



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

ST. ANDREWS RETIREMENT COMMUNITY
ST ANDREWS PLACE ASSISTED LIVING
520 EAST PARK AVE
PORT ANGELES, WA 98362

RE: ST ANDREWS PLACE ASSISTED LIVING License # 1195

Dear Administrator:

This letter addresses Compliance Determination(s) 75110 (Completion Date 04/01/2026) and 71362 (Completion Date 01/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/01/2026 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-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-e, WAC 388-78A-2320-3-c, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2474-1, WAC 388-78A-2474-2-b, WAC 388-78A-2474-2-e, WAC 388-78A-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3, WAC 388-78A-2120-4, WAC 388-78A-2610-1, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2-a, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-2-b, WAC 388-78A-2140-2, WAC 388-78A-2140-3

The Department staff who did the on-site verification:

Celeste Vashey, ALF LTC Licenser
Anissa Bearden, Licenser

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

ST ANDREWS PLACE ASSISTED LIVING # 1195

04/01/2026

Page 2 of 2

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 1195	Compliance Determination # 71362
Plan of Correction	ST ANDREWS PLACE ASSISTED LIVING	Completion Date
Page 1 of 27	Licensee: ST. ANDREWS RETIREMENT COMMUNITY	01/28/2026

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 01/14/2026 and 01/16/2026 of:

ST ANDREWS PLACE ASSISTED LIVING
520 EAST PARK AVE
PORT ANGELES, WA 98362

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:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Clinton Fridley RN
Residential Care Services

01/29/2026
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.

Laura Dadd
Administrator (or Representative)

2/5/26
Date

Type te

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

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

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

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff had the required credentials and documentation for 1 of 3 staff (Staff C), failed to ensure the residents nurse delegation was implemented in their negotiated service agreement for 1 of 3 residents (Resident 2), and failed to ensure delegated nursing services were reviewed and updated every 90 days for 3 of 3 residents (Resident 2, 4 and 8). These failures resulted in all residents receiving medication administration services by staff who were not specifically delegated to perform the tasks and at risk for unmet care and medical needs.

Findings included...

Washington Administrative Code (WAC) 246-840-930 Criteria for delegation. (1) In community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE... (8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction... (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (m) Supervision shall occur at least every 90 days.

Record review of the facility's policy titled, "Nurse Delegation in Community Based Care Settings," undated, documented nursing assistance must be currently registered or certified as a nursing assistant in Washington State and the licensed registered nurse to delegate nursing care tasks consistent with nursing regulations.

Staff C

Record review of the facility document that was untitled and undated, documented Staff C, Caregiver, started employment at the facility on 08/13/2024.

Record review of the facility's document titled, "Nurse Delegation: Credentials and Training Verification," dated 10/15/2025, documented that Staff C's provider credential search was attached and there was no credentials listed.

Record review of Staff C's Washington State Department of Health credential verification, dated 10/15/2025, documented their home care aide certification was "pending."

Record review of the Washington State Department of Health credential verification database on 01/15/2026, documented their home care aide certification was "pending."

Resident 2 (R2)

Record review of R2's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2019 with multiple medical diagnoses that included [REDACTED]
[REDACTED]
[REDACTED].

Record review of R2's document titled, "Nurse Delegation: Nursing Visit," dated

10/15/2025, documented they were nurse delegated for their glucose monitoring and Staff C was listed to have active credentials, was observed or had demonstrated the task and completed the training. The document indicated R2's next nurse delegation visit would be on or before 01/15/2026. There was no updated or other nursing visit documentation in the binder for R2.

Record review of R2's document titled, "Long-Term Care Assessment and Care Plan [facility's version of negotiated service agreement]," dated 02/01/2025, documented they had daily use of insulin and blood sugar checks. There was no documentation in the care plan that indicated that R2's blood sugar checks were nurse delegated task.

Resident 4 (R4)

Record review of R4's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025.

Record review of R4's document titled, "Nurse Delegation: Nursing Visit," dated 10/15/2025 documented they were nurse delegated for their eye drops and Staff C was listed to have active credentials, was observed or had demonstrated the task and completed the training. The document indicated R4's next nurse delegation visit would be on or before 01/15/2026. There was no updated or other nursing visit documentation in the binder for R4.

Resident 8 (R8)

Record review of R8's document titled, "Nurse Delegation: Nursing Visit," dated 10/15/2025, documented they were nurse delegated for their glucose monitoring. Staff C was listed to have active credentials, was observed or had demonstrated the task and completed the training. The document indicated R8's next nurse delegation visit would be on or before 01/15/2026. There was no updated or other nursing visit documentation in the binder for R8.

Record review of the nurse delegation binder on 01/16/2026 at 10:52 AM, there were no updated nurse delegation visit for R2, R4 or R8 in the binder to review.

In an interview on 01/14/2026 at 12:28 PM, Staff A, Administrator, stated Staff F, Registered Nurse Delegator, was scheduled to come to the facility next to review and update the nurse delegation on 02/07/2026.

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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3/5/2026.

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

Laura Dodd
Administrator (or Representative)

2/5/26
Date

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

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 3 of 3 sampled Staff (Staff C, D and E) received all required Tuberculosis (infectious bacterial disease of the lungs) testing within the required time frames. This failure resulted in the facility failing to test staff for Tuberculosis (TB) and placed all residents, staff and visitors at risk for exposure to highly communicable disease.

Findings included...

Staff C

Record review of the facility document that was untitled and undated, documented Staff C, Maintenance Director, started employment at the facility on 08/13/2024.

Record review of Staff C's document titled, "Patient Vaccination Record," dated 05/21/2025, documented they had a TB test read on 08/14/2024 with no documentation when the TB test was administered. Staff C completed a TB test on 05/19/2025.

Staff D

Record review of the facility document, that was untitled and undated, documented Staff D, caregiver, started employment at the facility on 09/08/2025.

Record review of Staff D's document titled, "Patient Vaccination Record," dated 12/04/2025, documented they had a TB test completed on 10/07/2025 and 12/01/2025.

Staff E

Record review of the facility document, that was untitled and undated, documented Staff E, caregiver, started employment at the facility on 09/13/2025.

Record review of Staff E's document titled, "Patient Vaccination Record," dated 11/12/2025, documented they had a TB test completed on 11/10/2025. There were no other TB tests completed.

In an interview on 01/16/2026 at 1:33 PM, Staff A, Administrator, stated once facility staff was hired, their TB test was to be completed at the local health department and that they were only available to be administered once a week. Staff A stated after the restrictions from the pandemic, they were unaware that all staff were required to have a two-step TB test if they didn't meet the requirements per the regulations.

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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) <u>3/5/26</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Laura Dodd</u> Administrator (or Representative)	<u>2/5/26</u> 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:

(b) Basic;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff G) completed their annual continuing education units (CEU) and failed to ensure 1 of 2 new sampled staff (Staff E) complete required certificates within the required time frame. These failures placed all residents at risk of receiving care from staff who are not up to date on training and certifications.

Findings included...

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

CEU

Staff G

Record review of the facility document that was untitled and undated, documented Staff E, caregiver, started employment at the facility on 09/13/2025 and their birthday was October 15th.

On 01/16/2026 at 12:58 PM, Staff E's CEU's for 10/15/2024 through 10/15/2025 were requested.

Record review of Staff G's CEU's document they had completed three of 12 required hours. As of 01/19/2026 at 5:30 PM, no additional CEU's for Staff G were provided.

In an interview on 01/16/2026 at 1:33 PM, Staff A, Administrator, stated Staff H, Office Manager, was the person responsible to ensure facility staff completed their CEU's and acknowledged Staff G did not have the required 12 hours CEU's completed.

70-hour Certificate

WAC 388-112A-0110 May a home employ a long-term care worker who has not completed the 70-hour home care aide training or certification requirements? (1) If an individual previously worked as a long-term care worker, but did not complete the training or certification requirements under RCW 18.88B.041, 74.39A.074, 74.39A.076, and this chapter, an adult family home, enhanced services facility, or assisted living facility must not employ the individual to work as a long-term care worker until the individual has completed the required training or certification unless the date of hire has been reset as described under subsection (2) of this section. (2) The original date of hire may be reset according to

WAC 388-112A-0115. A long-term care worker who is not currently certified or eligible to reactivate an expired credential shall receive a new date of hire when beginning work with either a new employer or returning to a former employer after prior employment has ended. (3) Individuals who meet the criteria in subsection (2) of this section are allowed a new 120 days to complete the orientation, safety, and 70-hour home care aide basic trainings and a new 200 days to become certified as a home care aide, if required by WAC 246-980-020. (4) Individuals who meet the criteria in subsection (2) of this section must submit an application and fee to the department of health.

Staff E

Record review of the facility document that was untitled and undated, documented Staff E, caregiver, started employment at the facility on 09/13/2025.

On 01/15/2026 at 9:46 AM, all of Staff E's certificates were requested to review.

Record review on 01/16/2026 of Staff E's documents provided, documented there was no 70-hour basic certificate provided.

On 01/20/2026 at 11:59 AM and 01/21/2026 at 9:30 AM, Staff E's 70-hour basic certificate was requested to review. As of 01/21/2026 at 5:30 PM, Staff E's 70-hour basic certificate was not provided.

On 01/28/2026 at 9:21 AM, Staff A, Administrator, stated Staff H, Office Manager, was the person responsible to ensure facility staff completed their 70-hour basic certificate within the 120-day timeframe.

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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3/5/26.

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

Laura Dodd
Administrator (or Representative)

2/5/26
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor a change in resident condition that required intervention for 7 of 7 residents (Resident 5, 2, 7, 3, 4, 1 and 6). This failure placed these residents at risk of their care needs not being met and potential negative outcomes.

Findings included...

Record review of the facility's policy titled, "Alert Charting/Change in Condition," undated, documented the policy was implemented to ensure timely identification, documentation, communication and follow-up of significant changes in the resident's condition through the use of alert charting. Any staff member who observes or was informed of a significant change in a resident's physical, mental, emotional, or behavioral condition must initiate alert charting that would ensure prompt

communication to nursing, supervisory staff and care team for appropriate follow-up actions. Alert charting was focused documentation used to record, communicate, and track significant changes in a resident's condition that may require assessment, intervention, monitoring, or care plan updates. Some conditions that require alert charting include falls, sudden changes in mental status or behavior, injury, bruising, changes in mobility or strength, signs or symptoms of infection, medication refusals, skin breakdown, hospitalizations, emergency room visits and returning back from the hospital. Staff were to document the changes in the residents' record promptly and continue to monitor and document follow-up observations. Supervisors would monitor the documentation for completeness, timeliness, follow-up and care coordination.

Record review of the facility's document titled, "Alert Status Flow Sheet," undated, documented vital signs (measurable indicators of the body's basic functions used to detect and monitor medical problems and assess physical functioning) were to be documented after four, eight and 24 hours. The flow sheet contained a table to document the date, time, temperature, pulse, respiration, oxygen, blood pressure, pain, and initials after one, two, and four hours. Facility staff were to notify the nurse immediately of adverse symptoms which included altered level of consciousness, increased pain and fever.

R5

Record review of R5's document titled, "Personal Information," undated, documented they moved into the facility [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED].

Record review of R5's document titled, "Long-Term Care Assessment and Care Plan," dated 05/28/2025, documented they were alert and oriented to person, place, and time with some confusion noted time to time. R5 was independent with making their needs known, dressing and if needed assistance to inform the nurse, independent with toileting with the use of pads daily for urinary incontinence that only required staff to remind them of mealtimes.

Record review of R5's chart note, dated 11/03/2025 at 3:39 AM, documented they were wandering in their room with nothing on except for socks and slippers with their apartment door open. R5 was assisted to the bathroom where there was small bloodstain on their bathroom counter and on a paper towel with small amount of blood in the trash can. R5 had three separate pairs of pants that were soaked in urine in their laundry basket.

Record review of R5's chart note, dated 11/04/2025 at 5:56 AM, documented they were irate with staff about a single hand towel that was forgotten with their laundry.

Record review of R5's chart notes, dated 11/04/2025 through 11/06/2025, documented there were no further documentation about the residents change in mood and behavior.

Record review of R5's chart note, dated 11/06/2025 at 9:22 AM, documented that they had a bout of urinary incontinence and required assistance to be changed.

Record review of R5's chart note, dated 11/09/2025 at 12:30 PM, documented from 12:05 AM through 12:25 AM, R5 dry heaved phlegm and small bits of food. There was no documentation about R5's condition on 11/10/2025 or any follow up.

Record review of R5's chart note, dated 11/11/2025 at 10:42 AM, documented they had a cough and choking fit at breakfast that resulted in R5 vomiting for a few minutes. There was no further documentation in the chart notes dated 11/12/2025 through 11/16/2025 on R5's condition.

Record review of R5's chart noted, dated 11/23/2025 at 11:58 AM, documented they had difficulties that morning when they were unable to hold their bladder when they stood up and exclaimed in pain while they urinated into the toilet.

Record review of R5's chart note, dated 11/23/2025 at 3:04 PM, documented for the nurse to be notified if R5 complained of pain while urinating and would need to go to the walk-in clinic to be examined.

Record review of R5's chart note, dated 11/24/2026 at 5:06 AM, documented they had wet themselves and required staff to assist them with getting new clothes and change their incontinence pad. R5 called the facility staff ten minutes later, telling them that they needed help to get changed and did not remember that they were just helped with getting changed.

Record review of R5's chart note, dated 12/06/2024 at 5:40 AM, documented at 5:10 AM, R5 requested staff to change the incontinence pad on their chair. Shortly after R5 came down to the dining room, sat at a dining room table, turned their cups right-side up and poured several sugar packets into one cup. R5 told the caregiver that they were waiting for breakfast and were unaware of the time.

Record review of R5's chart note, dated 12/07/2025 at 7:30 AM, documented they were more confused and they felt lost. R5 required assistance with changing their clothes. At 12:28 PM, R5 was documented that they had vomited and was attempting to spit up phlegm and stomach bile built up in their throat.

Record review of R5's chart note, dated 12/08/2025 at 7:30 AM, documented they came down to the dining room at 1:45 AM and refused any assistance. R5 went to the dining room, sat down at the dining room table when they turned their cups right-side up and poured several sugar packets into one cup and then left. There was no further documentation in the charting notes on R5's behaviors, urinary incontinence, or

vomiting for dates 12/09/2025 through 12/22/2025.

On 01/21/2026 at 9:41 AM, the facility was requested to send all documentation that showed R5 was assessed and monitored for their change in behaviors and urinary incontinence for October 2025 through December 2025. As of 01/22/2025 at 5:30 PM, there was no documentation provided.

R2

Record review of R2's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2019 with multiple medical diagnoses that included [REDACTED].

Record review of R2's document titled, "Long-Term Care Assessment and Care Plan," dated 02/01/2025, documented they were alert and oriented to person, place, time, situation and able to communicate their needs. R3 has a history of nausea, vomiting and inability to have bowel movements that required medications. The facility office staff would make R3's appointments and transportations as needed.

Record review of R2's chart note, dated 11/15/2025 at 11:15 AM, documented they vomited in the trash can. At 11:38 AM, they documented R2 refused to go to lunch because they had loose stools. There was no further charting for dates 11/16/2025 through 11/20/2025 about R2's vomiting, loose stools and overall condition.

Record review of R2 chart note, dated 11/20/2025 at 3:57 PM, documented they started a new medication atorvastatin (medication to help lower fats in the blood). There were no other chart notes for dates 11/21/2025 through 11/25/2025 documented about how R2 was doing on the new medication.

Record review of R2's chart note, dated 12/18/2025 at 5:19 PM, documented while they were on the bus, it was hit by another vehicle. There was no documentation for dates 12/20/2025 through 12/28/2025.

Record review of R2's chart notes, dated 12/28/2025 at 6:48 AM and 10:08 AM, documented that they were complaining of hip pain that they believed was from the auto accident that occurred on 12/18/2025. R2 saw their primary care provider on 12/29/2025 and received new orders for right lower back pain related to a back muscle sprain. There was no further documentation on R2's back sprain pain and overall condition for dates 12/30/2025 through 01/07/2026.

On 01/21/2026 at 9:41 AM, the facility was requested to send all documentation that showed R2 was monitored after they were involved in the car accident on the bus on 12/18/2025, after vomiting on 1/15/2025 and after loose stools on 11/22/2025. As of

01/22/2025 at 5:30 PM, there was no further documentation provided.

R7

Record review of R7's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 with multiple medical diagnoses that included [REDACTED].

Record review of R7's chart note, dated 12/11/2025 at 5:14 PM, document they had a skin tear to their left forearm below the elbow. Staff cleaned the area and applied the dressing that was to remain clean and dry. There was no further documentation about R7's skin tear for dates 12/12/2025 through 12/16/2025.

Record review of R7's chart note, dated 12/16/2025 at 11:43 AM, documented they were dizzy that morning and did not eat breakfast. There was no further documentation in the chart notes for dates 12/17/2025 through 12/24/2025.

On 01/21/2026 at 9:41 AM, the facility was requested to send all documentation that showed R7 was monitored after they were found with a skin tear and their dizziness. As of 01/22/2025 at 5:30 PM, there was no further documentation provided.

R3

Record review of R3's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R3's chart note, dated [REDACTED]/2025, documented they moved into the facility that day and had low vision specifically in their left eye and general left side weakness. There was no further documentation about R3 adjusting to the facility in their chart notes for 11/01/2025 and 11/02/2025.

On 01/21/2026 at 9:41 AM, the facility was requested to send all documentation that showed R3 was monitored after they moved into the facility. As of 01/22/2025 at 5:30 PM, there was no further documentation provided.

R4

Record review of R4's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 and had a medical diagnosis of [REDACTED].

Record review of R4's document titled, "Long-Term Care Assessment and Care Plan," dated 09/08/2025, documented R4 had a stroke in 2016.

Record review of R4's document titled, "Chart Notes for [R4]," dated 01/01/2026, at 7:16 PM, R4's power of attorney requested R4 emergency medication technician transport related to a possible stroke.

Record review of R4's document titled, "Chart Notes for [R4]," dated 01/04/2026, at 2:35 PM documented R4 had a new diagnosis of [REDACTED]. R4 had a procedure that caused nasal dryness and pain and needed to be monitored and used pain medication as needed. At 7:42 PM, R4 returned home from the medical facility.

Record review of R4's document titled, "Chart Notes for [R4]," dated 01/05/2026, at 8:57 AM, R4's power of attorney took R4 to the emergency department because R4 was far from their base line. At 4:12 PM, R4 was scheduled to have a magnetic resonance imaging (non-invasive, radiation-free medical imaging test that produced detailed images of organs, tissues, and bones).

Record review of R4's document titled, "Chart Notes for [R4]," dated 01/05/2026, at 9:02 PM, R4 returned home from the emergency room due to weakness and complications of their recent procedure. There were no other chart notes to review related to R4's return to the facility.

On 01/21/2026 at 11:50 AM, R4's flow sheet that regarded their return to the facility was requested to review. As of 01/21/2026 at 5:30 PM, R4's flow sheet was not provided.

Record review of R4's document titled, "Chart Notes for [R4]," dated 01/12/2026, at 11:43 AM, R4 had difficulty swallowing their medication which led to a coughing fit. There were no other chart notes to review related to R4's difficulty swallowing and coughing fit.

On 01/21/2026 at 11:50 AM, R4's flow sheet that regarded difficulty swallowing was requested to review. As of 01/21/2026 at 5:30 PM, R4's flow sheet were not provided.

R1

Record review of R1's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2021 and had a medical diagnosis of [REDACTED].

[REDACTED]

Record review of R1's document titled, "Long-Term Care Assessment and Care Plan," dated 06/23/2025, documented R1 had a stroke. R1 was able to understand what others were communicating to them and respond appropriately.

Record review of R1's document titled, "Chart Notes for [R1]," dated 12/23/2025, documented R1 had a bloody nose at breakfast and facility staff would continue to monitor. There were no other chart notes to review related to R1's bloody nose.

On 01/21/2026 at 11:50 AM, R1's flow sheet that regarded their bloody nose was requested to review. As of 01/21/2026 at 5:30 PPM, R1's flow sheet were not provided.

R6

Record review of R6's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 and had a medical diagnosis of [REDACTED].

Record review of R6's document titled, "Long-Term Care Assessment and Care Plan," dated 07/04/2025, documented R6 took warfarin (medication that prevented blood clots from forming and existing ones from growing) and facility staff were to report any bleeding to the nurse.

Record review of R6's document titled, "Chart Notes for [R6]," dated 11/21/2025, documented R6 did not come down for breakfast, they stated they did not feel good, they felt old and everything hurt. There were no other chart notes related to R6 condition to review.

On 01/21/2026 at 11:50 AM, R6's flow sheet that regarded them feeling unwell was requested to review. As of 01/21/2026 at 5:30 PPM, R6's flow sheet were not provided.

Record review of R6's document titled, "Chart Notes for [R6]," dated 12/29/2025, documented R6 nicked a scab on their head and their head bleed. There were no other chart notes related to R6's bleeding to review.

On 01/21/2026 at 11:50 AM, R6's flow sheet that regarded their head bleeding was requested to review. As of 01/21/2026 at 5:30 PPM, R6's flow sheet were not provided.

Record review of R6's document titled, "Chart Notes for [R6]," dated 01/04/2026, documented R6 was not feeling well, they were congested, lethargic (a persistent state of fatigue, exhaustion, or lack of energy that goes beyond normal tiredness), and they thought they had a cold. There were no other chart notes to review related to R6's condition.

On 01/21/2026 at 11:50 AM, R6's flow sheet that regarded them feeling unwell was requested to review. As of 01/21/2026 at 5:30 PPM, R6's flow sheet were not provided.

In an interview on 01/16/2026 at 11:09 AM, R6, stated, they recently were sick and quarantined themselves in their room.

On 01/16/2026 at 9:10 AM, Staff K, Activities Director, stated they picked up caregiving shifts at the facility. Staff K stated caregivers were able to document alert charting on the residents. Staff K stated they documented alert charting on a task sheet. Staff K stated the facility had an alert charting reference sheet that informed staff the timeframe of how long they were required to document alert charting. Staff K stated alert charting should be documented immediately as facility staff were required to take the residents vitals after an incident occurred.

On 01/16/2026 at 9:30 AM, Staff J, Caregiver, stated if a resident had an incident, they would immediately completed an incident report and they wrote a chart note. Staff J did not provide an answer on the timeframe of how long they would chart for. Staff J stated at shift change they verbally informed the next facility staff member of any incidents that occurred on their shift.

On 01/16/2026 at 9:49 AM, Staff B, Health Care Coordinator, stated if a resident had an incident the facility staff were verbally informed about it. Staff B stated the facility staff completed hourly, two-hourly and four-hourly checks and documented the information on the alert status flow sheet form. Staff B stated facility staff completed a chart note immediately after the incident. Staff B stated the facility did not have a template on how long or how often facility staff were to complete chart notes for.

On 01/16/2026 at 1:33 PM, Staff A, Administrator, stated the facility staff documented alert charting on the flow sheet for one day. Staff A stated if the resident was not back to their baseline after one day, then the resident would continue to be monitored, and another flow sheet would be 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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3/5/26.

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

Laura Dodd
Administrator (or Representative)

2/5/26
Date

WAC 388-78A-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff washed their hands, per the recommended guidance, for 3 of 3 staff members (Staff G, I and J) observed. These failures resulted in a break in hand hygiene practices and placed all residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Record review of the facility's policy titled, "Hand Hygiene and Infection Prevention Policy," dated 07/01/2026, documented the facility would reduce the spread of infections among residents, staff and visitors by establishing standardized hand hygiene practices in accordance with Centers for Disease Control and Prevention (CDC). All staff were expected to follow proper hand hygiene practices while in the facility that was a required component of standard precautions and infection prevention. Hand hygiene was required after removing gloves, before prepping, handling or serving food, after touching residents' surroundings or shared equipment and before and after resident contact. All staff were responsible for adhering to the policy.

Staff G

On 01/15/2026 at 4:45 PM, Staff G, Caregiver, was at the medication cart outside of the dining room and they had been observed to wear disposable gloves on each of their hands. There were multiple unknown residents next to the medication cart in the sitting area. Staff G had been observed to give an unknown resident their medication and returned to the medication cart. Staff G did not doff (take off) their gloves or perform hand hygiene before they touched the medication cart, retrieved another resident's medication and distributed the medication to another unknown resident in the sitting area. Staff G did not doff their gloves or perform hand hygiene before they touched the laptop on top of the medication cart. One of the unknown residents in the sitting area

requested Staff G's help with a strap that was attached to their wheelchair. Staff G touched the unknown residents back and helped fix the strap. Staff G did not doff their gloves or perform hand hygiene before they touched their keys, opened the medication cart and retrieved another resident's medication. Staff G touched their keys to open another drawer in the medication cart, retrieved a piece of paper, walked down the hallway and knocked on an unknown resident's apartment door. Staff G stated to the unknown resident that they would see them down there. With the same gloved hands Staff G was observed to knock on another unknown resident's door. The unknown resident answered their door and exited their apartment in their wheelchair. Staff G had been observed to put a blood pressure cuff on the unknown resident's wrist, they took off the blood pressure cuff, wrote on their paper and returned to the medication cart. Staff G doffed their gloves, used hand sanitizer, donned (put on) another pair of disposable gloves, touched their keys, opened the medication cart, touched the mouse to the laptop with their right gloved hand, and retrieved another resident's medication. Staff G doffed their gloves, used hand sanitizer, donned another pair of disposable gloves, retrieved medication out of the medication cart and distributed it to an unknown resident in the dining room. Staff G had been observed to doff their gloves, Staff G did not perform hand hygiene before they donned their right glove, touched the mouse on the laptop, and then exited the area at 4:58 PM.

Staff I

On 01/15/2026 at 5:04 PM, Staff I, Dishwasher was observed inside of the dining room with gloved hands and they rolled the beverage cart into the kitchen. Staff I retrieved the beverage cart and rolled it into the dining room next to a table of residents. Staff I placed their hand and arm around an unknown resident's shoulder and back and inquired what they wanted to drink. With the same gloved hands Staff I poured juice out of a pitcher into a cup and gave it to the unknown resident. After Staff I put down the unknown resident's cup and they placed their hand on the back of the unknown resident's chair. Staff I proceeded to go into the kitchen, picked up multiple plates of food and distributed it to the residents.

Staff J

On 01/16/2026 at 9:26 AM, Staff J, Caregiver, was observed to exit R9's apartment wearing disposable gloves and held a small bag of trash that they placed inside of a larger trash can that rolled. Without doffing their gloves or performing hand hygiene Staff J knocked on R7's apartment door, Staff J entered and explained they were collecting trash and exited the room with a small trash bag that they placed inside the rolling trash can. Staff J knocked on R10's apartment door, opened R10's apartment door with their gloved hand, retrieved the small trash bag that they placed inside the rolling trash can. Staff J knocked on R11's apartment door, opened R11's apartment door with their gloved hand, retrieved the small trash bag that they placed inside the rolling trash can. At 9:30 AM, Staff J wore the same pair of disposable gloves and sat in a chair in the hallway to answer questions about hand hygiene. Staff J stated they were to wash their hands as often as possible which included when they entered a resident's apartment, after they helped resident with care and after they doffed their gloves. Staff J stated there was hand sanitizer in common areas in the facility they were able to use. At 9:38 AM, Staff J doffed their gloves, without performing hand hygiene or using hand sanitizer they were observed to knock on R12's apartment door and exited with a small bag of trash that they placed inside the rolling trash can.

In an interview on 01/16/2026 at 9:49 AM, Staff B, Health Care Coordinator, stated hand hygiene should be performed before entering a resident's apartment, before care facility staff were to wash their hands before they donned their gloves, if facility staff touched a resident and when facility staff doffed their gloves. Staff B acknowledged some facility staff members wore gloves in the hallways and that it was not the facility protocol to do so.

In an interview on 01/16/2026 at 1:33 PM, Staff A, Administrator, stated hand hygiene should be performed if a facility staff provided care to a resident, their hands were visibly soiled, and in between gloves changes.

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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3/5/26.

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

Laura Dodd
Administrator (or Representative)

2/5/26
Date

WAC 388-78A-2210 Medication services.

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

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

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

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

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the residents physician as required and monitor the resident after 3 of 3 residents (Resident 2, 3 and 4) refused

their medications and for 2 of 2 sampled residents (Resident 1 and 3) missed medications. These failures placed all residents at risk of medical complications and not getting medication as prescribed.

Findings included...

Record review of the facility's undated policy titled, "[Facility Name]," documented the facility physician notification policy related to missed or refused medications. The facility staff would notify the residents physician the same day the resident missed or refused their medication. The physician would be notified immediately when missed or refused medication was accompanied by any worsening of the condition for which the medication was prescribed. All missed or refused medications must be documented in the medical record which included the medication name, dose, scheduled time, reason for refusal and physician notifications and any new orders.

Record review of the facility's document titled, "Alert Status Flow Sheet," undated, documented vital signs (measurable indicators of the body's basic functions used to detect and monitor medical problems and assess physical functioning) were to be documented after four, eight and 24 hours. The flow sheet contained a table to document the date, time, temperature, pulse, respiration, oxygen, blood pressure, pain, and initials after one, two, and four hours. Facility staff were to notify the nurse immediately of adverse symptoms which included altered level of consciousness, increased pain, and fever.

R1

Record review of R1's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2021 and had a medical diagnosis of [REDACTED].

Record review of R1's document titled, "Long-Term Care Assessment and Care Plan," dated 06/23/2025, documented R1 had a stroke. R1 needed facility staff to reorder, keep all medication on the medication cart and provide R1 their medication at the correct time.

Record review of R1's, "Medication Administration Record," dated 11/01/2025 through 11/30/2025, documented R1 had an order for acetaminophen (medication used to treat mild to moderate pain), amoxicillin-pot clavulanate (medication used to treat bacterial infection), atorvastatin (medication used to help cholesterol), donepezil (medication used to treat confusion), gabapentin (medication used to prevent and control seizures), memantine (medication used to treat moderate to severe confusion), mirtazapine (medication used to treat depression) and R4 missed their medication on 11/24/2025 because R1 was away from the facility when the medication was supposed to be administered.

On 01/21/2026 at 11:50 AM, R1's flow sheet and notification to their medical doctor was requested for their missed medications on 11/24/2025. As of 01/21/2026 at 5:30 PM, R1's flow sheet and notification to their medical provider was not provided to review.

Record review of R1's, "Medication Administration Record," dated 12/01/2025 through

12/31/2025, documented R1 had an order for acetaminophen, adult low dose aspirin (medication that reduced fever and relieved pain), gabapentin, lisinopril-hydrochlorothiazide (medication used to treat high blood pressure), memantine, metoprolol succinate (medication used to treat chest pain, heart failure and high blood pressure) and R4 missed their medications on 12/10/2025 because R1 was away from the facility when the medication was supposed to be administered. R1 missed multiple of their medications on 12/30/2025 due to the orders were missing at the time the order was to be administered.

On 01/21/2026 at 11:50 AM, R1's flow sheets and notifications to their medical doctor was requested for their missed medications on 12/10/2025 and 12/30/2025. As of 01/21/2026 at 5:30 PM, R1's flow sheets and notifications to their medical provider was not provided to review.

R2

Record review of R2's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2019 with multiple medical diagnoses that included [REDACTED].

Record review of R2's document titled, "Long-Term Care Assessment and Care Plan," dated 02/01/2025, documented they take insulin injections daily for their uncontrolled diabetes type two hyperglycemia. The registered nurse would notify R2's primary care physician when they refuse part of their insulin doses.

Record review of R2's MAR, dated 11/01/2025 through 11/30/2025, documented they had order for Humalog mix (medicated injection to help lower blood sugars quickly and over a long period of time) insulin injection to administer 20 units every morning and 30 units every day before dinner. Review of the administrations documented that R3 refused their morning dose four times and their before dinner dose two times.

On 01/21/2026 at 9:41 AM, the facility was requested to send primary care physician notifications of R2 refusing their insulin on 11/08/2025, 11/13/2025, 11/17/2025, 11/19/2025, 11/23/2025 and 11/25/2025. As of 01/22/2026 at 5:30 PM, there was no documentation provided that R2's primary care physician was notified of the refusals.

Resident 3 (R3)

Record review of R3's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 with multiple medical diagnoses that included [REDACTED].

Review of R3's Medication Administration Record (MAR), dated 12/01/2025 through 12/31/2025, documented they had an order for Lidocaine (medicated patch that was applied to the skin to help with pain and discomfort) patch applied to skin daily. Review of the administration documented that R3 refused the patch application on 12/25/2025 through 12/31/2025. On 12/01/2025, 12/02/2025 and 12/10/2025 through 12/24/2025 R3's lidocaine was not available for administration.

Record review of R3's MAR, dated 01/01/2026 through 01/14/2026, documented they refused to have the lidocaine patch applied every day.

On 01/21/2026 at 9:41 AM, the facility was requested to send all R3's physician notifications of their lidocaine patch not being available and it being refused by R3 for December 2025 and January 2026.

As of 01/22/2026 at 5:30 PM, the facility was unable to provide any documentation that R3's physician was notified that they were refusing the lidocaine patch application.

R4 Record review of R4's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 and had a medical diagnosis of [REDACTED].

Record review of R4's document titled, "Long-Term Care Assessment and Care Plan," dated 09/08/2025, documented R4 had a stroke in 2016. R4's medications were kept inside of the medication cart, provided to R4 at the correct times and facility staff reordered R4's medications.

Record review of R4's, "Medication Administration Record," dated 11/01/2025 through 11/30/2025, documented R4 had an order for Refresh Celluvisc one % ophthalmic (eye) dropperette gel (eye drops that provided relief for moderate to severe dry, burning and irritated eyes). R4 refused their eye drops 11/24/2025 through 11/26/2025, R4 missed their eye drops on 11/27/2025 and R4 refused their eye drops 11/28/2025 through 11/30/2025.

Record review of R4's document titled, "Chart Notes for [R4]," dated 11/23/2025, Staff G, Caregiver, documented they spoke with R4's power of attorney regarding R4's eye drops running out, R4's eye drops were shipped to R4's power of attorney's house instead of the facility, and R4's power of attorney requested once the eye drops ran out to chart it as R4 refused their medication.

On 01/21/2026 at 11:50 AM, R4's flow sheet and notification to their medical doctor was requested for their missed eye drops on 11/24/2025 through 11/30/2025. As of 01/21/2026 at 5:30 PM, R4's flow sheet and notification to their medical provider was not provided to review.

Record review of R4's, "Medication Administration Record," dated 12/01/2025 through 12/31/2025, documented R4 had an order for CoQ10 300 MG (milligram) PO (by mouth) Soft gel (medication used to support heart health) and missed their medication 12/06/2025 through 12/11/2025.

On 01/21/2026 at 11:50 AM, R4's flow sheet, notification to their medical doctor and documentation to show the facility attempted to reorder R4's CoQ10 300 MG PO Soft gel medication 12/06/2025 through 12/11/2025. As of 01/21/2026 at 5:30 PM, R4's flow sheet, notification to their medical doctor and documentation to show the facility attempted to reorder R4's medication was not provided to review.

On 01/16/2026 at 9:49 AM, Staff B, Health Care Coordinator, stated the day shift and night shift medication technicians had two different systems of how they reordered resident's medications. Staff B stated the day shift medication technicians filled out individual refill request forms that they placed in a file folder. Staff B stated once the medication was obtained, they shredded the communication with the resident's medical

providers at the end of the month. Staff B stated the night shift medication technicians had a running list of when they ordered residents medications. Staff B stated they had to follow up with Staff A, Administrator regarding the facility process on how the medication technicians were supposed to reorder resident's medications. Staff B stated if a resident missed or refused a medication the facility staff were informed verbally. Staff B stated the facility staff did not document when they monitored the resident. If a resident had adverse signs or symptoms, they were to report concerns to Staff A, Staff B, or the facility nurse. Staff B stated if a resident missed or refused a medication communication with the resident's medical provider were kept in a folder and they thought were filed into the resident's hard medical chart.

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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3/5/26.

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

Laura Dodd
Administrator (or Representative)

2/5/26
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:
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
 - (a) Exclusively for the individual resident; or

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

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document, in the resident's Negotiated Service Agreements (NSA), the plan to provide necessary health support services from outside providers, the plan to provide intermittent nursing services, the alternative plan for providing services for 4 of 7 residents (Resident 1, 4, 5 and 6). These failures placed the residents at risk for unmet care needs and care and services not being provided per the NSA.

Findings included...

Record review of the facility's policy titled, "Care Plan and Assessment Policy," undated, documented the Washington Administrative Code 388-76-10355 outlined the requirements for the negotiated care plans that were regulation for adult family homes and not for assisted living facility. The plans must include a list of care and services to be provided, when and how the care and services would be provided, how medications would be managed, other preferences and choices about issues important to the residents such as food and daily routine and a new care plan would be completed with any change of condition.

R1

Record review of R1's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2021 and had a medical diagnosis of [REDACTED].

Record review of R1's document titled, "Long-Term Care Assessment and Care Plan [facility's version of the NSA]," dated 06/23/2025, documented the facility would do R1's laundry and housekeeping weekly but did not incorporate the days the services would be provided.

Record review on 01/15/2026 at 2:30 PM, of R1's hard medical chart showed there was no documentation or addendums to the service plan that indicated what days laundry and housekeeping services would be provided.

On 01/16/2026 at 9:49 AM, Staff B, Health Care Coordinator, stated updates to resident care plans were added on a separate paper and the addendum was placed on top of the resident's care plan in their hard medical chart.

R4

Record review of R4's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 and had a medical diagnosis of [REDACTED].

[REDACTED]

Record review of R4's document titled, "Chart Notes for [R4]," dated 11/23/2025, Staff G, Caregiver, documented they spoke with R4's power of attorney regarding R4's eye drops running out, R4's eye drops were shipped to R4's power of attorney's house instead of the facility, and R4's power of attorney requested once the eye drops ran out to chart it as R4 refused their medication.

Record review of R4's document titled, "Chart Notes for [R4]," dated 01/08/2026, documented home health nursing completed their admission for R4 to be seen by a registered nurse once a week and within the next ten days physical therapy would be out to see R4.

Record review of R4's document titled, "Long-Term Care Assessment and Care Plan," dated 09/08/2025, documented the facility would do R4's laundry and housekeeping weekly but did not incorporate the days the services would be provided. The NSA documented R4's power of attorney lived out of state. The NSA documented the facility kept all R4's medications in the medication cart, gave them to R4 at the correct times, and reordered their medications. The NSA had conflicting information as R4's power of attorney reordered R4's medications. The NSA did not incorporate a backup plan as to who was responsible to order medications if R4's power of attorney was unable. The NSA did not incorporate that R4 received home health services.

On 01/16/2026 at 9:49 AM, Staff B, stated if R4's power of attorney were unable to bring R4 their medication then another one of R4's family members who were local would. Staff B stated the backup plan was not incorporated into R4's NSA. Staff B stated if a resident was on home health services, it would be incorporated into their care plan.

Record review on 01/15/2026 at 2:30 PM, of R4's hard medical chart showed there was no documentation or addendums to the service plan that indicated a backup plan if R4's power of attorney was unable to bring R4's medications. There was no documentation or addendums that R4 received home health services on 01/08/2026. There was no documentation or addendums that indicated what days laundry and housekeeping services would be provided.

Record review on 01/15/2026 at 2:30 PM, of R4's hard medical chart showed there was no documentation or addendums to the service plan that indicated what days laundry and housekeeping services would be provided.

R6

Record review of R6's document titled, "Personal Information," undated, documented they moved into the facility on [REDACTED]/2025 and had a medical diagnosis of [REDACTED].

Record review of R6's document titled, "Long-Term Care Assessment and Care Plan," dated 07/04/2025, documented the facility would do R6's laundry and housekeeping weekly but did not incorporate the days the services would be provided.

Record review on 01/15/2026 at 2:30 PM, of R6's hard medical chart showed there was no documentation or addendums to the service plan that indicated what days laundry

and housekeeping services would be provided.

R5

Record review of R5's document titled, "Personal Information," undated, documented they moved into the facility [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED].

Record review of R5's chart note, dated 11/03/2025 at 3:39 AM, documented they were wandering in their room with nothing on except for socks and slippers with their apartment door open. R5 was assisted to the bathroom where there was small bloodstain on their bathroom counter and on a paper towel that was in the trash can. R5 had three separate pairs of pants that were soaked in urine in their laundry basket.

Record review of R5's chart note, dated 11/06/2025 at 9:22 AM, documented they had a bout of urinary incontinence and required assistance to be changed.

Record review of R5's chart note, dated 11/09/2025 at 12:30 PM, documented from 12:05 AM through 12:25 AM, R5 dry heaved phlegm and small bits of food. There was no documentation about R5's condition on 12/10/2025.

Record review of R5's chart note, dated 11/11/2025 at 10:42 AM, documented they had a cough and choking fit at breakfast that resulted in R5 vomiting for a few minutes.

Record review of R5's chart noted, dated 11/23/2025 at 11:58 AM, documented they had difficulties that morning and was unable to hold their bladder when they stood up and exclaimed in pain while they urinated into the toilet.

Record review of R5's chart note, dated 11/24/2026 at 5:06 AM, documented they had wet themselves and required staff to assist them with changing their incontinence pad and get new clothes. R5 called the facility staff ten minutes later, telling them that they needed help to get changed and did not remember that they were just helped with getting changed.

Record review of R5's chart note, dated 12/06/2024 at 5:40 AM, documented at 5:10 AM, R5 requested staff to change the incontinence pad on their chair. Shortly after R5 came down to the dining room, sat at a dining room table, turned their cups right-side up and poured several sugar packets into one cup. R5 told the caregiver that they were waiting for breakfast and were unaware of the time.

Record review of R5's chart note, dated 12/07/2025 at 7:30 AM, documented they were more confused and they felt lost. R5 required assistance with changing their clothes. At 12:28 PM, R5 was documented that they vomited and was attempting to spit up phlegm and stomach bile built up in their throat.

Record review of R5's chart note, dated 12/08/2025 at 7:30 AM, documented they came down to the dining room at 1:45 AM and refused any assistance. R5 went to the dining room and sat down at the dining room table when they turned their cups right-side up and poured several sugar packets into one cup and then left.

Record review of R5's document titled, "Long-Term Care Assessment and Care Plan," dated 05/28/2025, documented they were alert and oriented to person, place, and time

with some confusion noted time to time. R5 was independent with making their needs known, independent with dressing and if needed assistance to inform the nurse, independent with toileting and use pads daily for urinary incontinence, needs reminders of mealtimes and staff complete their laundry weekly. There was no documentation that R5 wandered or had a history of wandering or being disoriented and needing more hands-on assistance from staff with their personal care services.

Record review on 01/15/2026 at 2:28 PM, of R5's hard medical chart showed there was no documentation or care plan addendums for the documented changes in R5's increased need in care and services for dates 11/03/2025 through 12/08/2025.

On 01/16/2026 at 11:49 AM, Staff L, Caregiver, stated R5 needed staff assistance from getting to and from places, help with getting dressed and routine checks to ensure R5 was not wet with urine. Staff woke up R5 in the morning and assisted them with getting ready. Staff L stated R5 has been wandering more and required closure supervision from staff and at times redirection.

On 01/16/2026 at 12:34 PM, Staff B, Health Care Coordinator, stated once a week staff would assist R5 with a shower or a sponge bath that R5 does not like. R5 was capable of independently calling for staff assistance as they needed assistance. Staff would wake up R5 and set out their clothes each morning. R5 dressed themselves independently and at times R5 would need assistance with the elevator.

On 01/16/2026 at 1:29 PM, Staff A, Administrator, stated the facility nurse was the person responsible to update resident care plans and add addendums to them when needed.

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, ST ANDREWS PLACE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3/5/26.

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

Laura Dodd
Administrator (or Representative)

2/5/26
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

ST. ANDREWS RETIREMENT COMMUNITY
ST ANDREWS PLACE ASSISTED LIVING
520 EAST PARK AVE
PORT ANGELES, WA 98362

RE: ST ANDREWS PLACE ASSISTED LIVING # 1195

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 01/28/2026 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

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 Return the Plan/Attestation Statement and report with signatures to:

Clinton Fridley, Community Nurse Field Manager
Residential Care Services
Region 3, Unit E
Preferred methods:

eFax: (360) 992-7969

Email: rcsregion3email@dshs.wa.gov

Optional method:

800 NE 136th Ave Ste 200

Vancouver, WA 98684

- Complete correction(s) within 45 calendar days of Last Date of Data Collection (01/28/2026), no later than 03/14/2026 or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

- (1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

Based on observation and interview, the facility failed to ensure milk served to residents was below 41 degrees Fahrenheit. The facility had identified the concern and implemented a system to ensure that milk being served remained below the required temperature.

WAC 388-78A-2260 Storing, securing, and accounting for medications.

- (1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

Based on observation, interview and record review, facility failed to ensure 2 of 7 residents observed had all vitamins secured by the facility. Both residents denied using the medication and the facility removed and secured the medication upon notification and implemented a system to ensure residents medications remain secured by the facility.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

- (2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

Based on interview and record review, the facility failed to ensure two caregivers had updated Washington state (WA) food workers cards. The facility had the two staff complete the course and implemented a system to ensure that all staff have updated WA state food worker cards.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and
- (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

Based on observation and interview, the facility failed to ensure the outside and inside resident living quarters were clean, safe and sanitary. The facility had identified the concerns and had them cleaned and garbage removed with a system implemented to ensure the facility inside and outside resident living quarter areas remain safe, clean, and sanitary.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

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 You can make an IDR request and find directions on the IDR web page at:
<https://www.dshs.wa.gov/altsa/idr>

If You Have Any Questions:

- Please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E

ST ANDREWS PLACE ASSISTED LIVING # 1195

01/28/2026

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Residential Care Services

Enclosure