bed with bilateral SBRs in Resident 2's apartment. The left SBR (facing the window) was in the "up" position. Observation also showed a caregiver providing hands-on assistance for Resident 2 as they transferred from their bed to their wheelchair to use the restroom. After using the restroom, the caregiver assisted Resident 2 with a transfer from the wheelchair to their recliner chair. Resident 2 stated that they used the SBRs during transfers and repositioning.

Review of the ALRA also showed Resident 2's care and service needs included one person assistance with mobility and transfers, Activities of Daily Living (a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.), and toileting. The Assessment also showed Resident 2 was a high risk for falls and required a wheelchair for ambulation. The Assessment did not indicate Resident 2 used SBRs. The ALF failed to demonstrate and document the risks and benefits of SBR use were explained to Resident 2 and their representatives, so the resident and representatives could make an informed decision about them.

During an interview, on 08/20/2024 at 11:00 AM, Staff F (Executive Director) stated that Resident 2's family opted for the hospital bed and SBRs. Staff F expressed awareness the SBRs required additional documentation. Staff F also stated they looked for the additional documentation but did not find any.

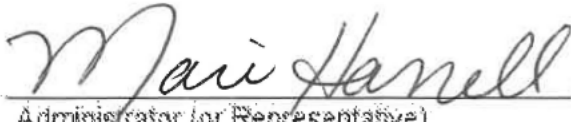
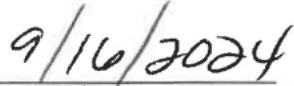
This deficiency was previously cited on 04/12/2023.

Plan/Attestation Statement

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

Statement of Deficiencies	License # 864	Compliance Determination # 45272
Plan of Correction	FRED LIND MANOR	Completion Date
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Administrator (or Representative)	Date

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

- (1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan.
- (b) Identifies the resident's immediate needs; and
- (c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.
- (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 observation, interview and record review, the Assisted Living facility (ALF) failed to complete a Service Plan/SP (equivalent to a Negotiated Service Agreement) for 1 of 7 sample residents (Resident 5). This failure left Resident 5 at risk for not receiving care and services appropriate for their needs.

Findings included...

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 5 on [REDACTED] /2023. Review of a Move-Out Report, dated 08/13/2024, showed diagnoses including [REDACTED] and [REDACTED].

Review of the ALF's electronic medical records system, on 08/12/2024, found no SP for Resident 5.

Observation, on 08/14/2024 at 2:20 PM, showed Resident 5 in their apartment. They answered the door independently and used a cane for ambulation.

In an interview during a preliminary exit conference with Staff F (Executive Director) on 08/14/2024 at 3:30 PM, the Department requested the ALF send Resident 5's SP to the Department if they had one. The Department gave a due date of close of business (5:00 PM) on 08/15/2024 to receive additional records.

Administrator (or Representative)

Date

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

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(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 observation, interview and record review, the Assisted Living facility (ALF) failed to complete a Service Plan/SP (equivalent to a Negotiated Service Agreement) for 1 of 7 sample residents (Resident 5). This failure left Resident 5 at risk for not receiving care and services appropriate for their needs.

Findings included...

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 5 on [REDACTED] /2023. Review of a Move-Out Report, dated 08/13/2024, showed diagnoses including [REDACTED] and [REDACTED].

Review of the ALF's electronic medical records system, on 08/12/2024, found no SP for Resident 5.

Observation, on 08/14/2024 at 2:20 PM, showed Resident 5 in their apartment. They answered the door independently and used a cane for ambulation.

In an interview during a preliminary exit conference with Staff F (Executive Director) on 08/14/2024 at 3:30 PM, the Department requested the ALF send Resident 5's SP to the Department if they had one. The Department gave a due date of close of business (5:00 PM) on 08/15/2024 to receive additional records.

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License #: 564
FRED LIND MANOR
Licensee: FRED LIND MANOR

Compliance Determination # 45272
Completion Date
08/22/2024

As of 08/19/2024 at 5:00 PM, the Department did not receive an SP for Resident 5.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024.

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

Mari Hamill
Administrator (or Representative)

9/16/2024
Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain signatures on the Service Plans (equivalent to Negotiated Service Agreement) for 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6 and Resident 7). This prevented the residents and/or their representative from confirming their agreement with and acceptance of the contents of the plans.

Findings included...

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 1 on [REDACTED] 2023. Review of their Service Plan (SP) showed a "Last Service Plan Review Completed" (completion date) of 11/22/2023. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 2 on [REDACTED] 2022. Review of their SP showed a completion date of 01/05/2024. The SP was not signed or agreed upon by the resident or their representative.

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

As of 08/19/2024 at 5:00 PM, the Department did not receive an SP for Resident 5.

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, FRED LIND MANOR 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-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 Assisted Living Facility (ALF) failed to obtain signatures on the Service Plans (equivalent to Negotiated Service Agreement) for 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6 and Resident 7). This prevented the residents and/or their representative from confirming their agreement with and acceptance of the contents of the plans.

Findings included...

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 1 on [REDACTED]/2023. Review of their Service Plan (SP) showed a "Last Service Plan Review Completed" (completion date) of 11/22/2023. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 2 on [REDACTED]/2022. Review of their SP showed a completion date of 01/05/2024. The SP was not signed or agreed upon by the resident or their representative.

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Review of the CR showed the ALF admitted Resident 3 on [REDACTED] 2018. Review of their SP showed a completion date of 01/10/2024. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 4 on [REDACTED] 2023. Review of their SP showed an initiation date of [REDACTED] 2023. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 5 on [REDACTED] 2024. The ALF did not complete an SP for Resident 5. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 3 on [REDACTED] 2019. Review of their SP showed a completion date of 08/22/2023. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 3 on [REDACTED] 2016. Review of their SP showed a completion date of 08/21/2023. The SP was not signed or agreed upon by the resident or their representative.

The Department emailed a request for the signature pages to Staff F (Executive Director) on 08/13/2024 at 10:25 AM.

In an interview during an exit conference, on 08/14/2024 at 3:30 PM, Staff F stated if the ALF had the signature pages they would send them to the Department. The Department gave a due date of close of business (5:00 PM) on 08/15/2024 to receive additional records.

As of 08/19/2024 at 5:00 PM, the Department did not receive the signature pages.

This is a recurring deficiency previously cited on 04/12/2023 and 06/15/2024.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024.

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

Review of the CR showed the ALF admitted Resident 3 on [REDACTED]/2018. Review of their SP showed a completion date of 01/10/2024. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 4 on [REDACTED]/2023. Review of their SP showed an initiation date of [REDACTED]/2023. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 5 on [REDACTED]/2024. The ALF did not complete an SP for Resident 5. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 3 on [REDACTED]/2019. Review of their SP showed a completion date of 08/22/2023. The SP was not signed or agreed upon by the resident or their representative.

Review of the CR showed the ALF admitted Resident 3 on [REDACTED]/2016. Review of their SP showed a completion date of 08/21/2023. The SP was not signed or agreed upon by the resident or their representative.

The Department emailed a request for the signature pages to Staff F (Executive Director) on 08/13/2024 at 10:25 AM.

In an interview during an exit conference, on 08/14/2024 at 3:30 PM, Staff F stated if the ALF had the signature pages they would send them to the Department. The Department gave a due date of close of business (5:00 PM) on 08/15/2024 to receive additional records.

As of 08/19/2024 at 5:00 PM, the Department did not receive the signature pages.

This is a recurring deficiency previously cited on 04/12/2023 and 06/15/2024.

Plan/Attestation Statement

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

Statement of Deficiencies

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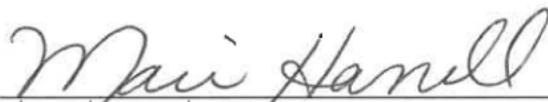
FRED LIND MANOR

Completion Date

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Licensee: FRED LIND MANOR

08/22/2024



Administrator (or Representative)

9/16/2024

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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 3 sampled pets (Pet 2 and Pet 3) remained current with their required vaccinations. This placed 42 Assisted Living (AL) residents at risk for exposure to a pet whose vaccination records were out of date.

Findings included...

Record review of the ALF's policy, "Guideline for Pet Owners", revised January 1 2019, Item 5, showed, "Pets must be licensed, immunized and spayed/neutered, and resident must provide written confirmation. Immunizations must be current in accordance with city policy".

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 9 on [REDACTED] 2020. The CR also showed the ALF admitted Resident 10 on [REDACTED] 2022.

A review of pet records showed Resident 9 owned a cat (Pet 2). The pet records showed vaccines for Pet 2 expired on 10/17/2023. Record review also showed Resident 10 owned a cat (Pet 3). The pet records showed Pet 3's rabies vaccine expired on 03/04/2024.

Review of an email received on 08/14/2024 at 1:42 PM from Staff F (Executive Director) showed the pet records received by the Department were all the ALF had in their file. The email also showed Staff F checked with Resident 9 and Resident 10 about vaccine updates. The residents both replied their pet vaccine records would be updated as soon as they were able to do it.

During an interview, on 08/19/2024 at 2:47 PM, Pet 2 and Pet 3's owners and families were notified the pets required updated vaccines.

Plan/Attestation Statement

_____ Administrator (or Representative)	_____ Date
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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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 3 sampled pets (Pet 2 and Pet 3) remained current with their required vaccinations. This placed 42 Assisted Living (AL) residents at risk for exposure to a pet whose vaccination records were out of date.

Findings included...

Record review of the ALF's policy, "Guideline for Pet Owners", revised January 1 2019, Item 5, showed, "Pets must be licensed, immunized and spayed/neutered, and resident must provide written confirmation. Immunizations must be current in accordance with city policy".

Record review of a 2024 Characteristics Roster (CR) showed the ALF admitted Resident 9 on [REDACTED] 2020. The CR also showed the ALF admitted Resident 10 on [REDACTED]/2022.

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Review of an email received on 08/14/2024 at 1:42 PM from Staff F (Executive Director) showed the pet records received by the Department were all the ALF had in their file. The email also showed Staff F checked with Resident 9 and Resident 10 about vaccine updates. The residents both replied their pet vaccine records would be updated as soon as they were able to do it.

During an interview, on 08/19/2024 at 2:47 PM, Pet 2 and Pet 3's owners and families were notified the pets required updated vaccines.

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08/22/2024

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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

Mari Harrell

Administrator (or Representative)

9/16/2024

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 Assisted Living Facility (ALF) failed to ensure the ALF's hot water boiler maintained a temperature between 105 degrees and 120 degrees Fahrenheit (F). This placed 42 residents at risk for scalding or other burn injuries.

Findings included...

The environmental tour began on 08/12/2024 at 10:40 AM and was conducted with Staff H (Director of Facilities).

Observation during the environmental tour found the following water temperatures throughout the ALF:

10:43 AM – 4th floor unlocked Staff restroom – water temperature was 130.4 degrees F

10:48 AM – 4th floor Laundry Room sink – water temperature was 132.5 degrees F

10:55 AM – 3rd floor Laundry Room sink – water temperature was 136.2 degrees F

11:10 AM – 2nd floor Laundry Room sink – water temperature was 133.3 degrees F

During interviews with four sample residents, the Department measured water temperatures in their apartments:

08/13/2024 02:50 PM Resident 3 – Apartment [REDACTED] – water temperature was 130.1 degrees F

08/14/2024 11:40 AM Resident 1 – Apartment [REDACTED] – water temperature was 127.7 degrees F

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, FRED LIND MANOR 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-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 Assisted Living Facility (ALF) failed to ensure the ALF's hot water boiler maintained a temperature between 105 degrees and 120 degrees Fahrenheit (F). This placed 42 residents at risk for scalding or other burn injuries.

Findings included...

The environmental tour began on 08/12/2024 at 10:40 AM and was conducted with Staff H (Director of Facilities).

Observation during the environmental tour found the following water temperatures throughout the ALF:

10:43 AM – 4th floor unlocked Staff restroom – water temperature was 130.4 degrees F
10:46 AM – 4th floor Laundry Room sink – water temperature was 132.5 degrees F
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During interviews with four sample residents, the Department measured water temperatures in their apartments:

08/13/2024 02:50 PM Resident 3 – Apartment [REDACTED] – water temperature was 130.1 degrees F
08/14/2024 11:40 AM Resident 1 – Apartment [REDACTED] – water temperature was 127.7 degrees F

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08/14/2024 01:56 PM Resident 7 – Apartment [REDACTED] – water temperature was 133.3 degrees F
 08/19/2024 02:43 PM Resident 2 – Apartment [REDACTED] – water temperature was 125.2 degrees F

In an interview, on 08/12/2024 at 10:45 AM, Staff H stated that Staff I (Lead Maintenance Tech) checked water temperatures daily and maintained a water temperature log.

Observation during the environmental tour showed the ALF consisted of four floors and a basement.

Record review of a Temperature Log (TL), dated February 2024 through August 2024, showed Staff I completed water temperature checks on 08/05/2024. All water temperature checks for the basement through the 3rd floor were documented as "pass". Apartment 401 on the 4th floor was documented as "fail". The TL also showed water temperature checks for a variety of apartments, restrooms, laundry room sinks and a kitchen sink from 01/29/2024 through 08/01/2024. All water temperature measurements were recorded as exactly 120.0 degrees F. The TL was not complete and did not reflect the actual water temperatures in the building.

In an interview, on 08/14/2024 at 2:00 PM, Staff H stated that they notified the boiler operator on 08/12/2024 via email the hot water temperature exceeded 120 degrees F. Staff H notified the boiler operator again on 08/14/2024. The interview showed the ALF could not independently adjust the water temperatures and had to contact the boiler operator to do so.

Plan/Attestation Statement

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

Mari Hamill
 Administrator (or Representative)

9/16/2024
 Date

WAC 388-76A-2300 Food and nutrition services.

(1) The assisted living facility must:

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

08/14/2024 01:56 PM Resident 7 – Apartment [REDACTED] – water temperature was 133.3 degrees F
08/19/2024 02:43 PM Resident 2 – Apartment [REDACTED] – water temperature was 125.2 degrees F

In an interview, on 08/12/2024 at 10:45 AM, Staff H stated that Staff I (Lead Maintenance Tech) checked water temperatures daily and maintained a water temperature log.

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Administrator (or Representative)

Date

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

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the kitchen area kept clean and sanitary, and food products were stored in a manner that would prevent contamination, and accurately monitor food temperatures. These failures placed 42 of 42 residents at risk for food-borne illnesses.

Findings included...

CLEANLINESS:

Note: Food Code 246-215-04615 Objective--Nonfood-contact surfaces. Non-FOOD-CONTACT SURFACES of EQUIPMENT must be cleaned at a frequency necessary to preclude accumulation of soil residues.

An observation, on 08/14/2024 at 7:55 AM, showed the kitchen floors, in the main area and the preparation areas, were unclean to sight with dark stains and bits of food. As the servers walked, the sounds of their shoes unsticking from the floor could be heard. On the side of the dishwasher where dirty dishes were stacked, directly above the stainless-steel backsplash, there were five 4" (inch) X 4" tiles missing, and a black substance was growing out of, and around, that area.

In an interview, on 04/14/2024 at 8:20 AM, Staff J (Dining Services Director) stated that the kitchen had no cleaning schedule and wasn't sure about the missing tiles.

In an interview, on 08/20/2024 at 11:00 AM, Staff F (Executive Director) stated that the kitchen floors were "nasty."

STORAGE:

Note: Food Code 246-215-03351 Preventing contamination from the premises. (1) Except as specified in subsections (2) and (3) of this section, FOOD must be protected from contamination by storing the FOOD: (a) In a clean, dry location; (b) Where it is not exposed to splash, dust, or other contamination; and (c) At least six inches (15 cm) above the floor.

An observation, on 08/14/2024 at 7:55 AM, showed the kitchen walk-in freezer had four boxes stacked on the floor. The walk-in refrigerator showed a clear bin, half-filled with water and half-cut potatoes stored on the floor, with an additional clear bin, with water

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and potatoes, sitting on top of it. There was a cardboard box with open vegetables sitting on the floor.

In an interview, on 04/14/2024 at 08:05 AM, Staff K (Lead Cook) stated that food deliveries had happened the day prior, and the food would be put away soon.

TEMPERATURES:

Note: Food Code 246-215-03525 Temperature and time control—Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16). TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be maintained: (a) At 135°F (57°C) or above, except that roasts cooked to a temperature and for a time specified under 03400(2) or reheated as specified under 03440 may be held at a temperature of 130°F (54°C) or above; or (b) At 41°F (5°C) or less.

An observation and interview, on 08/14/2024 at 8:10 AM, showed Staff K preparing food on a plate and placing it under a heat lamp for a server. Staff K prepared three additional plates in the same way. There was no evidence of the food temperature being measured. Staff K stated that the kitchen measured the temperatures and kept a logbook of each meal. Staff K went to a different part of the kitchen, searched under two other binders, and found the temperature logbook (binder).

Record review of the ALF's temperature logbook showed the most recent entry of temperature was on 07/01/2024.

An observation and interview, on 08/14/2024 at 12:40 PM, showed the cold salad bar set up next to the main dining room. Staff J stated that temperatures were taken when the salad bar was set up, and the food items were kept cold by a cooler installed under the salad bar. The following items were measured, with the following temperatures: Black olives were 44 degrees Fahrenheit (F); cucumbers were 47 F; artichoke hearts were 48 F; green beans were 56 F. Staff J stated that the thermometer might be broken and the following temperatures were taken using the Department Representative's thermometer: Hardboiled egg was 43 F, and sliced onions were 56 F. Staff J stated that he would try to find out what was wrong with the cooler.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024.

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

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TEMPERATURES:

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Plan/Attestation Statement

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Statement of Deficiencies	License #: 864	Compliance Determination # 45272
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Mari Hanell
 Administrator (or Representative)

9/16/2024
 Date

WAC 388-76A-2300 Food and nutrition services:

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

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

(i) Approved by a dietitian; and

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

This requirement was not met as evidenced by:

Based on interview, and record review, that Assisted Living Facility (ALF) failed to ensure their dietary manual, and menu items, were approved by a dietitian and reviewed every five years. This failure placed 42 of 42 residents at risk for not receiving adequate nutrition.

Findings included...

Record review of the ALF's Disclosure of Services, form dated 2017, showed the ALF was required to offer prescribed, specialized, diets to include low sodium, diabetic diets, and mechanical soft diets.

Record review showed no dietary manual approved by a dietitian.

In an interview, on 08/13/2024 at 3:10 PM, Staff F (Executive Director) stated that she didn't know if there was any documentation and wasn't aware of this rule.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) *10/6/2024*

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

Administrator (or Representative)

Date

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

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

- (a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:
 - (i) Approved by a dietitian; and
 - (ii) Reviewed and updated as necessary or at least every five years.

This requirement was not met as evidenced by:

Based on interview, and record review, that Assisted Living Facility (ALF) failed to ensure their dietary manual, and menu items, were approved by a dietician and reviewed every five years. This failure placed 42 of 42 residents at risk for not receiving adequate nutrition.

Findings included...

Record review of the ALF's Disclosure of Services, form dated 2017, showed the ALF was required to offer prescribed, specialized, diets to include low sodium, diabetic diets, and mechanical soft diets.

Record review showed no dietary manual approved by a dietician.

In an interview, on 08/13/2024 at 3:10 PM, Staff F (Executive Director) stated that she didn't know if there was any documentation and wasn't aware of this rule

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, FRED LIND MANOR 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.

Statement of Deficiencies

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Licensee: FRED LIND MANOR

08/22/2024



 Administrator (or Representative)

 9/16/2024
 Date
WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

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

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

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

(v) Policies, procedures, and equipment necessary to perform duties;

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

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 new staff (Staff A, B and C) received facility orientation prior to working with the residents. This failure placed 42 residents at risk of receiving care from staff who were not aware of their job duties.

Findings included...

NOTE: 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 Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation

Administrator (or Representative)

Date

WAC 388-78A-2450 Staff.

- (2) The assisted living facility must:
- (h) Provide staff orientation and appropriate training for expected duties, including:
 - (i) Organization of the assisted living facility;
 - (ii) Physical assisted living facility layout;
 - (iii) Specific duties and responsibilities;
 - (iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;
 - (v) Policies, procedures, and equipment necessary to perform duties;
 - (vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and
 - (vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 new staff (Staff A, B and C) received facility orientation prior to working with the residents. This failure placed 42 residents at risk of receiving care from staff who were not aware of their job duties.

Findings included...

NOTE: 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 Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation

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showing Staff A received any orientation to the facility.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B received any orientation to the facility.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C received any orientation to the facility.

In an interview, on 08/13/24 at 1:45 PM, Staff G (Business Office Manager) stated that she would look for documentation but wasn't sure there was any.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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

Mari Hamel
Administrator (or Representative)

9/16/2024
Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 new staff (Staff C) completed a Washington state name and date of birth background check prior to working with residents. This failure resulted in 42 residents receiving care from someone whose criminal history is unknown.

Findings included...

showing Staff A received any orientation to the facility.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B received any orientation to the facility.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C received any orientation to the facility.

In an interview, on 08/13/24 at 1:45 PM, Staff G (Business Office Manager) stated that she would look for documentation but wasn't sure there was any.

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, FRED LIND MANOR 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-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 new staff (Staff C) completed a Washington state name and date of birth background check prior to working with residents. This failure resulted in 42 residents receiving care from someone whose criminal history is unknown.

Findings included...

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Record review of Staff C's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 06/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed a background check before working in the ALF.

In an interview, on 08/13/2024 at 1:45 PM, Staff G (Business Office Manager) stated that she would send everything she had by the end of the day. Evidence of this document was not submitted.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/16/2024

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

Maw Hanel
Administrator (or Representative)

9/16/2024
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 4 sampled staff (Staff A and Staff D) updated their background checks after 2 years. This failure resulted in residents receiving care from someone whose criminal history is unknown.

Findings included:

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. Further review showed Staff A's

Record review of Staff C's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed a background check before working in the ALF.

In an interview, on 08/13/2024 at 1:45 PM, Staff G (Business Office Manager) stated that she would send everything she had by the end of the day. Evidence of this document was not submitted.

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, FRED LIND MANOR 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-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 4 sampled staff (Staff A and Staff D) updated their background checks after 2 years. This failure resulted in residents receiving care from someone whose criminal history is unknown.

Findings included...

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. Further review showed Staff A's

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

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most recent background check expired on 09/01/2023.

Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/27/2021 as a fulltime caregiver. Further review showed Staff D's most recent background check expired on 03/03/2021.

In an interview, on 08/20/2024 at 11:15 AM, Staff F (Executive Director) stated that she was not aware of this rule.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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

Mari Hanell
Administrator (or Representative)

9/16/2024
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 Assisted Living Facility (ALF) failed to ensure 4 of 4 sampled staff (Staff A, B, C and D) completed a national fingerprint background check. This failure resulted in 42 residents receiving care from someone whose criminal history is unknown.

Findings included:

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed a National Fingerprint background check.

most recent background check expired on 09/01/2023.

Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/27/2021 as a fulltime caregiver. Further review showed Staff D's most recent background check expired on 03/03/2021.

In an interview, on 08/20/2024 at 11:15 AM, Staff F (Executive Director) stated that she was not aware of this rule.

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, FRED LIND MANOR 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 Assisted Living Facility (ALF) failed to ensure 4 of 4 sampled staff (Staff A, B, C and D) completed a national fingerprint background check. This failure resulted in 42 residents receiving care from someone whose criminal history is unknown.

Findings included...

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed a National Fingerprint background check.

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

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Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed a National Fingerprint background check.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed a National Fingerprint background check.

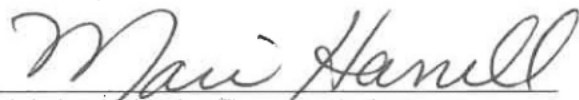
Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/07/2021 as a fulltime caregiver. There was no documentation showing Staff D completed a National Fingerprint background check.

In an interview, on 08/29/2024 at 11:15 AM, Staff F (Executive Director) stated that she was not sure why this wasn't completed, or if they were completed and there was an issue with record keeping.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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


Administrator (or Representative)

9/16/2024
Date

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed a National Fingerprint background check.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed a National Fingerprint background check.

Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/07/2021 as a fulltime caregiver. There was no documentation showing Staff D completed a National Fingerprint background check.

In an interview, on 08/20/2024 at 11:15 AM, Staff F (Executive Director) stated that she was not sure why this wasn't completed, or if they were completed and there was an issue with record keeping.

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, FRED LIND MANOR 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-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;

- (c) A psychiatric advanced registered nurse practitioner, or
- (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 4 of 4 sampled caregivers (Staff A, B, C and D) received specialized training for Mental Health. This placed 7 of 42 residents at risk for being cared for by untrained staff.

Findings included...

Record review of the Resident Characteristic Roster, undated, showed there were seven residents with a [REDACTED] diagnosis living at the ALF. Record review of the ALF's Disclosure of Services, dated 2017, showed the ALF accepted residents with mental health issues.

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed specialized training in mental health.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed specialized training in mental health.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed specialized training in mental health.

Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/07/2021 as a fulltime caregiver. There was no documentation showing Staff D completed specialized training in mental health.

In an interview, on 08/14/2024 at 3:30 PM, Staff F (Executive Director) stated that she didn't know why these were not completed and would talk to the Business Office Manager.

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Plan of Correction

FRED LIND MANOR

Completion Date

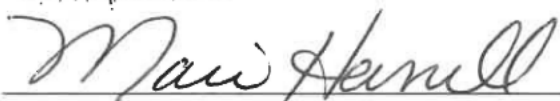
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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024.

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



Administrator (or Representative)



Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure 4 of 4 sampled caregivers (Staff A, B, C and D) received specialized training for dementia. This placed 14 of 42 residents at risk for being cared for by untrained staff.

Findings included...

Record review of the Resident Characteristic Roster, undated, showed there were 14 residents with a [REDACTED] diagnosis living at the ALF. Record review of the ALF's Disclosure of Services, dated 2017, showed the ALF accepted residents with dementia.

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed specialized training in dementia.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed specialized training in dementia.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed specialized training in dementia.

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, FRED LIND MANOR 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-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure 4 of 4 sampled caregivers (Staff A, B, C and D) received specialized training for dementia. This placed 14 of 42 residents at risk for being cared for by untrained staff.

Findings included...

Record review of the Resident Characteristic Roster, undated, showed there were 14 residents with a [REDACTED] diagnosis living at the ALF. Record review of the ALF's Disclosure of Services, dated 2017, showed the ALF accepted residents with dementia.

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed specialized training in dementia.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed specialized training in dementia.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed specialized training in dementia.

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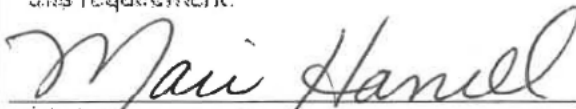
Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/07/2021 as a fulltime caregiver. There was no documentation showing Staff D completed specialized training in dementia.

In an interview, on 08/14/2024 at 3:30 PM, Staff F (Executive Director) stated that she would check with the Business Office Manager about the missing documents. In an interview, on 08/19/2024 at 11:15 AM, Staff F stated she could find no record of this training.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024.

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


Administrator (or Representative)

9/16/2024
Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 newly hired staff (Staff A, B and C) were screened for tuberculosis (TB) within three days of employment. This failure placed 42 of 42 residents at risk for TB.

Findings included...

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed TB screening.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed TB screening.

Record review of Staff D's (NAC) personnel file showed the ALF hired them on 03/07/2021 as a fulltime caregiver. There was no documentation showing Staff D completed specialized training in dementia.

In an interview, on 08/14/2024 at 3:30 PM, Staff F (Executive Director) stated that she would check with the Business Office Manager about the missing documents. In an interview, on 08/19/2024 at 11:15 AM, Staff F stated she could find no record of this training.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FRED LIND MANOR 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-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 newly hired staff (Staff A, B and C) were screened for tuberculosis (TB) within three days of employment. This failure placed 42 of 42 residents at risk for TB.

Findings included...

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed TB screening.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed TB screening.

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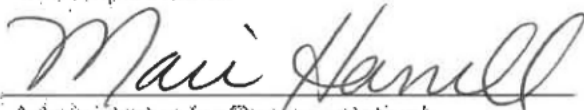
Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. Review of a TB screening form, dated 05/03/2024, showed a first-step test was initiated on 05/03/2024, but the results were never documented. Further review showed another test was initiated on 06/11/2024, but the results were never documented.

In an interview, on 08/14/2024 at 3:30 PM, Staff F (Executive Director) stated that she wasn't sure why the tests were not completed.

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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


Administrator (or Representative)

9/16/2024
Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

- (a) The operation of the assisted living facility;
- (b) Complying at all times with the requirements of this chapter, chapter 18-20 RCW, and other applicable laws and rules; and

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

- (b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. Review of a TB screening form, dated 05/03/2024, showed a first-step test was initiated on 05/03/2024, but the results were never documented. Further review showed another test was initiated on 06/11/2024, but the results were never documented.

In an interview, on 08/14/2024 at 3:30 PM, Staff F (Executive Director) stated that she wasn't sure why the tests were not completed.

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, FRED LIND MANOR 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-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

- (a) The operation of the assisted living facility;
- (b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

- (b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:
- (iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to maintain a Medical Testing Site Waiver/Clinical Laboratory Improvement Amendments (MTSW/CLIA) waiver certificate, failed to ensure 2 of 5 sampled staff (Staff B and C) had a medical clearance for fit-testing, and 4 of 5 sample staff (Staff A, B, C and E) were fit-tested for respirator masks, and failed to ensure a copy of the results of

the previous inspection were posted for residents, and resident representatives, to view. This placed 42 residents at risk for receiving waived tests, such as in-house diagnostic tests, without the ALF having maintained the proper certificate, and at risk for communicable infection, and at risk for not knowing the ALF's licensing inspection status with the Department.

Findings included...

MTSW/CLIA Waiver

Note: A "Dear Assisted Facility Administrator" letter, issued by the Department on 08/03/2022, showed that ALFs were informed about state and federal regulations related to COVID-19 (an infectious disease which can result in illness with symptoms including cough, fever, malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) and other medical tests done on site. A MTSW certificate is required in Washington state to conduct these tests. The MTSW meets both federal and state requirements and includes a federally- issued CLIA number.

Observation during the environmental tour, on 08/12/2024 at 10:40 AM, showed no MTSW/CLIA certificate posted in the ALF.

Record review of a copy of the certificate showed the MTSW/CLIA waiver expired on 06/30/2023.

During an interview, on 08/13/2024 at 2:22 PM, Staff F (Executive Director) stated that they were looking into the renewal process for the MTSW/CLIA waiver.

MEDICAL CLEARANCE/FIT-TESTING

Note: Review of a "Dear Administrator" letter, dated 04/30/2021, showed the Department informed ALFs of their responsibility to develop and maintain an RPP. An RPP is defined by the Washington State Department of Health (DOH) as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALFs were required to provide initial and annual fit-tests for each Health Care Worker (HCW) with the same model, style, and size respirator that the HCW would be required to wear for protection against COVID-19 and airborne hazards. The ALF were required to provide fit-tested respirators, such as NN95, to all HCWs with the potential to have contact with residents with known or suspected COVID-19. The ALF were required to provide gowns, gloves, and eye protection to staff who were providing care to residents.

Note: Washington Administrative Code 296-842-12005 is a Washington State Department of Labor and Industries (L&I) rule that requires employers to develop a written RPP to safeguard employees from airborne hazards. The nine key requirements of a Respiratory Protection Program are: Written program with policies and procedures; Program Administrator; Hazard Evaluation & Respirator Selection; Medical Evaluation for

Respirator Wearers; Fit Testing: Initial, Annual, after any Physical Changes that Affect Fit; Proper Respirator Use, Storage, Maintenance, Repair, Disposal, and Training; Program Evaluation; Record Keeping.

Record review of Staff A's (Nursing Assistant Certified/NAC) personnel file showed the ALF hired them on 09/07/2023 as a fulltime caregiver. There was no documentation showing Staff A completed an annual fit test, or what respirator mask make and model to be used in the event of an infectious outbreak.

Record review of Staff B's (NAC) personnel file showed the ALF hired them on 05/27/2024 as a fulltime caregiver. There was no documentation showing Staff B completed a medical clearance to wear a respirator mask, completed an annual fit test, or what respirator mask make and model to be used in the event of an infectious outbreak.

Record review of Staff C's (NAC) personnel file showed the ALF hired them on 05/29/2024 as a fulltime caregiver. There was no documentation showing Staff C completed a medical clearance to wear a respirator mask, completed an annual fit test, or what respirator mask make and model to be used in the event of an infectious outbreak.

Record review of Staff E's (NAC) personnel file showed the ALF hired them on 04/21/2001 as a fulltime server. There was no documentation showing Staff E completed a medical clearance to wear a respirator mask, completed an annual fit test, or what respirator mask make and model to be used in the event of an infectious outbreak.

During an interview, on 08/14/2024 at 2:10 PM, Staff F (Executive Director) stated that she would look into the lack of medical clearance and respirator mask fit testing required of a respiratory protection program.

INSPECTION RESULTS

An observation, on 08/14/2024 at 10:15 AM showed there was no evidence of the ALF's previous full inspection results from the Department.

In an interview, on 08/14/2024 at 10:16 AM, Staff L (Concierge) stated that it was posted on a wall but was taken down "a few months ago" when the wall was painted.

This is a recurring deficiency previously cited for subsections (1)(b) on 10/19/2023, 12/22/2023, and 02/27/2024.

Statement of Deficiencies

License #: 864

Compliance Determination # 45272

Plan of Correction

FRED LIND MANOR

Completion Date

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Licensee: FRED LIND MANOR

08/22/2024

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, FRED LIND MANOR is or will be in compliance with this law and / or regulation on (Date) 10/6/2024

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

Mari Hamell
Administrator (or Representative)

9/16/2024
Date

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FRED LIND MANOR 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