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

HUNTINGTON RETIREMENT HOMES INC
Village Green Senior Living of West Seattle
2615 SW BARTON STREET
SEATTLE, WA 98126

RE: Village Green Senior Living of West Seattle License # 924

Dear Administrator:

This letter addresses Compliance Determination(s) 39674 (Completion Date 04/17/2024) and 35454 (Completion Date 02/12/2024).

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

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2100-2-a, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-5, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2730-1-a, WAC 388-78A-2730-1-b, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3100-3

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, Licensor

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

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J

Residential Care Services

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

02/13/2024

Licensee: HUNTINGTON RETIREMENT HOMES INC
Village Green Senior Living of West Seattle
2615 SW BARTON STREET
SEATTLE, WA 98126

RE: Village Green Senior Living of West Seattle License # 924

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 02/12/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

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

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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

You May:

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

In Addition, You May:

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

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

If You Have Any Questions:

- Please contact me at (425)670-6070.

Sincerely,

Jamie Singer

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

Enclosure

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 #: 924	Compliance Determination # 35454
Plan of Correction	Village Green Senior Living of West Seattle	Completion Date
Page 3 of 18	Licensee: HUNTINGTON RETIREMENT HOMES INC	02/12/2024

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 and complaint investigation on 01/18/2024 and 01/22/2024 of:
Village Green Senior Living of West Seattle
2615 SW BARTON STREET
SEATTLE, WA 98126

This document references the following complaint numbers: 115154.

The following sample was selected for review during the unannounced on-site visit: 6 of 25 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

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.

Janice Singer
Residential Care Services

2/13/2024
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.

Tam Thomas
Administrator (or Representative)

02/14/2024
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to use an appropriate tool to annually assess the special needs related to dementia for 2 of 2 sampled residents (Residents 5 and 6). This placed Residents 5 and 6 at risk for not receiving proper care and services and deteriorating dementia conditions.

Findings included...

NOTE: Washington Administration Code 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: (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c) Dementia. While screening a resident for dementia, the assisted living facility must: (i) Base any determination that the resident has short-term memory loss upon objective evidence; and (ii) Document the evidence in the resident's record.

RESIDENT 5
Review of a Resident Information form (RI) showed the ALF admitted Resident 5 on [redacted]/2018 with dementia (a group of symptoms that affects memory, thinking and interferes with daily life).

Review of a Care Plan (CP - equivalent to Negotiate Service Agreement), dated 11/20/2023, under the Behavioral-Cognition section, showed the ALF staff would assist Resident 5 with orienting time, place, and surroundings as needed.

Review of an Assessment, dated 11/20/2023, under the Behavioral/Cognition section, showed Resident 5 was identified as having problems with memory, but Resident 5's memory issue would not interfere with daily function. Record review showed no

information as to whether the ALF evaluated Resident 5's cognition by using an appropriate screening tool to assess symptoms consistent with dementia, such as short-term memory loss.

In an interview, on 01/22/2023 at 2:30 PM, Staff F (Resident Care Manager) confirmed there was no other dementia assessment for Resident 5.

RESIDENT 6
Review of a RI form showed that the ALF admitted Resident 6 on [redacted]/2021 with multiple diagnoses including [redacted].

Review of an Assessment, dated 10/23/2023, showed that Resident 6 was identified as having problems with memory that did not interfere with daily functioning. Record review showed no additional assessment using an appropriate tool to determine Resident 6's dementia condition.

In an interview, on 01/22/2023 at 2:30 PM, Staff F confirmed that there was no other dementia assessment for Resident 6.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024

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

Tia M Thomas — Administrator (or Representative)

02/14/2024 — Date

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

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

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

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

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

(a) Exclusively for the individual resident; or

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

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to develop a Negotiated Service Agreement (NSA) that clearly defined roles and responsibilities of a private caregiver (PCG) for 1 of 2 sampled resident (Resident 1), information to meet care needs for 1 of 1 sampled resident (Resident 2) who used supplemental oxygen and took blood thinning medications, or for 1 of 3 sampled residents (Resident 5) who had [redacted] diagnoses. This placed Residents 1, 2 and 5 at risk of not having care needs met.

Findings included...

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [redacted]/2023 with [redacted] diagnoses. Review of and NSA, dated 10/17/2023, under the Medication Management section showed, "Family will provide all medications, if family is unable to provide medications House pharmacy will be used as backup plan." The NSA showed "Additional Detailed Medication Delivery: Hired caregiver [Named PCG], picks up from pharmacy and helps resident self-administer medications."

Observation and interview, on 01/22/2024 at 1:05 PM, showed Resident 1 in her apartment with Collateral Contact 1 (CC1 - a Financial Caregiver). When questioned on who provided care and services, CC1 stated Resident 1 had been receiving care and services from PCG 5 hours a day, 4 days a week. Resident 1 stated their PCG 1 stated would take them for walks, grocery shopping, and driving to doctor's appointments.

Review of an NSA, dated 10/17/2023, did not clearly define roles and responsibilities of

Resident 1's PCG. The NSA did not identify the days and hours the PCG was in the ALF. The NSA showed no alternate plan on how Resident 1 would receive care and services should the PCG be unavailable, or who would assist Resident 1 self-administer medications.

RESIDENT 2

Review of a RI form, showed the ALF admitted Resident 2 on [redacted]/2023 with multiple medically disabling diagnoses including [redacted], and [redacted]. The RI form identified Resident 1 as requiring supplemental oxygen (O2) treatment.

Observation and interview, on 01/22/2024 at 10:30 AM, Resident 2 had marked discoloration (bruising) on his forearms. Resident 2 stated, "I have fragile skin. I banged myself around. I'm taking those [blood thinning] medications."

Observation and interview, on 01/22/2024 at 1:00 PM, showed Resident 2 in his recliner wearing supplemental O2 by nasal cannula (a tube that delivers O2 through the nostrils). An O2 concentrator (a devices that provide pure oxygen by filtering and compressing the air from the environment, removing the nitrogen and other gases, and delivering oxygen at a high concentration through a mask or nasal cannula) was observed in the apartment. Resident 2 stated he used a portable O2 cannister when outside of his apartment, and he used the concentrator when in his apartment. Resident 2 stated they used O2 continuously and care staff occasionally assisted him with changing the water from the O2 concentrator.

Review of Resident 2's November and December 2023, and January 2024 electronic medication administration record (eMARs) showed Resident 2 received two prescribed routine blood thinning medications.

Review of an NSA, dated 12/13/2023, showed no information regarding Resident 2's use of O2. There was no information about the use of a portable O2 and the concentrator. There was no information on how facility staff or Resident 2 managed the O2 concentrator. The NSA showed no instructions for staff to follow on what to observe and to report for Resident 2's use of blood thinning medications.

RESIDENT 5

Review of a RI form showed the ALF admitted Resident 5 on [redacted]/2018 with multiple diagnoses including [redacted] and [redacted]

[redacted]). Review of the electronic Medication Administration Records showed Resident 5 had been taking a routine anti-depressant medication.

Review of Resident 5's Care Plan (CP, equivalent to NSA), dated 11/20/2023, under the Behavioral-Cognition section, showed, "No Problem" under the category for Depression. Review of the CP showed no approaches or interventions for staff to follow should Resident 3 manifest signs and symptoms of severe depression or ADHD.

In an interview, on 01/22/2024 at 2:30 PM, Staff F (Resident Care Manager) stated that they were responsible for developing each resident's care plan. Staff F confirmed that there was no intervention for Resident 5's behavior or mental health issues.

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, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024 .

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

Cam Thomas — Administrator (or Representative)

02/14/2024 — Date

WAC 388-78A-2210 Medication services.

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems to promote safe medication services for 2 of 6 sampled residents (Resident 2 and 3) who required staff assistance with medications. This resulted in Resident 2 and Resident 3 not receiving prescribed medications and placed them at risk for a deteriorated health conditions.

Findings included...

Review of an undated Medication policy and procedure (P&P) created by the ALF, under the Ordering Medications section, showed medications were available to ensure appropriate delivery to residents, and the ALF would maintain at least a seven-day supply of all stored medications. The Medication P&P showed, "Be aware of medications that have been reordered, but not received. Do Not wait until the last minute to follow-up with the pharmacy regarding medications that have not been received."

RESIDENT 2

NOTE: Review of the American Diabetes Association website showed diabetes is a disorder in which the body has high sugar levels for prolonged periods of time. The disease may be controlled with oral medications, injectable medications such as insulin, and by diet modification. According to the American Diabetes Association hyperglycemia, or high blood sugar, occurs when the body has too little insulin or cannot use insulin properly. Hypoglycemia, or low blood sugar, is defined as blood sugar below 70 mg/dL (milligrams per deciliter).

Review of records showed the ALF admitted Resident 2 on [redacted]/2023 with multiple medical disabling diagnosis including [redacted]. Review of ALF's Assessment and Negotiated Service Agreement (A/NSA), dated 12/13/2023, showed Resident 2 required staff assistance with medication management including blood sugar (BS) checks and insulin administration.

Review of a PN, dated 12/09/2023, showed Resident 2 was transported to the hospital due to shortness of breath. Resident 2 returned to the ALF the same day with a diagnosis of [redacted].

Review of the Discharge Instructions/Active Outpatient Medications, dated 12/09/2023, showed physician orders for acetaminophen 325 milligram (mg) tablets, take two tablet three times a day to relieve pain and prednisone (used to treat several conditions including swelling and allergies) 20 mg, take two tablets every morning with breakfast.

Review of December 2023 electronic medication administration record (eMAR) showed Resident 2 did not receive their prednisone, as ordered, on 12/15/2023, 12/16/2023, 12/17/2023, and 12/18/2023. The eMAR showed Resident 2 did not receive 56 doses of the acetaminophen, as ordered, from 12/10/2023 through 12/29/2023.

Review of Resident 2's eMAR showed physician's ordered medications to treat diabetes

included a glucagon emergency 1 mg kit as needed for emergency low BS and glucose tablets 16–32 gram (gm) as needed for low BS.

Review of the physician's order did not show parameters for what Resident 2's BS readings should be to give glucagon and glucose tablets.

Review of December 2023 and January 2024 eMAR showed a physician's order dated 08/30/2023 to check Resident 2's BS every morning. The eMAR showed on 12/06/2024 at 6:49 AM, 12/28/2023 at 6:41 AM, 12/29/2023 at 6:44 AM, and 01/03/2024 at 6:42 AM, Staff K (Medication Technician) gave Resident 2 the glucose 16-32 gm tablets with no BS readings documented. There was no documentation Staff K notified a licensed nurse (LN) or Resident 2's physician for the low BS readings and for the reason Staff K gave the hypoglycemic medication.

In an interview, on 01/18/2024 at 3:45 PM, Staff I (Vice President of Operations) responded to questions regarding Resident 2's missing medications and lack of low BS parameters by stating, "We need a nurse here."

RESIDENT 3

Review of a Resident Information form showed that the ALF admitted Resident 3 on [redacted]/2023 with multiple diagnoses, including h[redacted] (a[redacted]) and [redacted]. Review of a Care Plan (CP - equivalent to Negotiated Service Agreement), dated 01/08/2024, showed that Resident 3 required staff assistance with medications. The PSP CP, under the Medications Management section, showed that the ALF would assist, record, maintain, and reorder all medications.

In an interview, on 01/22/2024 at 1:30 PM, Resident 3 stated that the ALF staff had been assisting them with medications.

Review of a current medication list, dated 11/16/2023, showed that a Primary Care Provider (PCP) had prescribed Resident 3 to take multiple medications, including furosemide (a medication that reduces fluid build-up in the body by increasing the flow of urine) twice daily, metoprolol (a medication to lower blood pressure) daily, and levothyroxine (a medication that is used to treat hypothyroidism) daily.

Review of the December 2023 eMARs showed the furosemide order had not been transcribed into the eMARs until 12/17/2023. Resident 3 did not receive furosemide twice a day for five days.

Review of the December 2023 eMARs showed that from 12/13/2023 through 12/28/2023,

the ALF staff put their initials in a column for metoprolol, circled their initials, and documented, "[metoprolol was] not here need to order a new", "still waiting for the delivery refill", "not here [the ALF] yet", and "Waiting for the pharmacy refill".

Review of a fax form to Resident 3's PCP, dated 12/13/2023, showed the ALF requested the PCP to refill the order for Resident 3's metoprolol, after the metoprolol had completely run out. Review of a progress note, dated 12/20/2023, showed the ALF followed up on the previous metoprolol refill order on one occasion only, one week after metoprolol ran out. The eMARs showed that Resident 3 did not receive metoprolol until 12/29/2023.

In an interview, on 01/22/2024 at 2:30 PM, Staff F (Resident Care Manager) stated that Resident 3 had not received metoprolol until the pharmacy delivered it.

Review of the January 2024 eMARs showed that from 01/12/2024 through 01/17/2024 the ALF staff put their initials in a column for levothyroxine, circled their initials, and documented that the medication was not available. On 01/12/2024, the ALF staff documented that the ALF did not have the right dose (of levothyroxine) because the pharmacy delivered a different dose. The ALF staff talked to the pharmacy the previous day and the ALF was still waiting for it. Record review showed no other documentation as to whether the ALF had contacted the pharmacy per the ALF's P&P, regarding the levothyroxine that had not been received. Resident 3 did not receive levothyroxine for six days.

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, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024.

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

Tia M Thomas — Administrator (or Representative)

02/14/2024 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

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

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled staff (Staff B) received specialty training for dementia and mental health in a timely manner. This failure placed residents' cognitive loss or mental health diagnosis at risk of harm due to an untrained care staff.

Findings included...

NOTE: Washington Administrative Code 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:

NOTE: 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).

Record review of a Resident Characteristics Roster identified five with diagnoses of [redacted]. Review of sampled residents showed and three with [redacted] diagnoses.

Record review showed Staff B (Medication Technician/ Caregiver) was hired on 08/24/2023. Record review showed Staff B did not complete the dementia and mental health specialty training.

Interview, dated 01/26/2024 at 10:30 AM, Staff H (Executive Director) stated that after contacting Staff B's previous employer, it was confirmed Staff B did not complete the specialty training for dementia and mental health.

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, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024

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

Liam Thomas — Administrator (or Representative)

02/14/2024 — Date

WAC 388-78A-2600 Policies and procedures.

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to implement their policy for bed mobility devices for 2 of 3 sampled residents (Resident 4 and 6). This placed Resident 4 and Resident 6 at risk of for serious bodily harm, including death from entrapment from their side bed rail (SBR).

Findings included...

Note: On 05/15/2013, a "Dear Assisted Living Facility Administrator" letter was issued to Assisted Living Facility Providers related to the safety risks associated with the use of all medical devices to include, i.e. "some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted."

Review of an undated policy (P&P) created by the ALF titled, "Bed Rails and Enablers" stated, "The use of bed rails is discouraged in all Powell Communities. Half bed rails are only utilized to assist in mobility and not as a restraint. Bed rails are used only with specific Physician's Orders mandating the use and will require the permission of the Vice President of Operations." The policy included, under section 3, that side rail risks and benefits shall be outlined to the resident and family; section 4, use of rails will be documented in the resident's service plan along with instructions for monitoring, and section 6, enablers must be mechanically attached to a metal bed frame and meet the following spacing

specifications: A. a maximum of four and ¾ inch opening within rails and B. a maximum of two and 1/3 inch from the mattress.

RESIDENT 4

Review of a Resident Information (RI) form showed the ALF admitted Resident 4 on [redacted]/2023 with multiple disabling diagnoses including [redacted].

Review of Resident 4's Supportive Device Assessment (SDA), dated 09/21/2023, under the section of Medical Device, showed Resident 4 could not reposition himself in bed, had difficulty in balance and poor trunk control. Review of Resident 4's Negotiated Service Agreement (NSA), dated 11/07/2023, under the section of Fall Risk showed: Assistive Devices - Side Rail.

Interview and observation, on 01/22/2024 at 10:30 AM, showed an uncovered quarter-size metal frame SBR located on the right side of the Resident 4's bed. There was 17-inch x 11-inch large open gap between the bed rails. The SBR was held to the bed by two horizontal bar supports that were secured under the mattress. Resident 4 stated, "That [SBR] is critical to me." Resident 4 stated that he used the SBR to get in and out of bed.

Record review showed the ALF obtained a physician's order dated 08/30/2023 for Resident 4's SBR for bed mobility. Records showed no documentation the risks and benefits of the SBR were reviewed with Resident 4. Observation showed the gaps in the SBR exceeded the maximum space outlined in the ALF's policy.

RESIDENT 6:

Review of a RI form showed the ALF admitted Resident 6 on [redacted]2021 with multiple disabling diagnoses, [redacted].

Review of the Residents' Characteristics Roster, dated 01/18/2024, showed that the ALF identified Resident 6 as having a medical device.

Observation and interview, on 01/22/2024 at 1:15 PM, showed an up-side-down U-shaped SBR attached to the right side of the bed in Resident 6's apartment. Observation showed an open space/gap inside of the u-shaped device (the hand grip area) measuring 12 inches length and 12 inches high. Observation also showed a SBR attached to the other, left side of the bed, and an open space/gap inside SBR measuring 17 inches in length and six inches high. Resident 6 stated that they had been using the left side SBR for getting in and out and re-positioning in the bed. When asked whether they had used the right side

U-shaped SBR, Resident 6 stated, "sometimes".

Review of a Supportive Device Assessment (SDA), under the Conclusion section, dated 09/21/2023, showed Resident 6 would use a side rail that acts as an assistive device to keep Resident 6 independent in repositioning, and to go from lying down to sitting up independently. But the SDA did not specify whether Resident 6 needed the use of two (left and right) SBRs.

Review of the SDA showed the SBR fits the ALF's P&P for Bed rails and Enablers criteria. But the ALF's P&P stated, "an open space for a bed rail should be 4 and ¾ inches". Record review showed no documentation of risk and safety considerations concerning entrapment in the open space inside the SBRs.

In an interview, on 01/22/2024 at 4:00 PM, Staff F (Resident Care Manager) confirmed there was no other assessment for Resident 6's SBRs.

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, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024.

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

Tiam Thomas — Administrator (or Representative)

02/14/2024 — 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

This requirement was not met as evidenced by:

Based on observation, record review and interview, the Assisted Living Facility (ALF) failed to obtain a Medical Testing Site Waiver/Clinical Laboratory Improvement Amendments (MTSW/CLIA) waiver certificate and implement their Respiratory Protection Program (RPP) when 1 of 2 sampled staff (Staff A) did not have medical clearance and respiratory mask

fit-testing. This placed 25 of 25 residents at risk for harm from medical testing done without certification and for contacting respiratory illnesses.

Findings included...

MTSW/CLIA

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 was required in Washington state to conduct these tests. The MTSW met both federal and state requirements and included a federally- issued CLIA number. ALFs were also made aware of the deadline of 06/30/2023 for submitting the certificate application.

Observation during the environmental tour with Staff H (Executive Director), on 01/18/2024 at 10:05 AM, did not show a MTSW/CLIA certificate posted anywhere in the ALF. Staff H was unaware of the MTSW/CLIA certification.

Record review showed the ALF had no documentation of MTSW/CLIA certification.

During the exit interview, on 01/22/2024 at 3:30 PM, Staff H (Executive Director) confirmed that the ALF did not have the MTSW/CLIA waiver.

Respiratory Protection Program (RPP)

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 the N95, to all HCWs with the potential to have contact with residents with known or suspected COVID-19. The ALFs 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.

Review of RPP records showed the ALF had no documentation of medical evaluations or respiratory mask fit-testing for sampled Staff A (Medication Technician/Caregiver).

During an interview, on 01/22/2024 at 1:35 PM, Staff H (Executive Director) stated that medical evaluations and respiratory mask fit- testing were missed for Staff A.

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, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024

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

Tiam Thomas — Administrator (or Representative)

02/14/2024 — Date

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

(1) The residents' characteristics and needs;

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

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure ambulatory residents with mental health and cognitive impairment did not have access to chemicals and hazardous items. This failure placed 8 residents at risk for exposure to hazardous materials.

Findings included...

Record review of sampled residents identified five residents with diagnosis of [redacted] ([redacted]) or [redacted], and three residents with mental health issues. All sampled residents

were ambulatory.

On 01/18/2024, between 10:05 AM and 11:45 AM, an ALF walkthrough was conducted with Staff H (Executive Director) The following were observed:

There was an unlabeled green color spray bottle liquid under the hand washing sink in the Tea Room at 10:40 AM. Staff H stated, "That should be labeled."

In Building 3 at 10:50 AM, there was a Comet disinfectant cleaner found in the shower room with precautionary label: contains harsh chemicals that can irritate skin and eyes, and the fumes can be harmful if inhaled in large quantities, and an unlabeled blue color liquid spray bottle. Staff H stated, "It looked like a window cleaner to me."

In Building 3, the Janitor / Caregiver room was found unlocked at 11:00 AM. An unlabeled blue color spray bottle liquid was found, 2 Comet disinfectant cleaner bottles, and an unlabeled spray bottle with clear liquid with "Keep Out of Reach of Children" written on the bottle. Staff M (Housekeeper) stated, "It may be glass cleaner, I do not know."

In Building 4 1st floor, the vacuum closet in the main dining room was found unlocked at 11:14 AM with a bottle of Insecticide Home Defense Spray with precautionary label to, "Keep Out of Reach of Children, Do not eat, drink or smoke when using this product. Wash hands thoroughly after handling IF SWALLOWED: Call a POISON CENTER..." At 11:19 AM, there were multiple paint cans found in an unlocked storage room. Staff H stated, "Those paints should not be there."

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, Village Green Senior Living of West Seattle is or will be in compliance with this law and / or regulation on (Date) 03/28/2024

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

Ciara Thomas — Administrator (or Representative)

02/14/2024 — Date