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

Victoria Aid Opco LLC
Victoria Place
491 Discovery Rd
Port Townsend, WA 98368

RE: Victoria Place License # 2185

Dear Administrator:

This letter addresses Compliance Determination(s) 60204 (Completion Date 05/29/2025) and 57934 (Completion Date 04/22/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/29/2025 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-2320-2, WAC 388-78A-2320-2-b, WAC 388-78A-2320-3, WAC 388-78A-2320-3-b, WAC 388-78A-2320-3-c, WAC 388-78A-2320-3-d, WAC 388-78A-2320-3-e, WAC 388-78A-2474-1, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-b, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2474-2, WAC 388-78A-2474-4, WAC 388-78A-2474-5, WAC 388-78A-2474-6

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

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

Sincerely,

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

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

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

The department completed data collection for an unannounced on-site follow-up on 04/14/2025 of:
Victoria Place
491 Discovery Rd
Port Townsend, WA 98368

This document references the following SOD dated: 04/22/2025

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:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Residential Care Services _____ Date _____

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

Administrator (or Representative) _____ Date _____

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

(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;

(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:

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure nurse delegation was completed and documented for 3 of 3 sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]) reviewed. This failure resulted in residents receiving medication services from unqualified staff, and placed delegated residents at risk for unmet medical care 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. ASSESS (4) Determine the task to be delegated is within the delegating nurse's area of

responsibility. (5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient. (6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care. (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. PLAN (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; IMPLEMENT (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. EVALUATE (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide..."

Record review of the "Department of Social And Health Services" document, Completion date 02/21/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2320] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 03/10/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 03/31/2025."

Record review of the Department of Social and Health Services document titled, “Community Nurse Delegation Orientation 2025”, undated, showed a registered nurse (RN) must teach and supervise the nursing assistant, as well as provide ongoing nursing assessment of the patient’s condition. RN’s responsibilities tasks include teach the long-term care worker (LTCW) the nursing task, evaluate the performance of the long-term care worker, and provide ongoing supervision and evaluation of the long-term care workers performance of the nursing task. Medication administration was when the client was not functionally able and or not cognitively aware they were receiving medications. The LTCW was authorized to do so with delegation of the medication. The LTCW must be delegated for each task. All forms must be left where the client resides for complaint with the facility and rules. Documentation must be client specific. The RN delegator must verify that the medication technicians had the required certificates and credentials prior to being delegated to administer RN delegated tasks for the residents.

Record review of the facility’s Plan of Corrections, dated 03/10/2025, under section titled, “WAC 388-78A Intermittent Nursing Services”, showed delegation services would be reviewed routinely to maintain compliance with regulations by a nurse consulting services until the community could employ a full-time resident care director. If the facility received verbal consent that was obtained for delegation process, written consent would be obtained within 30 days.

R1

Record review of the facility’s document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R1 moved into the facility on [redacted]/2022. The roster showed R1 had nurse delegation services and diagnosis of [redacted]

Record review of R1’s Service Agreement (facility’s version of the negotiated service agreement), dated 04/01/2025, showed R1 had confusion and dementia. Under the section titled, “medication management”, showed R1’s cognition varied. R1 at times was aware that they took medications, but other times R1 could not. R1 required RN delegation services.

Record review on 04/14/2025 at 1:30 PM, review of the two RN delegation binders provided for review, showed there was no RN delegation documentation for R1 in the binder for review.

R2

Record review of the facility’s document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R2 moved into the facility on [redacted]/2021. The roster showed R2 was on nurse delegated services and had diagnosis of [redacted].

Record review R2’s Service Agreement, dated 04/18/2025, showed R2 had a diagnosis of [redacted]. Under the section titled, “medication

management", dated 02/21/2025, showed R2 required RN delegation for all medications and treatments.

Record review of R2's RN Assessment for Delegation, dated 02/12/2025, showed R2 was forgetful and had impaired judgement.

Record review of R2's Nurse Delegation Nursing Visit, dated 02/12/2025, showed R2 required nurse delegation for all oral medication administration.

Record review of R2's Nurse Delegation: Consent for Delegation Process, dated 12/23/2024, showed it was electronically signed by Staff D, Former RN Delegator. Under the section titled, "consent for the Delegation Process", showed there was not client or authorized representative signature, date, or verbal consent obtained, documented for review. The section showed if verbal consent was obtained, written consent was required within 30 days of verbal consent.

R3

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R3 moved into the facility on [redacted]/2025. The roster showed R3 was on nurse delegated services and had diagnosis of [redacted].

Record review R3's Service Agreement, dated 04/18/2025, showed R3 had dementia. Under the section titled, "medication management", dated 02/21/2025, showed R3 required RN delegation services for all medications and treatment services. R3 had cognitive deficit related to their dementia. R3 tended to be more confused in the morning.

Record review of R3's RN Assessment for Delegation, dated 02/24/2025, showed R3 had impaired judgement and was forgetful.

Record review of R3 Nurse Delegation: Nursing Visit, dated 02/24/2025, showed R3 required nurse delegation for their oral medication administration related to R3's cognitive limitations.

Record review of R3's Nurse Delegation: Consent for Delegation Process, dated 02/12/2025, under the section titled, "consent for the delegation process", showed there was verbal consent obtained from R3's power of attorney on 02/12/2025. The section showed "if verbal consent is obtained, written consent is required within 30 days of verbal consent". There was no written signature consent on the form for review from R3's power of attorney.

In an interview on 04/14/2025 at 1:33 PM, Staff B, Vibrant Life Director, stated R1 had declined and required their crushed medications to be spoon feed to them. Staff B stated R1 was unable to spoon feed themselves their medications related to their decline in condition and remained on hospice services.

In an interview on 04/14/2025 at 2:00 PM, Staff F, Resident Care Coordinator, stated they assumed the facility or Staff E, Registered Nurse Delegator, would get the residents RN delegation consent forms signed. Staff F stated they would need to contact Staff E to find out exactly who was responsible to get the RN delegation consent forms

signed.

In an interview on 04/16/2025 at 10:54 AM, Staff E stated they always got the verbal consent from the residents representatives. Staff E stated they would leave the residents RN delegation consent forms at the facility and the facility would be responsible to get the consent form signed within 30 days of the verbal consent. Staff E stated they were unaware that R1 required the medication technicians to be spoon feeding their medications and was declining in condition. Staff E acknowledged that R1 required RN delegation services but had not been on delegated services by themself.

This is an uncorrected and recurring deficiency previously cited on 02/21/2025 and 01/02/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

(a) Orientation and safety;

(b) Basic;

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

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this

section, obtain the home-care aide certification.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under chapter 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009 .

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 1 sampled staff (Staff C) had the dementia (a group of brain conditions that cause a decline in thinking, memory, and reasoning) specialty training certificate and had their home care aid certification as required. These failures resulted in residents being cared for by staff without required trainings and placed 25 of 25 residents at risk of harm in the event of an emergency due to staff not being trained on life saving measures, unaware of the facility's expectations, and risk of unmet care needs by untrained staff.

Findings included…

Washington Administrative Code (WAC) 388-112A-0400 "(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450. (b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement. (c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (b) Dementia specialty training as described in WAC 388-112A-0440; (4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (b) Dementia specialty training as described in WAC 388-112A-0440; and (5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire. (6) For long-term care workers who have completed the 75-hour training and do not have a specialty training certificate that indicates

completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs."

WAC 388-112A-0490 "What are the specialty training requirements for applicants, resident managers, administrators, and other types of entity representatives in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities. (3) If an assisted living facility serves one or more residents with special needs, the assisted living facility administrator or designee must complete specialty training and demonstrate competency within one hundred twenty days of date of hire. (4) If a resident develops special needs while living in an assisted living facility, the assisted living facility administrator or designee has one hundred twenty days to complete specialty training and demonstrate competency, or demonstrate proof of specialty training."

WAC 388-112A-0300 "(1) The 70-hour home care aide basic training is in addition to orientation and safety training. It is 70 hours and includes: (a) The core competencies and skills that long-term care workers need in order to provide personal care services effectively and safely; (b) Practice and demonstration of skills; and (c) Population specific competencies. (2) DSHS must approve the 70-hour home care aide basic training curricula. (3) On-the-job training may be applied to the core competencies of 70-hour home care aide basic training for an amount that must be approved by the department. (4) The DSHS developed fundamentals of caregiving (FOC) or another department approved training may be used to teach the core competencies of the 70-hour home care aide basic training but the FOC must include enhancements. Additional student materials are required to ensure the enhancements are well planned and documented for students. Materials must be submitted for approval and approved per WAC 388-112A-1020. Examples of enhancements include, but are not limited to: (a) More time for workers to practice skills including: (i) The mechanics of completing the skill correctly; (ii) Resident centered communication and problem solving associated with performing the skill; (iii) The different levels of care required for each skill including independent, supervision, limited, extensive, and total; (iv) Working with assistive devices associated with a skill; (v) Helpful tips or best practices in working through common resident challenges associated with a skill; and (vi) Disease specific concerns or challenges associated with a skill. (b) Augmenting or adding additional materials, student activities, videos, or guest speakers that: (i) More deeply reinforce and fortify the learning outcomes required for basic training; (ii) Ensure each student integrates and retains the knowledge and skills needed to provide quality basic personal care; and (iii) Prepares workers for the certification testing environment and process. (c) Enhancements are not materials or activities that are one or more of the following: (i) Are out of the scope of practice for a long-term care worker such as content clearly written for registered nurses; (ii) Are identical to, or a direct replacement of, those already included in the FOC; (iii) Fail to reinforce Washington state laws associated with resident rights and resident directed care; (iv) Long-term care workers are not paid to provide; (v) Are written above a high school reading level. (5) The delivery mode of the 70-hour home care aide basic training may be either in-person or virtual classroom instruction, or a hybrid of online and in-person, remote, or virtual classroom instruction. One hour of completed classroom instruction or other form of training (such as a virtual classroom, remote or online course) equals one hour of training. (a) Online and virtual classroom modules must be interactive, provide the student with access to the instructor, and adhere to the DSHS online and virtual classroom standards posted on DSHS's website at https://bit.ly/dshs-online-standards. (b) The in-person skills training or

remote skills training portion of hybrid modules must be no less than 16 hours of the total basic training hours and include in-person or remote instruction on the personal care tasks supporting activities of daily living, as described in WAC 388-112A-0320. (6) The long-term care worker must be able to ask the instructor questions during the training. (7) There is no challenge test for the 70-hour home care aide basic training."
WAC 388-112A-0105 "Who is required to obtain home care aide certification and by when? (1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (2) The following individuals must obtain home care aide certification as follows… (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire."

WAC 388-112A-0080 "Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090… Assisted living facilities. (4) Assisted living facility administrators or their designees within one hundred twenty days of date of hire. (5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training."

Record review of the "Department of Social And Health Services" document, Completion date 02/21/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2474] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 03/10/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 03/31/2025."

Record review of the facility's Plan of Corrections, dated 03/10/2025, under the section titled, "WAC 388-78A-2474 Training and Home Care Aide Certification requirements", showed a training tracker of state specific requirements would be reviewed monthly to ensure care staff remain in compliance with requirements. Upon hire, staff would complete in-house training from employee handbooks, job description and job orientation.

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed 22 of 25 residents were marked to have either dementia (a group of brain conditions that cause a decline in thinking, memory, and reasoning) /Alzheimer's (a progressive brain disorder that gradually destroys memory and thinking skills)/cognitive impairments.

Record review of, "[Facility Name] Staff", undated document showed Staff C, Care Manager, was hired at the facility on 12/08/2023.
Dementia Specialty Training

On 04/15/2025 at 11:31 AM, Staff C's dementia specialty training certificates were requested. At 1:30 PM Staff C's dementia specialty training certificate was not provided .

Home Care Certificate

Record review of State of Washington Department of Health Credential Verification, dated 04/14/2025, showed Staff C's nursing assistance registration was pending.
On 04/15/2025 at 12:39 AM, Staff C's 70 hour basic training certificate and Washington state Department of Health Credentials were requested for review. At 1:30 PM, Staff C's 70 hour basic training certificate and Washington state Department of Health Credentials were not provided.

In an interview on 04/14/2025 at 1:51 PM, Staff A, Senior Executive Director, stated Staff C was in the middle of completing the 70 hour basic training course. Staff A stated Staff C was to have the course completed in March 2025. Staff A stated Staff C was unable to complete the dementia specialty course until they had completed the 70 hour basic training course. Staff A acknowledged that Staff C was to completed both of the course within 120 days of employment.

This is an uncorrected and recurring deficiency previously cited on 02/21/2025 and 01/02/2025 for subsection (1)(2)(a)(b)(c)(d)(4).

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

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

The department completed data collection for an unannounced on-site follow-up on 02/18/2025 of:
Victoria Place
491 Discovery Rd
Port Townsend, WA 98368

This document references the following SOD dated: 02/21/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 26 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Residential Care Services _____ Date _____

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

Administrator (or Representative) _____ Date _____

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

(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;

(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:

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain and provide current nurse delegation documents for 3 of 3 sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 4 [R4]) reviewed. This failure resulted in residents receiving medication services from unqualified staff, and placed delegated residents at risk for unmet medical care 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. ASSESS (4) Determine the task to be delegated is within the delegating nurse's area of

responsibility. (5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient. (6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care. (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. PLAN (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; IMPLEMENT (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. EVALUATE (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide..."

Record review of the "Department of Social And Health Services" document, Completion date 01/02/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2320] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/31/2025."

Record review of the Department of Social and Health Services document titled, “Community Nurse Delegation Orientation 2025”, undated, showed a registered nurse (RN) must teach and supervise the nursing assistant, as well as provide ongoing nursing assessment of the patient’s condition. RN’s responsibilities tasks include teach the long-term care worker (LTCW) the nursing task, evaluate the performance of the long-term care worker, and provide ongoing supervision and evaluation of the long-term care workers performance of the nursing task. Medication administration was when the client was not functionally able and or not cognitively aware they were receiving medications. The LTCW was authorized to do so with delegation of the medication. The LTCW must be delegated for each task. All forms must be left where the client resides for complaint with the facility and rules. Documentation must be client specific. The RN delegator must verify that the medication technicians had the required certificates and credentials prior to being delegated to administer RN delegated tasks for the residents.

Record review of the facility’s untitled and undated document titled “February”, dated 02/02/2025 through 02/08/2025, showed a schedule of the caregivers and medication technicians for the facility. On 02/02/2025 showed Staff G, Agency Medication Technician, from 10:00 PM until 6:00 AM, they were the medication technician. On 02/05/2025 through 02/07/2025 for times 6:00 AM until 2:00 PM, Staff O, Vibrant Life Director, was the scheduled medication technician for the facility. On 02/06/2025 and 02/07/2025 for times 2:00 PM until 6:00 AM, Staff G was the scheduled medication technician for the facility. On 02/08/2025 for times 2:00 PM until 10:00 PM, Staff E, Agency Medication Technician, was the medication technician for the facility, and for times 10:00 PM until 6:00 AM, Staff G was the scheduled medication technician.

Record review of the facility’s untitled and undated document titled “February”, dated 02/09/2025 through 02/15/2025, showed a schedule of the caregivers and medication technicians for the facility. On 02/09/2025 for times 2:00 PM until 10:00 PM, Staff N, Medication Technician, was the scheduled medication technician and for times 10:00 PM until 6:00 AM, Staff G was the scheduled medication technician. On 02/12/2025 for times 6:00 AM until 10:00 PM, Staff N was the scheduled medication technician. On 12/13/2025 for times 6:00 AM until 2:00 PM, Staff N was the scheduled medication technician and for times 2:00 PM until 6:00 AM Staff G was the scheduled medication technician. On 02/14/2025 and 02/15/2025 for times 2:00 Pm until 6:00 AM, Staff G was the scheduled medication technician and for times 6:00 AM until 2:00 PM, Staff O was the scheduled medication technician.

Record review of the facility’s untitled and undated document titled “February”, dated 02/16/2025 through 02/22/2025, was a schedule of the caregivers and medication technicians for the facility. On 02/16/2025 for times 2:00 PM until 6:00 AM Staff G was the scheduled medication technician. On 02/17/2025 and 02/18/2025 Staff O was the scheduled medication technician for the times 6:00 AM until 2:00 PM. On 02/18/2025 for times 2:00 PM until 10:00 PM, Staff N was the scheduled medication technician. It was noted on 02/19/2025 through 02/22/2025, Staff N and Staff G were scheduled to work as the facility’s medication technician.

R1

Record review of the facility’s document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R1 moved into the facility on [redacted]/2024. The roster showed R1 had nurse delegation services and

diagnosis of [redacted].

Record review of R1's Service Agreement (facility's version of the negotiated service agreement), dated 01/16/2025, showed R1 required nurse delegation related to their dementia. R1 was not always aware that they took medication and required RN delegation.

Record review of R1's Nurse Delegation: Consent for Delegation Process, dated 12/23/2024, showed it was not signed by the resident or the resident's representative either written or verbally. The consent form was only signed and dated by Staff H, Registered Nurse Delegator. The consent form showed under the section titled, "consent for delegation process", showed "if verbal consent is obtained, written consent is required within 30 days of verbal consent."

Record review of R1's Nurse Delegation: Nursing Visit document, dated 12/23/2024, showed R1 required nurse delegation for tasks routine and PRN (as needed) medication administration: topical, nasal spray, and inhalers related to R1's cognitive limitations. Review of the documentation showed Staff N, Agency Medication Technician, Staff G, Agency Medication Technician, Staff O and Staff E, Agency Medication Technician, were not listed, that they had been trained to administer R1's nurse delegated tasks.

Record review of R1's Comprehensive Nursing Assessment, dated 12/23/2024, showed R1 had impaired judgement, confusion, and was forgetful.

Record review of R1's Medication Administration Record (MAR), dated 02/01/2025 through 02/18/2025, showed R1 had an order for ipratropium nasal spray (prescribed medication nasal spray that helps dry out the glands in your nose), used one spray in each nostril two times daily. Review of the administrations showed agency medication technician administered R1's nasal spray at 8:00 PM on 02/08/2025 and 02/09/2025. Staff G administered R1' their nasal spray at 8:00 PM six of 17 administrations. Staff O administered R1's nasal spray at 8:00 AM on 02/17/2025, and Staff N administered R1's nasal spray medication at 8:00 AM on 02/12/2025 and 02/13/2025.

R2

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [redacted] 2022. The roster showed R2 was on nurse delegated services and had diagnosis of [redacted].
Record review R2's Service Agreement, dated 01/16/2025, showed R4 had multiple medical diagnoses that included [redacted] and [redacted]. Under the section titled, "nurse delegation required", showed R2's condition could vary at times if they were aware they took medication and could request as needed medication and at times they could not. R4 had functional deficit that required their medications crushed and given by spoon related to their tremors. R4 required RN delegation.

Record review R2's Nurse Delegation: Consent for Delegation Process, dated 12/23/2024, showed it was only signed and dated by Staff H. There was no signature from R2 or R2's responsible party. The consent form showed under the section titled, "consent for delegation process", showed "if verbal consent is obtained, written consent

is required within 30 days of verbal consent."

Record review of R2's Nurse Delegation: Nursing Visit document, dated 12/23/2024, showed R2 required nurse delegation for tasks routine and PRN (as needed) medication administration: crushed oral, nasal spray, topicals related to cognitive limitations. Review of the documentation showed Staff N, Staff G, Staff O and Staff E were not listed, that they had been trained to administer R2's nurse delegated tasks.

Record review of R2's Comprehensive Nursing Assessment, dated 12/23/2024, showed R2 had impaired judgement, confusion, and was forgetful.

Record review of R2's MAR, dated 02/01/2025 through 02/18/2025, showed R2's medication was administered by Staff N, two of 18 days. Staff G administered R2's medication six of 18 days. Staff O administered R2's medications two of 18 days, and Staff E administered R2's medications two of 18 days.

R4

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R4 moved into the facility on [redacted]/2024. The roster showed R4 was on nurse delegated services and had diagnosis of [redacted].

Record review of R4's Service Agreement, dated 01/20/2025, showed R4 had multiple medical diagnoses that included [redacted]. R4 required RN delegation for all medications and treatments. Under the section titled, "orientation occasional reminders Assisted Living", showed R4 had dementia and needed reminders.

Record review R4's Nurse Delegation: Consent for Delegation Process, dated 12/23/2024, showed it was only signed and dated by Staff H. There was no signature from R4 or R4's responsible party. The consent form showed under the section titled, "consent for delegation process", showed "if verbal consent is obtained, written consent is required within 30 days of verbal consent."

Record review of R4's Nurse Delegation: Nursing Visit document, dated 12/23/2024, showed R4 required nurse delegation for tasks routine and PRN (as needed) medication administration: sublingual (under the tongue) and topical medications related to cognitive limitations. Review of the documentation showed Staff N, Staff G, Staff O and Staff E were not listed, that they had been trained to administer R4's nurse delegated tasks.

Record review of R4's Comprehensive Nursing Assessment, dated 12/23/2024, showed R2 had impaired judgement, confusion, and was forgetful.

Record review of R4's MAR, dated 02/01/2025 through 02/18/2025, showed R4's medication was administered by Staff N, two of 18 days. Staff G administered R4's medication six of 18 days with two days that R4 refused the medication. Staff O administered R4's medications two of 18 days that R4 had refused to have applied, and Staff E administered R4's medications two of 18 days.

In an interview on 02/18/2025 at 1:30 PM, Staff I, Resident Care Coordinator, stated R4 had a severe cognitive deficit and was going to be moving to a locked memory care

facility for better placement.

In an interview on 02/18/2025 at 4:10 PM, Staff B, Licensed Practical Nurse Regional Clinical Specialist, stated the facility had a new RN delegator that started at the facility on Wednesday 02/12/2025 and came out again on Saturday 02/15/2025. Staff B stated the new RN delegation was very thorough and would reach out to them to locate the updated resident RN delegation documents for review.

In an interview and observation on 02/18/2025 at 4:40 PM, Staff B came into the library and looked at the RN delegation binder that was black. Staff B clarified that the black RN delegation binder was the only binder provided to review. Staff B looked through the binder and acknowledged that the new RN delegation documentation was not in the binder. Staff B stated the facility was currently looking for the new binder as the new RN delegator stated they made a new binder and left it at the facility on Saturday 02/15/2025.

In an interview and observation on 02/18/2025 at 4:43 PM, R4 scrunched their face, shook their head side to side, when they were asked if the facility gave them medications. R4 stated they did not take medications. Resident 5 stated the facility did provide R4 their medications every day.

In an interview on 02/19/2025 at 4:41 PM, Staff H stated they were the RN delegator for the facility until the facility's own RN took over the delegation oversight. Staff H stated on the nursing visit form showed they were only delegated for specific routes of medications. Staff H clarified that R4 was only delegated for sublingual and topical medications and not their oral medications as R4 were able to place them in their mouth despite their cognition deficit. Staff H acknowledged that depending on the time of the day when anyone talked with R4 they would know if they took medications. Staff H stated they check with the staff that work with the residents to know what their baseline was and that was how they decided what medications were delegated for the resident.

In an interview on 02/18/2025 at 5:33 PM, Staff B stated the facility was unable to locate the new RN delegators binder with the new documents for the department to review and were actively looking.

As of 02/18/2025 at 5:50 PM, the facility was unable to provide the updated RN delegation documentation for review.

This is an uncorrected deficiency previously cited on 01/02/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2470 Background check Employment-disqualifying information Disqualifying negative actions.

(1) The assisted living facility must not employ an administrator, caregiver, or staff person, to have unsupervised access to residents, as defined in RCW 43.43.830 , if the individual has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, unless the individual is eligible for an exception under WAC 388-113-0040 .

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 3 sampled staff (Staff D) with disqualifying negative background check results was not employed by the facility. This failure resulted in 26 of 26 residents being cared for by a staff member who had a disqualifying history.

Findings included…

Revised Code of Washington (RCW) 43.43.830 Background Checks- Access to children or Vulnerable persons- Definitions. “(13) "Unsupervised" means not in the presence of: (a) Another employee or volunteer from the same business or organization as the applicant; or (b) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the applicant has access during the course of his or her employment or involvement with the business or organization… (14) "Vulnerable adult" means "vulnerable adult" as defined in chapter 74.34 RCW, except that for the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, it shall also include adults of any age who lack the functional, mental, or physical ability to care for themselves.”

Washington Administrative Code (WAC) 388-113-0101
“(1) The requesting entity will receive a background check result. The background check result by itself does not include criminal history record information but identifies the source of any criminal or negative action records. The possible types of results are: …
(c) A "disqualify" letter, which means the applicant, or one or more data sources reported a background issue that automatically disqualifies the applicant from a

position that has unsupervised access to minors or vulnerable adults…"

WAC 388-113-0020 "(1) Individuals who must satisfy background checks requirements under chapters 388-71, 388-101, 388-106, 388-76, 388-78A, 388-97, 388-825, 388-115, and 388-107 WAC must not work in a position that may involve unsupervised access to minors or vulnerable adults if the individual has been convicted of or has a pending charge for any of the following crimes:
(a) Abandonment of a child;
(b) Abandonment of a dependent person;
(c) Abuse or neglect of a child;
(d) Arson 1;
(e) Assault 1;
(f) Assault 2 (less than five years);
(g) Assault 3 (less than five years);
(h) Assault 4/simple assault (less than three years);
(i) Assault 4 domestic violence felony:
(j) Assault of a child;
(k) Burglary 1;
(l) Child buying or selling;
(m) Child molestation;
(n) Coercion (less than five years);
(o) Commercial sexual abuse of a minor/patronizing a juvenile prostitute;
(p) Communication with a minor for immoral purposes;
(q) Controlled substance homicide;
(r) Criminal mistreatment;
(s) Custodial assault;
(t) Custodial interference;
(u) Custodial sexual misconduct;
(v) Dealing in depictions of minor engaged in sexually explicit conduct;
(w) Drive-by shooting;
(x) Drug crimes involving one or more of the following:
(i) Manufacturing or possession with the intent to manufacture a drug;
(ii) Delivery or possession with the intent to deliver a drug other than marijuana;
(iii) Delivery of marijuana (less than three years).
(y) Endangerment with a controlled substance;
(z) Extortion 1;
(aa) Extortion 2 (less than five years);
(bb) Forgery (less than five years);
(cc) Homicide by abuse, watercraft, vehicular homicide (negligent homicide);
(dd) Identity theft (less than five years);
(ee) Incendiary devices (possess, manufacture, dispose);
(ff) Incest;
(gg) Indecent exposure/public indecency (felony);
(hh) Indecent liberties;
(ii) Kidnapping;
(jj) Luring;
(kk) Malicious explosion 1;
(ll) Malicious explosion 2;
(mm) Malicious harassment;
(nn) Malicious placement of an explosive 1;
(oo) Malicious placement of an explosive 2 (less than five years);
(pp) Malicious placement of imitation device 1 (less than five years);..."

Record review of the “Department of Social And Health Services” document, Completion date 01/02/2025, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2470] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/31/2025.”

Record review of the facility document, “Plan of Corrections”, undated, showed for WAC 388 78A 2470 the executive director would screen all background checks for employment within the first two weeks of hire, pursuant of the Washington State regulations. Any employees with disqualifying information would be immediately removed from the schedule. This would be a continuing process, and dates of each background check would be tracked to ensure compliance.

Record review of the facility document, “Integral Senior Living Job Description”, dated 07/18/2022, showed the position of the Dining Services Director, included that they were responsible to meet all customer service to all residents, prospective residents and guests in all aspects of their dining experience. They were responsible to oversee the dining room and ensure that food was served in a friendly, courteous manner and with a helpful attitude. They were to perform a variety of duties in and around the dining room and reported to the Executive Director. Essential functions, duties, and responsibilities included to supervise service of meals to ensure maximum resident enjoyment of the dining experience and that services were delivered to residents. The Dining Service Director were to participate in formal and informal discussions to identify concerns and to confirm that recommended actions reinforced each resident's full potential. They were to actively participate in the resident orientation programs. They were to develop relationships with residents through conversation. They were to remain closely involved in resident transitions to the community during mealtimes to help ease anxiety and promote engagement. As needed, they were to personally serve meals to residents, family members, and visitors. They were to assist resident with menu selections if needed. The physical and mental requirements of the job included that they were to occasionally push wheelchairs, help residents walk, and help residents sit up.

Record review of an untitled and undated document showed Staff D, Director of Culinary Services, was hired at the facility on 01/06/2025.

Record review of Staff D’s Notification of background check result, completed 01/03/2025, showed it was Staff D’s interim fingerprint background check. Staff D had disqualifying information reported on one more background check data sources.

Record review of Staff D’s Notification of background check result, completed 02/05/2025, showed it was Staff D’s final fingerprint background check. “As of the date of the background data search, the applicant has: Disqualifying information* reported by one or more background check data sources. This means the applicant cannot have unsupervised access to children or vulnerable adults. If you allow the applicant to have

unsupervised access to children or vulnerable adults, you may be violating deferral or state regulations and your DSHS oversight program may take action against your license or contract. The applicants background check records are attached."

Record review of Staff D's state of Washington Department of Social and Health Services Background Check Central Unit Washington State Courts, dated 02/04/2025, showed Staff D had been guilty of a disqualifying crime as of 09/01/2024.

In an interview and observation on 02/18/2025 at 12:05 PM, Staff D had been observed inside of the kitchen. Staff D stated they had worked for the facility for approximately one month.

In an interview on 02/18/2025 at 3:00 PM, Staff D said when they were hired at the facility one month ago, Staff A, Senior Executive Director, informed them they had a disqualifying crime on their background check. Staff D said at times the residents would try and enter the kitchen. Staff D said at times the residents would knock on the kitchen door and ask them for snacks. Staff D said part of their job responsibilities included to attend monthly meetings to discuss residents feedback of the kitchen, food, and dining experience. Staff D said when they were hired at the facility, they were not informed they had to take special precautions or had any restrictions when they were around the residents.

In an interview on 02/18/2025 at 3:09 PM, Staff A stated the facility executive director was responsible to ensure all staff had their background checks completed and reviewed to ensure they were cleared to work. Staff A acknowledged that Staff D had a disqualifying crime on their Washington State Name and Date of Birth background check and was unable to be unsupervised around vulnerable adults. Staff A stated Staff D did not have unsupervised interactions with residents. Staff A acknowledged that the facility did not have a system in place to ensure that Staff D did not have unsupervised interactions with the residents at the facility. The Department requested a safety plan to ensure that Staff D did not have unsupervised interactions with the vulnerable adult residents.

This is an uncorrected deficiency previously cited on 01/02/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

(b) A national fingerprint background check.

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(c) Managers who do not provide direct care to residents; and

(d) Contractors other than the administrator and caregivers who may have unsupervised access to residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a Washington State name and Date of Birth background check completed for 2 of 2 contracted agency caregivers (Staff F and Staff G) prior to them working at the facility. This failure resulted in all 26 of 26 residents being cared for by staff members with unknown background check history.

Findings included…

Washington Administrative Code (WAC) 388-78A-2020 Definitions. “"Contractor" means an agency or person who contracts with a licensee to provide resident care, services, or equipment.”

Record review of the “Department of Social And Health Services” document, Completion date 01/02/2025, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2462] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/31/2025."

Record review of the facility document, "Plan of Corrections", undated, showed WAC 388 78A 2462 background checks were required for all current employees and obtained for all agency staff who worked in the community. Background checks for contracted agency workers would be available on site prior to the first shift worked in the community. All community staff would have background checks submitted within two weeks of hire and be available in a secured location in the community.

Staff F

In an interview on 02/21/2025 at 11:21 AM, Staff I, Resident Care Coordinator said Staff F's, Agency Medication Technician, first date worked at the facility was on 09/13/2024.

Record review of the facility's untitled and undated document titled "February", dated 02/02/2025 through 02/08/2025, showed a schedule of the caregivers and medication technicians for the facility. On 02/08/2025 from 2:00 PM until 6:00 AM, Staff F was scheduled to work.

As of 02/18/2025 at 5:50 PM, the facility was unable to provide a Washington State Name and Date of Birth background check for Staff F for review.

In an interview on 02/18/2025 at 5:33 PM, Staff A, stated the facility did not have a Washington State Name and Date of Birth background check for Staff F for the Department to review.

Staff G

Record review of an email sent to the Department on 02/20/2025 at 1:25 PM, showed Staff G's, Agency Medication Technician, first date worked at the facility was on 01/26/2025 as a facility caregiver.

Record review of the facility's untitled and undated document titled "February", dated 02/02/2025 through 02/08/2025, showed a schedule of the caregivers and medication technicians for the facility. On 02/02/2025 and 02/06/2025 through 02/08/2025 from 2:00 PM until 6:00 AM, Staff G was scheduled to work.

Record review of Staff G's Washington State Name and Date of Birth background check, dated 02/18/2025, showed it was completed after the Department requested it. The facility was unable to provide any Washington State Name and Date of Birth background results that were completed prior to Staff G's first day worked at the facility.

In an interview on 02/18/2025 at 3:09 PM, Staff A stated they were responsible to ensure that all employees and agency employees had their background check completed.

This is an uncorrected deficiency previously cited on 01/02/2025 for subsections 2462-(2)(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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

(a) Orientation and safety;

(b) Basic;

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

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under chapter 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009 .

This requirement was not met as evidenced by:

Based on interview and record review facility failed to ensure 2 of 2 sampled staff (Staff C and Staff D) had completed their facility orientation with all the required topics. The facility failed to ensure 1 of 2 sampled staff (Staff C) had the required Department of Social and Health Services (DSHS) five hour orientation and safety training. The facility failed to ensure 1 of 2 sampled staff (Staff E) had the required CPR (cardiopulmonary resuscitation) and First Aid training. The facility failed to ensure that 2 of 2 sampled staff (Staff C and Staff E) had the dementia (a group of brain conditions that cause a decline in thinking, memory, and reasoning) specialty training certificate as required. The facility failed to ensure 1 of 2 sampled Staff (Staff C) had their home care aid certification. These failures resulted in residents being cared for by staff without required trainings and placed 26 of 26 residents at risk of harm in the event of an emergency due to staff not being trained on life saving measures, unaware of the facility's expectations, and risk of unmet care needs by untrained staff.

Findings included…

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

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C)

Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection

from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments.
WAC 388-112A-0210 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."

WAC 388-112A-0220 "What is safety training, who must complete it, and when should it be completed? (1) Safety training is part of the long-term care worker requirements. It is a three hour training that must meet the requirements as described in WAC 388-112A-0230, and include basic safety precautions, emergency procedures, and infection control. Safety training must be completed prior to providing care to a resident. (2) All long-term care workers who are not exempt from home care aide certification as described in RCW 18.88B.041 hired after January 7, 2012, must complete three hours of safety training. This safety training must be provided by qualified instructors who meet the requirements in WAC 388-112A-1260. (3) The department must approve safety training curricula and instructors."

WAC 388-112A-0720 "What are the CPR and first-aid training requirements? (2) Assisted living facilities. (a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire. (b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire. (c) The form of the first-aid or CPR card or certificate may be

electronic or printed. “

WAC 388-112A-0400 “(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450. (b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement. (c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (b) Dementia specialty training as described in WAC 388-112A-0440; (4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (b) Dementia specialty training as described in WAC 388-112A-0440; and (5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire. (6) For long-term care workers who have completed the 75-hour training and do not have a specialty training certificate that indicates completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs.”

WAC 388-112A-0490 “What are the specialty training requirements for applicants, resident managers, administrators, and other types of entity representatives in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities. (3) If an assisted living facility serves one or more residents with special needs, the assisted living facility administrator or designee must complete specialty training and demonstrate competency within one hundred twenty days of date of hire. (4) If a resident develops special needs while living in an assisted living facility, the assisted living facility administrator or designee has one hundred twenty days to complete specialty training and demonstrate competency, or demonstrate proof of specialty training.”

WAC 388-112A-0300 “(1) The 70-hour home care aide basic training is in addition to orientation and safety training. It is 70 hours and includes: (a) The core competencies and skills that long-term care workers need in order to provide personal care services effectively and safely; (b) Practice and demonstration of skills; and (c) Population specific competencies. (2) DSHS must approve the 70-hour home care aide basic training curricula. (3) On-the-job training may be applied to the core competencies of 70-hour home care aide basic training for an amount that must be approved by the

department. (4) The DSHS developed fundamentals of caregiving (FOC) or another department approved training may be used to teach the core competencies of the 70-hour home care aide basic training but the FOC must include enhancements. Additional student materials are required to ensure the enhancements are well planned and documented for students. Materials must be submitted for approval and approved per WAC 388-112A-1020. Examples of enhancements include, but are not limited to: (a) More time for workers to practice skills including: (i) The mechanics of completing the skill correctly; (ii) Resident centered communication and problem solving associated with performing the skill; (iii) The different levels of care required for each skill including independent, supervision, limited, extensive, and total; (iv) Working with assistive devices associated with a skill; (v) Helpful tips or best practices in working through common resident challenges associated with a skill; and (vi) Disease specific concerns or challenges associated with a skill. (b) Augmenting or adding additional materials, student activities, videos, or guest speakers that: (i) More deeply reinforce and fortify the learning outcomes required for basic training; (ii) Ensure each student integrates and retains the knowledge and skills needed to provide quality basic personal care; and (iii) Prepares workers for the certification testing environment and process. (c) Enhancements are not materials or activities that are one or more of the following: (i) Are out of the scope of practice for a long-term care worker such as content clearly written for registered nurses; (ii) Are identical to, or a direct replacement of, those already included in the FOC; (iii) Fail to reinforce Washington state laws associated with resident rights and resident directed care; (iv) Long-term care workers are not paid to provide; (v) Are written above a high school reading level. (5) The delivery mode of the 70-hour home care aide basic training may be either in-person or virtual classroom instruction, or a hybrid of online and in-person, remote, or virtual classroom instruction. One hour of completed classroom instruction or other form of training (such as a virtual classroom, remote or online course) equals one hour of training. (a) Online and virtual classroom modules must be interactive, provide the student with access to the instructor, and adhere to the DSHS online and virtual classroom standards posted on DSHS's website at https://bit.ly/dshs-online-standards. (b) The in-person skills training or remote skills training portion of hybrid modules must be no less than 16 hours of the total basic training hours and include in-person or remote instruction on the personal care tasks supporting activities of daily living, as described in WAC 388-112A-0320. (6) The long-term care worker must be able to ask the instructor questions during the training. (7) There is no challenge test for the 70-hour home care aide basic training."

WAC 388-112A-0105 "Who is required to obtain home care aide certification and by when? (1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (2) The following individuals must obtain home care aide certification as follows… (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire."

WAC 388-112A-0080 "Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090… Assisted living facilities. (4) Assisted living facility administrators or their designees within one hundred twenty days of date of hire. (5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training."

Record review of the facility's document titled, "Disclosure of Services Required by RCW

18.20.300, dated “01/2023 ”, under the section titled, “care for residents with dementia, developmental disabilities, or mental illness”, showed the facility that chose to serve resident with dementia, developmental disabilities, or mental health issues must provide their staff with specialized training in those areas. The facility would serve persons with the following needs that included dementia.

Record review of the “Department of Social And Health Services” document, Completion date 01/02/2025, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2474] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 12/23/2024.”

Record review of the facility document, “Plan of Corrections”, undated, showed WAC 388 78A 2474 requirement would be met by completion of the training tracker for each nursing staff member. The purpose of the tracker was to monitor the completion of facility orientation, orientation and safety, specialty training for dementia, CPR and First Aid, and basic fundamentals of caregiving.

Record review of the facility’s document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed 22 of 26 residents were marked to have either dementia (a group of brain conditions that cause a decline in thinking, memory, and reasoning) /Alzheimer’s (a progressive brain disorder that gradually destroys memory and thinking skills)/cognitive impairments.
Record review of an untitled and undated document showed Staff C, Care Manager, was hired at the facility on 12/07/2023, Staff D, Director of Culinary Services, was hired at the facility on 01/06/2025, and Staff E, Medication Technician was hired at the facility on 01/02/2024.

Facility Orientation

Record review of Staff C’s, “[Facility Name] Physical Plant Orientation”, dated 01/21/2025, showed Staff C received orientation on the following systems in the community electrical, plumbing, water and gas shut-off, fire sprinkler system, thermostat settings, fire alarm system and location of fire alarm panel, emergency call system, and irrigation system. Staff C’s orientation did not cover all required topics per WAC 388-112A-0210.

Record review of Staff D’s, “[Facility Name] Physical Plant Orientation”, dated 01/21/2025, showed Staff D received orientation on the following systems in the community electrical, plumbing, water and gas shut-off, fire sprinkler system, thermostat settings, fire alarm system and location of fire alarm panel, emergency call system, and irrigation system. Staff D’s orientation did not cover all required topics per WAC 388-112A-0210.

In an interview on 02/18/2025 at 5:33 PM, Staff A stated that all new employees do

electronic onboarding documentation that they believed covered the facility orientation topic. Staff A stated they would provide the Department with a copy of the electronic onboarding documentation for Staff C and Staff D for review.

As of 02/19/2025 at 5:33 PM, the Department had not received a copy of the electronic onboarding documents that showed all topics were covered upon hire for Staff C and Staff D for review.

DSHS 5 Hour Orientation and Safety Training

Record request via email on 02/18/2025 at 11:26 AM, showed the Department requested Staff C's DSHS 5 hour orientation and safety training to review.

Record request via email on 02/18/2025 at 4:40 PM, showed the Department requested Staff C's DSHS 5 hour orientation and safety training to review.

In an interview on 02/18/2025 at 5:33 PM, the Department notified Staff A, Senior Executive Director and Staff B, Licensed Practical Nurse, they had not received Staff C's DSHS 5 hour orientation and safety training to review. Staff A stated they would follow up.

As of 02/20/2025 at 5:00 PM, the Department had not received Staff C's DSHS 5 hour orientation and safety training to review.

CPR/First Aid Certificate

Record review of Staff E's CPR/AED and Standard First-Aid certificate showed it was completed 02/18/2025. Staff E's certificate had been completed 57 days after the plan of correction attestation date.

Dementia Specialty Training

On 02/18/2025 at 5:33 PM, the Department requested to review Staff C and Staff E's dementia specialty training certificates.

Record request via email on 02/19/2025 at 3:20 PM, showed the Department requested Staff C and Staff E's dementia specialty training to review.

As of 02/19/2025 at 5:33 PM, the Department had not received a copy of Staff C and Staff E's dementia specialty training for review.

Record review of an email sent to the Department on 02/20/2025 at 1:25 PM, showed Staff A stated Staff C and Staff E said they had not taken the class to receive the certificate for the dementia specialty training.

Home Care Certificate

Record review of State of Washington Department of Health Credential Verification, dated 02/18/2025, showed Staff C's nursing assistance registration was pending.

Record review of an email sent to the Department on 02/20/2025 at 1:25 PM, showed Staff A stated Staff C did not have a test date to complete their HCA. Staff C reported

they had not completed their HCA courses.

In an interview on 02/18/2025 at 3:09 PM, Staff A stated they had made an electronic tracking sheet to ensure that all staff had the required documents and trainings completed within the required time frames. Staff A stated that included the employees continuing education, physical plant orientation, and certificates.

This is an uncorrected deficiency previously cited on 01/02/2025 for subsection (1)(2)(a)(b)(c)(d)(4)

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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 1 of 2 sampled Staff (Staff D) received their Tuberculosis (infectious bacterial disease of the lungs) test within the required time requirements. This failure placed 26 of 26 residents at risk for exposure to Tuberculosis (TB).

Findings included…

Record review of a Dear Provider Letter, titled, “Reinstatement of tuberculosis testing requirements July 1, 2022,” dated 05/17/2022 and amended on 05/26/2022, stated “Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This

will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the Centers for Disease Control and Prevention (CDC) website article titled, "Clinical Testing Guidance for Tuberculosis: Health Care Personnel", dated 12/15/2023, showed TB screening programs for health care personnel were part of TB infection control plans. CDC recommended all United States health care personnel should be screened for TB upon hire.

Record review of the CDC's website article titled, "Baseline Tuberculosis Screening and Testing for Health Care Personnel", dated 12/19/2023, showed All United States health care personnel should be screened for tuberculosis upon hire. The process should include a risk assessment, symptom evaluation, and TB blood test or TB skin test. If the Mantoux tuberculin skin test (TST) used for baseline testing of the health care personnel, they were to get a two-step skin test. The two-step skin test was recommended for the initial TB skin test for adults who may be tested periodically, such as health care personnel. The first step of the skin test should be administered results were negative then the skin test would be repeated with another TB skin test completed one to three weeks after the first TB skin test results read. The TB skin test was to be read within 48-72 hours. If the person failed to return within 72 hours to have the TB skin test read, the TB skin test was to be repeated.

Record review of the facility's policy titled, "Infection Control 14- Tuberculosis- Care Staff", dated 05/13/2022, showed all care staff would be screened for TB infection and disease per state regulations prior to beginning employment. Under the section titled, "screening care staff", showed each newly hired care staff member would be screened for TB infection and disease after employment offer was made but prior to the employee's duty assignment. Each staff person was screened for TB within three days of employment. Per the CDC guidance, test results should be read 48-72 hours after administration by a healthcare worker trained to read TST results. If the staff member does not return within 72 hours, they would need to be rescheduled for another skin test. Unless the staff person meets the requirements for having not 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 that included an initial skin test within three days of employment and a second skin test done one to three weeks after the first step. The assisted living facility must keep records of TB test results in the assisted living facility, make them readily available to the licensing agency, retain the records for at least two years after the staff person either quits or was terminated.

Record review of the "Department of Social And Health Services" document, Completion date 01/02/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2484] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law

and/or regulation on 12/23/2024."

Record review of the facility document, "Plan of Corrections", undated, showed WAC 388 78A 2484 an initial skin test would be completed within 3 days of employment and would be performed by the RCD (Resident Care Director), with a second to be done one to three weeks after the initial test. The information would be placed in the training tracker to ensure compliance.

Record review of an untitled and undated document showed Staff D, Director of Culinary Services, was hired at the facility on 01/06/2025.

Record review of Staff D's, "Employee TB Test Record", undated, showed Staff D received their first TB skin test on 02/11/2025. That was 33 days after the required time frame it was to be completed.

In an interview on 02/21/2025 at 11:21 AM, Staff I, Resident Care Coordinator, stated the facility nurse was responsible to complete new employee's TB testing. Staff I stated the facility did not have a nurse at this time. At 11:25 AM, Staff B, Licensed Practical Nurse Regional Nurse Consultant, stated all new employees TB testing was to be completed within three days of hire. Staff B stated if they were in the facility then they would complete the new employee's TB testing. Staff B acknowledged that Staff D's TB testing was not completed within three days of hire.

This is an uncorrected deficiency previously cited on 01/02/2025 for subsection 2484(1).

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow and implement safe food handling and storing practices for 1 of 1 area reviewed (the kitchen). These failures placed 26 of 26 residents at risk of for food-borne illnesses due to receiving improperly handled food.

Findings included…

Washington Administrative Code (WAC) 246-215-04605 “Objective—Equipment food-contact surfaces and utensils (FDA Food Code 4-602.11). (1) EQUIPMENT, FOOD-CONTACT SURFACES, and UTENSILS must be cleaned: (5) Except when dry cleaning methods are used as specified under WAC 246-215-04620, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be cleaned: (a) At any time when contamination might have occurred; (b) At least every twenty-four hours for iced tea dispensers and CONSUMER self-service UTENSILS such as tongs, scoops, or ladles; (c) Before restocking CONSUMER self-service EQUIPMENT and UTENSILS such as condiment dispensers and display containers; and (d) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (i) At a frequency specified by the manufacturer; or (ii) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.”

WAC 246-215-04920 “Storing—Equipment, utensils, linens, and single-service and single-use articles (FDA Food Code 4-903.11). (1) Except as specified in subsection (4) of this section, cleaned EQUIPMENT, UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES must be stored: (a) In a clean, dry location; (b) Where they are not exposed to splash, dust, or other contamination; and (c) At least six inches (15 cm) above the floor. (2) Clean EQUIPMENT and UTENSILS must be stored as specified under subsection (1) of this section and must be stored: (a) In a self-draining position that allows air drying; and (b) Covered or inverted. (3) SINGLE-SERVICE and SINGLE-USE ARTICLES must be stored as specified under subsection (1) of this section and must be kept in the original protective package or stored by using other means that afford protection from contamination until used. (4) Items that are kept in closed packages may be stored less than six inches (15 cm) above the floor on dollies, pallets, racks, and skids that are designed as specified under WAC 246-215-04268.”

WAC 246-215-03300 “Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305".
WAC 246-215-02310 Hands and arms—"When to wash (FDA Food Code 2-301.14). FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) After handling soiled EQUIPMENT or UTENSILS; (6) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing

tasks; (7) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (8) Before donning gloves for working with READY-TO-EAT FOOD unless a glove change is not the result of contamination; and (9) After engaging in other activities that contaminate the hands or gloves."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation." Record review of the "Department of Social And Health Services" document, Completion date 01/02/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2305] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/21/2025."

Record review of the facility document, "Plan of Corrections", undated, showed for WAC 388 78A 2305 the facility obtained quotes from contactors to renovate the broken cabinets, drawers, and kitchen countertops. An in-service training on hand hygiene would be conducted for all facility staff on 01/21/2025.

Record review of the facility provided document titled, "Culinary Sanitation", dated "10/2018", showed it was the company policy to ensure all appropriate sanitations measures were followed in the culinary department to prevent food-borne illness. All kitchen equipment just be cleaned regularly in accordance with the cleaning log.

Record review of the facility's "walkthrough safety audit", dated 02/08/2025 , under section titled, "general safety", showed "main fax is malfunctioning, temp in place."

Record review of the facility's "walkthrough safety audit", dated 02/09/2025 through 02/15/2025, under section titled, "general safety", showed "satisfactory" was checked that all office machines were properly maintained.

Record review of the document titled, "January In Service Training All Staff", dated 01/21/2025 showed hand hygiene had been a covered topic. Staff D, Director of Culinary Services and Staff J, Care Manager, signed that they acknowledged and understood the information and that they would use the information to perform their job responsibilities.

Record review of the facility provided document titled, "Weekly Kitchen Cleaning Schedule", undated, showed on Thursdays the utensil area should have been removed and scrubbed. On Friday's the items in the drawers were to be removed and cleaned. On Saturdays the vents were to be cleaned.

Record review of the facility provided document titled, "Monthly Kitchen Cleaning Schedule", undated, showed the ice machine cleaning task had been assigned to the

culinary service director and the building service director.

Kitchen Cleanliness

In an interview and observation on 02/18/2025 at 12:20 PM, Staff D said they were unsure who had been responsible to clean the inside of the ice machine and how often it was supposed to be cleaned. Staff D said they cleaned the outside of the ice machine as needed. Staff D said they had been unsure when the maintenance was scheduled to take place inside of the kitchen to fix the cabinet drawers and missing cabinet doors. Staff D said three days ago they were provided four blue cloths to drape over the cabinet doors that were missing. Observation of the blue cloths showed they were velcroed at the top of the cabinet. The blue drapes were very long with the bottom of the drapes laid on the ground of the kitchen. Staff D moved one of the blue cloth drapes and on the backside that was white was a yellow stained area that resembled something had been spilled on the back of the drape. Staff D said they wanted the drapes to be cleaned every three to four days and they planned but there was no actual set time they were to get cleaned. Staff D said some of the drawers inside of the kitchen did not close all the way. Staff D had been observed to open a drawer that was attached to the kitchen island and faced the kitchen stove. The drawer could not evenly go into the hole it was intended to. Staff D said they cleaned inside of the drawers often. One of the drawers that could not evenly go into the hole contained kitchen utensils such as spoons and spatulas that sat on an unknown white residue. The Department touched the bottom of the drawer's surface, and the white residue stuck to their finger. Staff D confirmed they used the kitchen utensils inside of all of the drawers and that the drawers were soiled. There had been a kitchen sink that was located next to the stove. The sink did not have any cabinet doors or drapes on the right- or left-hand side. At 12:25 PM, the kitchen cabinet on the right-hand side of the sink had cloths, pans, and other cookware inside of it that. The cabinet did not have a blue drape that covered it. Staff D said the cabinet did not have a blue drape over it because they only were provided a total of four to use to see if the drape system would work. Staff D said they still had to pull the drapes back and clean the surfaces behind the drapes. At 12:29 PM, the vents above the kitchen stove showed that they appeared soiled with brown fuzzy substance. Staff D said they were unsure who had been responsible to clean the vents inside of the kitchen. Behind the stove the wall had been covered in a grey fuzzy matter. Staff D said they cleaned the wall as far as they could reach. Staff D said the grey fuzzy matter had been dust. Staff D pointed out the left side of the wall did not have grey matter on it because they were able to reach that surface, but they could not reach the right-hand side. Staff D said they had been unsure who was responsible to clean the air conditioning unit that was in the kitchen window. The air conditioning unit had been observed to have black spots on the outside and the inside of the device. Staff D said they were unsure if the air conditioning unit worked but noted it would need to be cleaned before it was turned on. The vent on the ceiling above the coffee pot that had brewed coffee inside of it, had brown fuzzy matter. The kitchen island had four cabinet doors that were missing without the blue drapes. The island that faced the ice machine had a clear bucket, wicker basket, four drink pitchers that sat on unknown substances.

In an interview on 02/18/2025 at 1:08 PM, Staff A, Senior Executive Director, said the facility did not have a start date of when maintenance work was scheduled to take place inside of the kitchen. Staff A said they received two bids for the work that needed to be completed inside of the kitchen. Staff A said they were requested to obtain a third bid before ownership would decide to move forward with the kitchen maintenance. Staff A said the maintenance department would clean and service the inside of the ice machine

twice a year. Staff A said Staff D had been responsible to complete visual checks inside of the ice machine to make sure it was clean. Staff A said they were unsure which facility staff member had been responsible to clean the kitchen vents and walls. Staff A said the four drapes that were provided to the kitchen was to provide a temporary barrier of additional sanitization inside of the kitchen. Staff A said they were inside of the kitchen today. Staff A acknowledged not every drape covered the missing cabinet doors. Staff A said they had not observed inside of the kitchen drawers or behind the drapes.

Hand Hygiene

In an interview and observation on 02/18/2025 at 12:08 PM, Staff J, Care Manager, said the expectation of when facility staff were to perform hand hygiene was when staff entered the kitchen. At 12:11 PM, Staff J had been observed to enter the kitchen door and did not perform hand hygiene. Staff J retrieved three plates of food and put them on a tray. Staff J held the tray in one hand and a single plate of food in the other hand and exited the kitchen. At 12:12 PM, Staff J reentered the kitchen door with the empty tray. Staff J did not perform hand hygiene before they retrieved three more plates of food and put them on the tray before they exited the kitchen.

In an interview and observations on 02/18/2025 at 12:14 PM, in the kitchen, Staff D was in the kitchen behind the island countertop with disposable gloves on. Staff D left the island countertop, entered their office, grabbed a piece of paper that was the alternative menu that was to be offered to the residents for meals. Staff D brought and set the alternative menu paper on the counter with their gloved hands. Staff D took the gloves off and threw them away. Staff D then adjusted their cloths and crossed their hands and arms on over their apron and chest. Staff J came into the kitchen to get residents lunch plates. Staff D grabbed new disposable gloves from the box on the island countertop. At 12:15 PM, Staff D put the new gloves on and then started to dish ready to eat food onto the plates for the residents. Staff D was not observed to preform hand hygiene after they removed their gloves or prior to putting the new gloves on. At 12:17 PM, Staff D removed their gloves and again adjusted their cloths and apron and crossed their hands and arms over their chest and apron. At 12:25 PM, Staff J came in and asked for some salad dressing for a resident. Staff D grabbed a new pair of disposable gloves and put them on. Staff D was not observed prior to putting the new gloves on to perform hand hygiene or when they took their gloves off at 12:17 PM. After Staff D put the new gloves on, they opened the refrigerator grabbed a large container of salad dressing. Staff D poured some salad dressing into a small cup and then handed it to Staff J to serve to a resident. At 12:26 PM, Staff D removed their disposable gloves and threw them away. Staff D was not observed to perform hand hygiene. Staff D stated they were expected to wash their hands before putting gloves on, after taking gloves off, if their hands are soiled or visibly dirty, when they entered the kitchen, and before cooking. As of 12:35 PM, Staff D was not observed to perform any hand hygiene since first started to be observed at 12:14 PM.

In an interview on 02/18/2025 at 1:23 PM, Staff A said the expectation of when facility staff were to perform hand hygiene was anytime their hands were visibly soiled, when they touched food that was not thoroughly cooked, if they returned a dirty dish before they touched a clean dish, and acknowledged in the kitchen hand hygiene should be constant. Staff D said the facility staff should perform hand hygiene before they put on gloves, when they completed a task, and when they removed their gloves.

This is an uncorrected deficiency previously cited on 01/02/2025 for subsection 2305(1).

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

(1) The assisted living facility must:

(c) Ensure all menus:

(iii) Include all food and snacks served that contribute to nutritional requirements;

(v) Provide a variety of foods; and

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(ii) Individual preferences to the extent reasonably possible.

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

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

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

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a variety of food for 1 of 1 kitchens reviewed. These failures placed all 26 of 26 residents at risk of diminished quality of life.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 01/02/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2300] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/06/2025."

Record review of the facility document, "Plan of Corrections", undated, showed WAC 388 78A 2300 the community would provide a variety of food. The culinary director had received training and would receive on going training to ensure they understood how to maintain compliance.

Record review of the facility provided document titled, "Menu Guidelines", dated "07/2023", showed every community would offer a daily "Always Available" menu which included a minimum of four choices for lunch and dinner and one signature entrée for all resident populations and one daily special which would be updated daily. The purpose was to provide every resident the opportunity to enjoy a positive dining experience with a variety of food choices. The procedure showed the culinary service director had been responsible to ensure residents were aware of the daily special and always available menu.The executive director and culinary service director were responsible to ensure adherence to the policy.

Variety of Food

In an interview on 02/18/2025 at 12:10 PM, Staff D, Director of Culinary Services, said they had not yet started to offer alternative food items to the residents. Staff D said the facility printer had been broken and they were not able to print and post in the dining room the alternative menu for residents to review.

In an interview and observation on 02/18/2025 at 12:15 PM, Staff J, Care Manager, said historically the menus with the alternative food options were delivered to each resident at the facility and they circled and turned in what food items they wanted to eat the next day.

In an interview on 02/18/2025 at 12:36 PM, Resident 6 [R6], said the facility had not yet offered alternative food options if the facility residents did not want to eat what was scheduled to be served. R6 said Staff D informed them the day prior the facility had a plan in effect to offer alternative food items, but the information had not yet been publicized.

In an interview on 02/18/2025 at 1:08 PM, Staff A, Senior Executive Director, stated the facility came up with a menu of alternative food choices on Wednesday 02/12/2025. Staff A stated they met with R6, Staff D and themselves to come up with the alternative menu. Staff A stated the alternative menu was implemented last week and should be posted as over the weekend the facility's printer was replaced.

This is an uncorrected deficiency previously cited on 01/02/2025 for subsection 2300 (1)(v)(g).

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2710 Disclosure of services.

(1) The assisted living facility must disclose to residents, the resident's representative, if any, and interested consumers upon request, the scope of care and services it offers, on the department's approved disclosure forms. The disclosure form shall not be construed as an implied or express contract between the assisted living facility and the resident, but is intended to assist consumers in selecting assisted living facility services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide a signed documentation that 5 of 5 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], and Resident 6 [R6]) received a copy of the facility's disclosure of services. This failure placed 26 of 26 residents, and resident representatives at risk from

not having knowledge of what services the facility provided.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 01/02/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2710] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/20/2025."

Record review of the facility document, "Plan of Corrections", undated, showed under WAC 388 78A 2710 the facility would utilize the Washington State Disclosure of Services form 18.20.300 as part of the lease paperwork for new admissions. The community would ask residents or their responsible party to sign and date the bottom of the form and retain a record in the resident business file. The community would ensure all current residents or responsible parties signed the form during their next care conference.

Record request via email on 02/18/2025 at 11:26 AM, the Department requested R1, R2, R3, and R4's signed disclosure of services to review.

Record request on 02/18/2025 at 3:09 PM, the Department requested R6's signed disclosure of services to review.

Record review of R6's, "Disclosure of Services Required by RCW (Revised Code Washington) 18.20.300", dated 02/18/2025, showed R6 signed the document on 02/18/2025.

In an interview on 02/18/2025 at 4:39 PM, R6 said the facility staff had provided them a copy of the facility disclosure of services form today and requested that R6 signed the document. R6 said prior to today the facility did not provide them with an updated copy of their most current disclosure of services.

Record request via email on 02/19/2025 at 3:20 PM, the Department requested R1, R2, R3, and R4's signed disclosure of services to review.

As of 02/20/2025 at 5:00 PM, the Department had not received R1, R2, R3, and R4's signed disclosure of services form to review.

In an interview on 02/18/2025 at 3:25 PM, Staff A, Senior Executive Director, stated they would have all the residents that had cognitive deficits, the resident's representatives sign a new copy of the disclosure of services at the residents next care conference. Staff A stated that the disclosure of services would be included into the admission agreement that would be signed upon admission for all new residents.

In an interview on 02/21/2025 at 11:21 AM, Staff I, Resident Care Coordinator, stated

they were tasks on 02/03/2025 to have all the residents and or the residents responsible party to have a new signed disclosure of services completed.

This is an uncorrected deficiency previously cited on 01/02/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid policy for 4 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]) for review. This failure placed 26 of 26 residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 01/02/2025, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2665] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Senior Executive Director, signed the document on 01/24/2025. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/20/2025.”

Record review of the facility document, “Plan of Corrections”, undated, showed under WAC 388 78A 2665 that the facility would work to obtain a document that clearly stated the circumstances under which the assisted living facility provides care for Medicaid eligible residents who become Medicaid eligible after admission. The information would be provided both orally and in writing in language the resident could understand. This would be provided prior to admission and to all current residents on a page that was separate from other documents and in at least 14-inch font. The document would be signed and dated by the resident and kept in the resident business record after signature.

Record request via email on 02/18/2025 at 11:26 AM, showed the Department requested R1, R2, R3, and R4’s signed Medicaid agreement to review.

In an interview on 02/18/2025 at 3:25 PM, Staff A, Senior Executive Director, stated they would have all the residents and or the resident’s representatives sign a copy of the Medicaid policy. Staff A stated that a Medicaid legal form was drafted and included into the admission agreement that would be signed upon admission for all new residents.

In an interview on 02/21/2025 at 11:21 AM, Staff I, Resident Care Coordinator, stated they were tasked on 02/03/2025 to have all the residents and/or the residents responsible party to sign the facility’s Medicaid disclosure document.

This is an uncorrected deficiency previously cited on 01/02/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

The department completed data collection for the unannounced on-site full inspection on 12/12/2024 and 12/13/2024 of:
Victoria Place
491 Discovery Rd
Port Townsend, WA 98368

The following sample was selected for review during the unannounced on-site visit: 7 of 26 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Residential Care Services _____ Date _____

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

Administrator (or Representative) Date

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

(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;

(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:

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had the required nurse delegation training and credentials for 5 of 5 staff (Staff I, Staff B, Staff E, Staff H, and Staff N) reviewed. The facility failed to maintain and provide current nurse delegation documents for 3 of 3 sampled residents (Resident 2 [R2], Resident 7 [R7], and Resident 8 [R8]) reviewed. These failures resulted in residents receiving nurse delegation services from unqualified staff and placed residents at risk for unmet medical care 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. ASSESS (2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii). (3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition. (4) Determine the task to be delegated is within the delegating nurse's area of responsibility. (5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient. (6) Analyze the complexity of the nursing task and determine the

required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. (7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction. (8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training; (d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care. (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. PLAN (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks, and may be more frequent. (13) The administration of

medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient. IMPLEMENT (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care. (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least every two weeks for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Record review of the facility's policy titled, "nurse Delegation", dated 05/13/2022, showed nurse delegation was implemented to benefit residents and the community's ability to provide care. The Registered Nurse (RN) would transfer performance of selected nursing tasks to competent unlicensed staff in selected situations, in accordance with the state regulations. The policy contained excerpts from the Washington state nurse delegation regulations.

Record review of the Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", undated, showed the RN would assess the residents to determine stability and predictability. All long-term care workers (LTCW) must have an active credential with the Washington State Department of health to be delegated. The RN delegator must verify that the medication technicians had the required certificates and credentials prior to being delegated to administer RN delegated tasks for the residents. The residents task must be delegated if the task was to be completed by the LTCW. Residents that were not functionally able and/or not cognitively aware that they received medications, the LTCW would be authorized to administer those medications with delegation. The LTCW must be delegated for each resident task. The document showed for a resident to be assisted with their medications the resident must be both functionally, able to get the medication to where it needs to go and cognitively, aware they receive medications, but not know the name or the intended side effects.

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed the facility had 26 residents that resided at the facility. The document showed 13 of 26 residents had been indicated to have Dementia (a condition that affects a person's way of thinking, behavior, and memory that was caused by poor blood flow to the brain)/Alzheimer's (a progressive brain disorder that affect the persons memory, judgement, thinking, and ability to carry out activities of daily living needs)/cognitive impairment. There was no documentation that any of the 26 residents required nurse delegation.

Record review on 12/13/2024 at 1:35 PM, of the facility's RN delegation binder showed there was no documentation in the binder to show that any residents had delegated services.

Record review of the RN delegation binder document titled, "Nurse Delegation: Assumption of Delegation", dated 06/05/2024, showed Staff M was the new RN delegator.

Staff Records

Record review of the untitled and undated document that had a list of active employees for the facility showed the facility had three medication technician's (Staff I, Staff E, and Staff H) and one resident care coordinator (Staff B) listed.

In an interview on 12/12/2024 at 10:26 PM, Staff D, Vibrant Life Director, stated all employee records were filed in an employee file for review.

Staff I

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff I's hire date was 09/11/2023.

Record review on 12/13/2024 at 1:35 PM, of the facility's RN Delegation binder showed there were no Washington State Department of Health (DOH) credentials in the binder for Staff I for review.

Record review of the Washington State DOH credential verification website on 12/13/2024 at 1:07 PM, showed Staff I did not have any records in the database for review.

In an interview on 12/13/2024 at 1:22 PM, Staff I stated that they were working on getting their credentials through the Washington State DOH and needed to mail in their certificates. Staff I acknowledged that they did not have any active credentials to

provide for review.

As of 12/17/2024 at 5:00 PM, the facility was unable to provide the Department any active Washington State DOH credentials for Staff I for review.

Staff E

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff E's date of hire was 01/02/2024.

Record review on 12/12/2024 of Staff E's employee file showed there were no Washington state DOH credentials for review.

Record review on 12/13/2024 at 1:35 PM, of the facility's RN Delegation binder showed there were no Washington State DOH credentials in the binder for Staff E for review.

Record review of the Washington State DOH credential verification website on 12/18/2024 at 1:35 PM, showed Staff E did not have any records in the database for review.

As of 12/18/2024 at 5:00 PM, the facility was unable to provide the Department any active Washington State DOH credentials for Staff E for review.

Staff B

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff B's date of hire was 09/11/2023.

In an interview on 12/12/2024 at 12:00 PM, Staff A, Executive Director, stated the employees with a hire date of 09/11/2023 was the date the new management company took over the facility. Staff A stated the employee's original hire date when first worked at the facility would be in their employee file.

Record review of Staff B's General Orientation showed Staff B's date of hire for the facility was on 02/23/2021.

Record review on 12/12/2024 of Staff B's employee file showed they had their Nursing Assistant Registration credential through the Washington state DOH that expired on 11/18/2024.

Record review of the Washington State DOH credential verification website on 12/12/2024 at 5:00 PM, showed Staff B's Nursing Assistant Registration credentials were expired.

On 12/12/2024 at 5:44 PM, the Department requested to review Staff B's Washington State DOH credentials.

Record review on 12/13/2024 at 1:35 PM, of the facility's RN Delegation binder showed Staff B's Nursing Assistant Registration had expired on 11/18/2024.

Staff H

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff H's date of hire was 09/11/2023.

Record review of Staff H's untitled document, dated 12/24/2018, showed Staff H started employment at the facility on 01/07/2019.

Record review on 12/12/2024 of Staff H's employee file showed they had their Home Care Aide Certification through the Washington state DOH that expired on 10/03/2024.

Record review of the Washington State DOH credential verification website on 12/12/2024 at 5:00 PM, showed Staff H's Home Care Aide Certification through the Washington state DOH that expired on 10/03/2024.

On 12/12/2024 at 5:44 PM, the Department requested to review Staff H's Washington State DOH credentials for review.

Record review on 12/13/2024 at 1:35 PM, of the facility's RN Delegation binder showed Staff H's Home Care Aide Certification had expired on 10/03/2024.

Staff N

Record review of an email provided by the facility, dated 12/10/2024 at 2:57 PM, showed Staff N, Medication Technician, was scheduled to work at the facility on Thursday 12/12/2024 night shift, Friday 12/13/2024 night shift, Saturday 12/14/2024 evening and night shift, and Sunday 12/15/2024 as the medication technician.

Record review on 12/13/2024 at 1:35 PM, of the facility's RN Delegation binder showed

Staff N did not have any credentials or certificates in the binder for review.

Resident Records

R2

Record review of R2's Face Sheet, dated 12/12/2024, showed R2 moved into the facility on [redacted]/2022, with multiple medical diagnoses that included [redacted].

Record review of R2's Level of Care Appraisal (facility's version of the residents assessment), dated 08/06/2024, showed R2 did not require nurse delegation. R2 required assistance with their medications three to four times daily. R2 did not receive special medications. All of R2's medications were signed for and administered by the facility staff.

Record review of R2's Service Agreement, dated 08/12/2024, showed R2 required staff assistance with medication management three to four times daily.

Record review of R2's Physician Order Sheet, dated 10/11/2024, showed R2 had current orders for tylenol (a medication that helps with generalize pain and discomfort) by mouth three times daily, buspirone (a prescribed medication to help treat behaviors and feeling of anxiousness) two times a day, caltrate with vitamin D (a vitamin medication to help replenish calcium and vitamin D into the body) chew tablet daily, carbidopa/levodopa (a prescribed medication to help treat symptoms like stiffness and tremors) every night for Parkinson's disease (a progressive brain disorder that causes nerve cells in the brain to weaken and die leading to muscle arm and leg stiffness and uncontrollable body tremors), cetirizine (a medication to help treat itchy eyes, runny nose, or symptoms of allergies) daily, clonazepam (a prescribed medication to help prevent seizures or whole body uncontrollable shaking, to slow down the nervous system) and three times daily, donepezil (a prescribed medication to help treat memory loss and mental changes) daily at night, duloxetine (a prescribed medication to help treat pain and feeling of sadness) daily, ferrous gluconate (a vitamin medication to help increase iron in the blood) two times daily, lamotrigine (a seizure medication) two times daily, omeprazole (a medication to help reduce the acid in the stomach) daily, pregabalin (a prescribed medication to help treat nerve and muscle pain) two times daily, and propranolol (a prescribed medication to help lower high blood pressure) two times daily.

Record review of R2's Medication Administration Record (MAR), dated 10/01/2023 through 10/31/2024, showed Staff H administered R2 their medications 14 of 28 days after their credentials had expired on 10/03/2024. R2's medications were administered by agency medication technicians (who were not delegated for the tasks) 12 of 31 days, Staff I administered R2's medications 13 of 31 days, and Staff E administered R2's medications 15 of 31 days.

Record review of R2's MAR, dated 11/01/2024 through 11/30/2024, showed R2's medications were administered by agency medication technicians for 10 of 30 days, Staff I administered R2's medications 16 of 30 days, Staff E administered R2's medications 15 of 30 days, and Staff H administered R2's medications 14 of 30 days.

Record review of R2's MAR, dated 12/01/2024 through 12/12/2024, showed R2's medications were administered by agency medication technicians for four of 12 days, Staff B administered R2's medications one of 12 days with an expired credentials, Staff E administered R2's medications 6 of 12 days, Staff I administered R2's medications four of 12 days, and Staff H administered R2's medications seven of 12 days.

Record review of R2's MAR, dated 12/01/2024 through12/31/2024, showed for dates 12/14/2024 through 12/19/2024 showed agency medication technicians administered four of six days and Staff E administered three of six days.

In an observation and interview on 12/13/2024 at 9:50 AM, Staff I stated that R2 took their medications crushed. Staff I was observed to crush all R2's medication and mixed them with applesauce. Staff I brought R2's medications into them in their room. Staff I handed R2 their medications. R2 was noted to have pronounced head, hand, and entire body uncontrollable shaking tremors. R2 was observed to have at times difficulties to get the medication spoon in their mouth.

In an interview on 12/13/2024 at 10:03 AM, Staff I stated they had to spoon feed R2 their medications often as R2 was unable to related to their hand and head tremors. Staff I stated R2's uncontrollable shaking tremors were the worst in the evening that required R2 to be spoon fed their medications.

In an interview on 12/13/2024 at 3:17 PM, R2 stated more often than not, the medication staff spoon fed them their medication because of their bad head and hand tremors they experienced. R2 stated that they had the tremors from their Parkinson's and had been like this for some time now.

R7

Record review of R7's Face Sheet, dated 10/24/2023, showed R7 moved into the facility on [redacted]/2021 with multiple medical diagnoses that included [redacted].

Record review of R7's Level of Care Appraisal, dated 10/04/2024, showed R7 did not require nurse delegation. R7 required medication assistance two times daily. R7 had memory impairments and required constant reminders and/or cueing. R7 had a diagnosis of [redacted]. R7 required total assistance with all

medications and was unable to self-administer any medications.

Record review of R7's Service Agreement, dated 10/04/2024, showed R7 required staff assistance with all aspects of their medication management. R7 was at risk to leave the building unsafely related to their diagnosis of [redacted]. R7 was unaware of the safety risk as they did not know the surroundings.

Record review of R7's Medication Administration Record (MAR), dated 12/01/2024 through 12/31/2024, showed R7 was administered tylenol two times daily, aspirin (a medication to help relieve minor discomfort and help with blood flow) daily, citalopram (a prescribed medication to help with decrease the symptoms of sadness) daily, desitin cream (a cream applied on the skin to help prevent or treat skin irritation) two times a day, lorazepam (a prescribed medication to help reduce the feeling of anxiousness, restless, or nervousness) once an evening, senna (a medication to help a person pass stool) daily, and vitamin D3 (a vitamin medication to help increase vitamin D levels in the body) daily. Review of the administrations for 12/01/2024 through 12/13/2024 showed Staff I administered R7 their medications 11 of 13 days, Staff B administered R7 their cream one of 13 days, Staff H administered R7's cream seven of 13 days, Staff E administered five of 13 days, and an agency medication technician administered R7's medication and creams five of 13 days. Record review of R7's medication administrations dated 12/14/2024 through 12/19/2024 showed agency medication technicians administered five of six days, Staff I administered one of six days, and Staff E administered one of six days.

In an interview on 12/13/2024 at 1:18 PM, R7 stated they had lived at the facility for two weeks. R7 stated they took medication every now and then, but not all the time. R7 stated they kept their medication at their house. R7 stated the staff at the facility did not provide them with any medications.

R8

Record review of R8's Level of Care Appraisal, dated 09/27/2024, showed R8 did not require nurse delegation. R8 required assistance with medication and special medications two times daily. R8 had memory impairment that required constant reminders and/or cueing. The assessment showed R8 had multiple medical diagnoses that included [redacted]. Staff were to assist with all medication management. R8 was able to understand others but was unable to follow step by step directions. R8 would exit seek and often became aggressive if they were told they were unable to leave the facility. R8 had short term memory loss related to their dementia. The assessment showed R8 was physically able to complete their activities of daily living (ADL) needs, but not cognitively able to complete ADL's independently.

Record review of R8's Service Agreement, dated 09/27/2024, showed R8 required redirection multiple times per shift related to their changes in behavior. R8 had dementia with memory loss that required the staff to remind R8 of activities, meals, and general reminders throughout the day. R8 took medications two times a day and

required medication powder to be applied daily.

Record review of R8's Medication Administration Record (MAR), dated 12/01/2024 through 12/31/2024, showed R8 was administered atorvastatin (a prescribed medication to help lower fat in the blood) daily, citalopram daily, donepezil daily, nystatin powder (a medicated powder to help treat a fungal infection on the skin) three times a day, olanzapine (a prescribed medication to help treat mental disorders or behaviors) daily, quetiapine (a prescribed medication to help treat excessively sad moods or behaviors) daily, and rexulti (a prescribed antipsychotic medication to help treat mental health disorders) daily. Review of the R8's medication administrations for dates 12/01/2024 through 12/13/2024, showed Staff I administered R8's medications five of 13 days, Staff B administered R8's medications one of 13 days, Staff E administered R8's medications six of 13 days, Staff H administered R8's medications seven of 13 days, and an agency medication technician administered R8's medication five of 13 days. Review of the R8's medication administrations for dates 12/14/2024 through 12/19/2024, showed agency medication technician administered R8's medications four of six days, and Staff E administered R8's medications three of six days.

In an interview on 12/13/2024 at 10:17 AM, Staff I, stated R8 was oblivious and had no idea that they had to have a medicated powder applied daily. Staff I stated R8 would throw the medication powder away if it was left in R8's room.

In an interview on 12/13/2024 at 1:13 PM, R8 stated they took medication and that the medications were on the wall. R8 stated she did not take medications when they were asked where their medications were stored. R8 was noted to speak word salad (a mixture of words or phrases that is confused and difficult to understand) during the interview. R8 stated they did not require a medication powder to be applied to their body daily.

In an interview on 12/13/2024 at 9:50 AM, Staff I, Medication Technician, stated they were unsure who the RN delegator was. Staff I stated they did not know where to find the RN delegation binder to know what residents were on delegation services. Staff I stated the previous Executive Director was supposed to have the RN delegator come in, but it never happened. Staff I stated they had been a medication technician for a few months and had their home care aide certificate.

In an interview on 12/13/2024 at 1:38 PM, Staff A, stated the RN delegator for the facility was Staff P, Registered Nurse. Staff A was informed that Staff B and Staff H's Washington State DOH credentials were expired.

In an interview on 12/13/2024 at 2:01 PM, Staff A stated Staff M, Registered Nurse Delegator, was the facility RN delegator.

In an interview on 12/13/2024 at 2:02 PM, Staff M stated they were the RN delegator for

the facility. Staff M stated they were told by the facility there were no residents that required RN delegation. Staff M was unaware that R2 was spoon fed their medication related to the uncontrollable tremors from their Parkinson's disease. Staff M stated R2 required RN delegation for the medication technicians to spoon feed the medications to them. Staff M stated they were unaware that the medication technicians did not have active Washington State DOH credentials and the qualifications to administer delegated tasks. Staff M acknowledged the request for a safety plan to ensure residents were assessed for need to have delegated tasks and to ensure the facility had qualified medication technicians scheduled for the delegated residents.

In an interview on 12/13/2024 at 2:20 PM, the Department requested a safety plan from Staff A, to address the medication technicians that were not qualified that were missing the required training and active Washington State DOH credentials. Staff A acknowledged the concerns.

In an interview on 12/13/2024 at 3:39 PM, the Department followed up with the request for the safety plan from Staff A in-regards to the residents that required RN delegation, and that unqualified staff scheduled to administer medications. Staff A stated the RN delegator would be at the facility on Monday 12/16/2024 to assess the residents. Staff A stated they would try to remedy the concern about qualified medication technicians to be scheduled to administer the RN delegated residents' tasks.

Record review of an email sent to the Department on 12/13/2024 at 4:23 PM, Staff A stated the medication technicians would be delegated tomorrow 12/14/2024 for cognitively impaired residents.

On 12/13/2024 at 5:46 PM, Staff A was requested to provide the Department a schedule that showed qualified staff were scheduled to administer the delegated tasks for the next week.

Record review of an email sent to the Department on 12/13/2024 at 5:55 PM, showed Staff A was in the process of confirming the time and would email the Department when they received that information. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

Record review of an email sent to the department on 12/13/2024 at 5:56 PM, that showed 10:00 AM tomorrow 12/14/2024 was the time the RN would be at the facility to assess the residents for RN delegation. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

On 12/17/2024 at 3:26 PM, the Department requested the safety plan that included the schedule that showed qualified medication technicians were scheduled to administer delegated tasks for review.

Record review of an email sent to the Department on 12/17/2024 at 3:56 PM, showed Staff A informed the Department that Staff B worked on Tuesday and Thursday. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

As of 12/17/2024 at 5:00 PM, the Department had not received a safety plan that included a schedule of qualified medication technicians to administer residents RN delegated medication tasks for review.

As of 12/18/2024 at 8:00 AM, the Department had not received a schedule that showed qualified medication technicians were scheduled to administer delegated tasks for review.

Record review of an email sent to the Department by Staff O, Executive Director, on 12/18/2024 at 1:33 PM, showed the facility's policies were provided for review. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

As of 12/18/2024 at 5:00 PM, the Department had not received a safety plan that included a schedule of qualified medication technicians to administer residents RN delegated medication tasks for review.

In an interview on 12/19/2024 at 3:11 PM, Staff B, Resident Care Coordinator, stated the scheduled medication technician for 12/19/2024 for morning and evening shifts was Staff E. Staff B stated Staff E was working a double shift that day. Staff B stated an agency medication technician was scheduled in the morning on 12/20/2024 and Staff I for the evening medication pass.

In an interview on 12/19/2024 at 3:31 PM, Staff A, stated they were unaware if the RN delegator came into the facility on 12/14/2024 to assess the residents. Staff A stated Staff O was responsible and the point of contact in regards to the facility's safety plan to address the unqualified staff administering RN delegated medication tasks. Staff A stated Staff O took over responsibilities of the facility on Wednesday 12/18/2024.

In an interview on 12/19/2024 at 3:35 PM, Staff O stated they officially took over the facility as the Executive Director on 12/16/2024. Staff A stated Staff M did come out to the facility on Saturday 12/14/2024 to assess the residents and delegate the staff. Staff O stated not all the staff were present at the facility and Staff M had to complete a virtual call on Monday 12/16/2024, to delegate to the staff. Staff O stated on Saturday 12/14/2024 in the evening Staff N, Medication Technician Agency, had worked as the scheduled medication technician. Staff O confirmed from the documentation of a MAR that an agency medication technician did administer residents evening medications. Staff O stated on 12/14/2024 through 12/16/2024 for the evening medication pass, an

agency medication technician administered all the residents' medications. Staff O stated they were unaware what the agency's staffs type of credentials were as they just assumed responsibility of the facility.

In an interview on 12/19/2024 at 3:58 PM, Staff M stated they tried to delegate the medication technician on Saturday 12/14/2024 through a zoom call, but the medication technician was unaware of what was needing to be completed, and the other medication technicians were not present. Staff M stated there were no medication technicians delegated on 12/14/2024 or residents assessed for delegated services. Staff M stated they had reached out to Staff B but had not had any contact back. Staff M stated they had not received a list of residents that required RN delegation services. Staff M stated Staff O was the new executive director for the facility and was to provide Staff M with a list of residents that needed to be RN delegated. Staff M stated they just got access to the facility's electronic system to review the resident's records. Staff M acknowledged that they had multiple residents that were unsafe to leave the facility unattended. Staff M stated they assumed there were more than just three or four residents that required RN delegation services.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2470 Background check Employment-disqualifying information Disqualifying negative actions.

(1) The assisted living facility must not employ an administrator, caregiver, or staff person, to have unsupervised access to residents, as defined in RCW 43.43.830 , if the individual has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, unless the individual is eligible for an exception under WAC 388-113-0040 .

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 6 sampled staff (Staff F) with disqualifying negative background check results was not employed by the facility. This failure placed 26 of 26 residents at risk of being cared for by a staff member who had a disqualifying history.

Findings included…

Washington Administrative Code (WAC) 388-113-0101
“(1) The requesting entity will receive a background check result. The background check result by itself does not include criminal history record information but identifies the source of any criminal or negative action records. The possible types of results are: …
(c) A "disqualify" letter, which means the applicant or one or more data sources reported a background issue that automatically disqualifies the applicant from a position that has unsupervised access to minors or vulnerable adults…”

WAC 388-113-0020
“(1) Individuals who must satisfy background checks requirements under chapters 388-71, 388-101, 388-106, 388-76, 388-78A, 388-97, 388-825, 388-115, and 388-107 WAC must not work in a position that may involve unsupervised access to minors or vulnerable adults if the individual has been convicted of or has a pending charge for any of the following crimes:
(a) Abandonment of a child;
(b) Abandonment of a dependent person;
(c) Abuse or neglect of a child;
(d) Arson 1;
(e) Assault 1;
(f) Assault 2 (less than five years);
(g) Assault 3 (less than five years);
(h) Assault 4/simple assault (less than three years);
(i) Assault 4 domestic violence felony;…”

Record review of the facility provided, “Census Report”, dated 12/12/2024, showed Staff F, Care Manager, had been hired at the facility on 10/10/2024.

Record review of the facility provided Staff Schedule, dated 10/27/2024 through 10/31/2024, showed Staff F worked three of five days.

Record review of the facility provided Staff Schedule, dated 11/01/2024 through 11/30/2024, showed Staff F worked 19 of 30 days.

Record review of the facility provided Staff Schedule, dated 12/01/2024 through 12/12/2024, showed Staff F worked eight of 12 days. The staff schedule showed that Staff F worked on 12/12/2024.

Record review of Staff F’s Notification of background check result, completed 10/06/2024, showed it was Staff F’s interim fingerprint background check. Staff F had a disqualifying information reported on one or more background check data sources. The document showed Staff F had disqualifying information reported by one or more background check data sources. This means the applicant cannot have unsupervised access to children or vulnerable adults. If you allow the applicant to have unsupervised

access to children or vulnerable adults, you may be violating federal or state regulations and your DSHS [Department of Social and Health Services] oversight program may take action against you license or contract."

Record review of Staff F's Washington State Patrol Criminal Record, dated 10/06/2024, showed that Staff F was charged with a disqualifying crime.

In an interview on 12/12/2024 at 5:00 PM, Staff A, Executive Director, reviewed Staff F's, Notification of Background Check Result, completed 10/06/2024, and confirmed Staff F had disqualifying information on the report. Staff A acknowledged that the Department needed a safety plan within the hour to address that Staff F had currently been on shift working when they had disqualifying information on their background check and were not to work with vulnerable adults.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated Staff C, Business Office Assistant, assisted to ensure that all staff had their background checks completed.

In an interview on 12/27/2024 at 12:49 PM, Staff B, Resident Care Coordinator, stated the facility's executive director or the corporation was responsible to review the staff's background check results when they were available for review. Staff B stated the facility's corporation was aware that Staff F had a disqualified Washington state name and date of birth background check. Staff B stated Staff T, Corporate, had reviewed Staff F's disqualified Washington state name and date of birth background check and gave the facility permission to proceed and hire the employee. Staff B stated that Staff F provided documentation from their attorney that showed the charges were dropped despite the Washington state name and date of birth background check showing there were still charges that were disqualifying on Staff F's record through the Washington state patrol office.

In an interview on 01/02/2025 at 12:02 PM, Staff O, Senior Executive Director, stated the executive director of the facility was responsible to review the results of any staff members background check results.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature had been maintained between 105 and 120 degrees Fahrenheit (F) for 1 of 1 facility (assisted living facility) reviewed. This failure placed 26 of 26 residents and 12 staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included…

Record review of the facility provided document titled, "Water Temperatures", undated, showed the purpose of recorded water temperatures was to assure the facility remained free from accidental burns and scalds and any issues were addressed promptly. Residents could be more susceptible to burns than other individuals due to decreased skin sensitivity, communication abilities, and the inability to react quickly when exposed to hot water. Each state has their own regulation on maximum water temperature allowed but typically it falls between 105 degrees F to 115 degrees F. For burn prevention federal guidelines advise that water temperatures be below 120 degrees F.

In an observation on 12/12/2024 at 10:49 AM, in the resident accessible and used laundry room, the handwashing sink's hot water temperature was 135.3 degrees F. When the hot water was running, there was hot steam rising.

In an observation on 12/12/2024 at 11:25 AM, inside the resident public restroom that was to the left across from the activity room, the sink's hot water temperature was 122.0 degrees F.

In an observation on 12/12/2024 at 11:27 AM, inside the resident public restroom that was to the right across from the activity room, the sink's hot water temperature was 121.2 degrees F.

In an interview on 12/12/2024 at 10:51 AM, Staff D, Vibrant Life Director, said the facility had been looking to fill the maintenance director position.

In an interview on 12/12/2024 at 11:32 AM, Staff K, Housekeeper, said the facility did not have a maintenance director. Staff K said historically they had checked the hot water temperatures at the facility weekly. Staff K said they had not been checking the hot water temperatures as that job task fell out of their job description of what management wanted them to do.

In an interview on 12/12/2024 at 1:18 PM, Resident 1, stated that at times their hot water from both the sinks in their apartment, got very hot.

In an observation on 12/13/2024 at 9:44 AM, in the resident accessible and used laundry room, the only handwashing sink's hot water temperature was 133.6 degrees F.

In an observation on 12/13/2024 at 10:08 AM, inside Resident 2's (R2) kitchen area sink, the hot water temperature was 124.2 degrees F. There was heat and steam observed and felt rising from the running hot water.

In an observation and interview on 12/13/2024 at 10:37 AM, inside the Resident 3's (R3) bathroom sink, the hot water temperature was 120.2 degrees F. R2 stated the hot water was always very hot.

In an interview on 12/13/2024 at 10:55 AM, Staff L, Building Service Director, stated the hot water temperatures for the facility were to be between 105 degrees F and 120 degrees F. Staff L stated the hot water temperatures were to be checked weekly and recorded. Staff K stated to Staff L that they had not been checking the hot water temperatures for the facility for some time. Staff L and Staff K were unaware that the facility hot water temperatures were a concern and out of the regulated temperature range.

In an interview on 12/13/2024 at 11:43 AM, Staff L stated the maintenance director for the facility had been terminated a month and half ago. Staff L stated they came to the facility once a week to help with overall maintenance of the facility but was not checking the hot water temperatures weekly. Staff L stated the hot water tank for the laundry room sink was also connected to the kitchen sinks and water supply. Staff L stated the hot water tank was set at 140 degrees F.

In an interview on 12/13/2024 at 11:51 AM, Staff L said the facility hot water tanks were set above the 120 degrees F maximum regulation and were set to 125 degrees F.

In an interview on 12/13/2024 at 3:10 PM, Resident 9 stated the hot water in the resident's public bathroom across from the activity room wall, got really hot.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

(5) The licensee must appoint the assisted living facility administrator consistent with WAC 388-78A-2520 .

This requirement was not met as evidenced by:

Based on interview and record review, the Licensee failed to ensure the facility operated in compliance with licensing requirements and to ensure residents received necessary care and services from qualified staff for 1 of 1 facility reviewed. These failures resulted in residents receiving care and services from untrained and unqualified staff, staff and residents not being aware of who was in charge of the facility, and resulted in the facility failing to take immediate actions to ensure resident safety and placed the residents at risk of harm.

Findings included…

Revised Code of Washington (RCW) 18.20.110 “Inspection of assisted living facilities—Approval of changes or new facilities. (1) The department shall make or cause to be made, at least every eighteen months with an annual average of fifteen months, an inspection and investigation of all assisted living facilities. However, the department may delay an inspection to twenty-four months if the assisted living facility has had three consecutive inspections with no written notice of violations and has received no written notice of violations resulting from complaint investigation during that same time period. The department may at anytime make an unannounced inspection of a licensed facility to assure that the licensee is in compliance with this chapter and the rules adopted under this chapter. Every inspection shall focus primarily on actual or potential resident outcomes, and may include an inspection of every part of the premises and an examination of all records, methods of administration, the general and special dietary, and the stores and methods of supply; however, the department shall not have access

to financial records or to other records or reports described in RCW 18.20.390. Financial records of the assisted living facility may be examined when the department has reasonable cause to believe that a financial obligation related to resident care or services will not be met, such as a complaint that staff wages or utility costs have not been paid, or when necessary for the department to investigate alleged financial exploitation of a resident. Following such an inspection or inspections, written notice of any violation of this law or the rules adopted hereunder shall be given to the applicant or licensee and the department. The department may prescribe by rule that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition, or new construction, submit plans and specifications therefor to the agencies responsible for plan reviews for preliminary inspection and approval or recommendations with respect to compliance with the rules and standards herein authorized.
(2) If a pandemic, natural disaster, or other declared state of emergency prevents the department from completing inspections according to the timeline in subsection (1) of this section, the department shall adopt rules to reestablish inspection timelines based on the length of time since last inspection, compliance history of each facility, and immediate health or safety concerns.
(a) Rules adopted under this subsection (2) are effective until the termination of the pandemic, natural disaster, or other declared state of emergency or until the department determines that all facility inspections are occurring according to time frames established in subsection (1) of this section, whichever is later. Once the department determines a rule adopted under this subsection (2) is no longer necessary, it must repeal the rule under RCW 34.05.353.
(b) Within 12 months of the termination of the pandemic, natural disaster, or other declared state of emergency, the department shall conduct a review of inspection compliance with subsection (1) of this section and provide the legislature with a report."

On 12/12/2024 at 10:15 AM, the Department entered the facility for their full annual inspection.

In an interview on 12/12/2024 at 10:16 AM, Staff D, Vibrant Life Director, stated Staff A,Executive Director, was in charge but was out of the facility at the time.

Record review of the Departments database on 12/12/2024, showed Staff U, Administrator, was the facility's executive director since 02/06/2023.

In an interview on 12/13/2024 at 11:27 AM, Staff G, Care Manager, stated Staff A was the facility's executive director.

In an interview on 12/13/2024 at 10:14 AM, Staff A's personnel file was asked for to review, Staff A stated Staff O, Senior Executive Director, was the facility's executive director and they were the delegate assisting Staff O.

In an interview on 12/13/2024 at 10:53 AM, Staff J, Lead Care Manager, stated Staff A

was the facility's executive director. Staff J stated they had never heard of Staff O being the facility's executive director and it had only been Staff A since before Thanksgiving Day.

In an interview on 12/12/2024 at 12:00 PM, Staff A introduce themselves as the executive director of the facility to the Department.

In an interview on 12/13/2024 at 10:14 AM, Staff A stated Staff O, Senior Executive Director, was the facility's executive director and that Staff A was the delegate assisting Staff O when the Department requested a copy of Staff A's administration qualification records for review.

Record review of the facility's RN delegation binder on 12/13/2024 at 1:35 PM, showed there were no residents documented that they required Registered Nursing (RN) delegation services. The RN delegation binder showed Staff P, Registered Nurse, had signed off on some of the documentation for staff in the binder for review.

Record review of the facility's document titled, "December 2024", undated, showed it was a staff schedule for dates 12/08/2024 through 12/14/2024 that showed what staff worked in the facility on specific shifts. Review of 12/14/2024 showed from 6:00 AM until 2:00 PM, Staff H, Medication Technician, was the medication technician that worked and for 2:00 PM until 6:00 AM, Staff N, Medication Technician Agency, was the medication technician that worked.

In an interview on 12/13/2024 at 1:38 PM, Staff A stated Staff P was the RN delegator for the facility. Staff A was notified that there was no resident documentation in the RN delegation binder for review. Staff A was notified that there were no Staff credentials for Staff I, Medication Technician, for review. Staff A was notified that Staff H, Medication Technician, and Staff B's, Resident Care Coordinator, Washington State Department of Health credentials were expired.

In an interview on 12/13/2024 at 2:01 PM, Staff A stated the facility's RN delegator was not Staff P, but was Staff M, Registered Nurse Delegator. Staff M acknowledged that R2 should be RN delegated for their oral medication as R2 had uncontrollable hand and head tremors that required the medication technicians to spoon feed them their medications. Staff M was unaware that R8 and R7 had cognitive deficit and was not always aware that they took medications. Staff M acknowledged that they were unaware that Staff I did not have any Washington state Department of Health (DOH) credentials or that Staff B and Staff H had expired credentials. Staff M stated they would come out to the facility and complete delegation. Staff M acknowledged that the Department requested a safety plan to address when the residents would be assessed and that staff that were on shift had all the requirement to ensure the residents that were delegated received their medication from a qualified delegated staff member.

In an interview on 12/13/2024 at 2:20 PM, the Department requested a safety plan from Staff A to address the residents that were not assessed that required delegated services and the medication technicians that were not qualified with no active Washington State DOH credentials. Staff A acknowledged the Department requested the safety plan to be

emailed in the new few hours. Staff A stated they would call Staff M to collaborate and email the Department a safety plan.

In an interview on 12/13/2024 at 3:39 PM, Staff A stated the RN delegator would be at the facility on Monday 12/16/2024 to assess the residents. Staff A stated they would try to remedy the concern about qualified medication technicians to be scheduled to administer the RN delegated residents' tasks and getting the residents assessed for delegation services as soon as possible.

Record review of an email sent to the Department on 12/13/2024 at 4:24 PM, showed Staff A stated the medication technicians would be delegated tomorrow, 12/14/2024, for cognitively impaired residents.

On 12/13/2024 at 5:46 PM, Staff A was requested to provide the Department a schedule that showed qualified staff were scheduled to administer the delegated tasks for the next week.

Record review of an email sent to the Department on 12/13/2024 at 5:55 PM, showed Staff A was in the process of confirming the time and would email the Department when they received that information. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

Record review of an email sent to the department on 12/13/2024 at 5:56 PM, showed at 10:00 AM tomorrow 12/14/2024, was the time the RN delegator would be at the facility to assess the residents for RN delegation. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

As of 12/16/2024 at 5:00 PM, the Department had not received any schedule of medication technicians that were qualified to administer delegated tasks for review.

On 12/17/2024 at 3:26 PM, the Department requested the safety plan that included the schedule of qualified medication technicians that were to administer delegated tasks to delegated residents for review.

Record review of an email sent to the Department on 12/17/2024 at 3:56 PM, showed Staff A informed the Department that Staff B worked on Tuesday and Thursday. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review.

As of 12/17/2024 at 5:00 PM, the Department had not received a safety plan that included a schedule of qualified medication technicians to administer residents RN delegated medication tasks for review.

As of 12/18/2024 at 8:00 AM, the Department had not received a schedule that showed qualified medication technicians were scheduled to administer delegated tasks for review.

Record review of an email sent to the Department by Staff O, Executive Director, on 12/18/2024 at 1:33 PM, showed the facility's policies were provided for review. There was no information in the email that showed what staff would be scheduled to administer the delegated medications to the delegated residents for review. In the body of the email was a copy of the second request that was made on 12/17/2024 at 3:26 PM, that showed the Department had requested the safety plan as soon as possible and no later than 5:00 PM on 12/18/2024.

As of 12/18/2024 at 5:00 PM, the Department had not received a safety plan that included a schedule of qualified medication technicians to administer residents RN delegated medication tasks for review.

In an interview on 12/19/2024 at 3:11 PM, Staff B, Resident Care Coordinator, stated Staff O was the executive director for the facility. Staff B stated Staff A was moved to a different facility as of Tuesday 12/17/2024. Staff B stated the medication technician that worked and was scheduled for 12/19/2024 for morning and evening shifts, was Staff E, Medication Technician. Staff B stated Staff E was working a double shift that day. Staff B stated an agency medication technician was scheduled in the morning on 12/20/2024 and Staff I for the evening medication pass.

In an interview on 12/19/2024 at 3:31 PM, Staff A stated they were unaware if the RN delegator came into the facility on 12/14/2024 to assess the residents. Staff A stated Staff O was responsible and the point of contact in regard to the facility's safety plan to address the unqualified staff administering RN delegated medication tasks. Staff A stated Staff O took over responsibilities of the facility on Wednesday 12/18/2024.

In an interview on 12/19/2024 at 3:35 PM, Staff O stated they officially took over the facility as the Executive Director on 12/16/2024. Staff A stated Staff M did come out to the facility on Saturday 12/14/2024 to assess the residents and delegate the staff. Staff O stated not all the staff were present at the facility and Staff M had to complete a virtual call on Monday 12/16/2024, to delegate to the staff. Staff O stated they had gotten an email that showed three residents at the facility were identified to need RN delegated services. Staff O stated on Saturday 12/14/2024 in the evening Staff N, Medication Technician Agency, had worked as the scheduled medication technician (without required nurse delegation training). Staff O confirmed from the documentation of a MAR that an agency medication technician did administer residents evening medications. Staff O stated on 12/14/2024 through 12/16/2024 for the evening medication pass, an agency medication technician (without required nurse delegation training) administered all the residents' medications. Staff O stated they were unaware what the agency's staffs type of credentials were as they just assumed responsibility of the facility. Staff O acknowledged the facility continued to have unqualified medication technicians administering medications and that residents had not been assessed by the RN delegator on 12/14/2024 as it was documented and told to the Department. Staff O acknowledged the seriousness of the situation with needing staff credentials and

qualifications for the safety of the residents.

In an interview on 12/19/2024 at 3:58 PM, Staff M stated they tried to delegate the medication technician on Saturday 12/14/2024 through a zoom call (video call through electronic device), but the medication technician was unaware of what was needing to be completed, and the other medication technicians were not present. Staff M stated there were no medication technicians delegated on 12/14/2024 or residents assessed for delegated services. Staff M stated they had reached out to Staff B but had not had any contact back. Staff M stated they had not received a list of residents that required RN delegation services. Staff M stated Staff O was the new executive director for the facility and was to provide Staff M with a list of residents that needed to be RN delegated. Staff M stated they just got access to the facility's electronic system to review the resident's records. Staff M acknowledged that they had multiple residents that were unsafe to leave the facility unattended. Staff M stated they assumed there were more than just three or four residents that required RN delegation services.

In an interview on 12/19/2024 at 4:26 PM, Staff O acknowledged that the facility had not completed resident assessments for RN delegated services on 12/14/2024 as documented in the safety plan that was provided to the Department. Staff O acknowledged that the facility was unable to provide a schedule of qualified staff to administer the delegated tasks of the resident for review.

Summary.

After interview and record review the facility failed to ensure that all staff were aware of who the acting executive director was for the facility including the Department. The facility failed to have a system in place to identify and notify the RN delegator that residents required RN delegation services and that all staff that were medication technician had active Washington state Department of Health credentials. When the facility was asked to provide a safety plan to include when the residents could be properly assessed and a schedule of staff that were qualified to administer delegated services, the facility was unable to provide a schedule of qualified staff to administer delegated tasks to the Department. The facility did not assess the residents as the facility stated on 12/13/2024 for delegated services.

Refer to Washington Administrative Code (WAC) 388-78A-2320, 388-78A-2470, 388-78A-2950, 388-78-24701, 388-78A-2462, 388-78A-2466, 388-78A-2471, 388-78A-2474, 388-78A-2484, 388-78A-2821, 388-78A-3090, 388-78A-2040, Revised Code of Washington (RCW) 70.129.070, 388-78A-2305, 388-78A-2300, 388-78A-2732, 388-78A-2610, 388-78A-2400, 388-78A-2660, 388-78A-2260, 388-78A-2710, 388-78A-2665, 388-78A-2120, 388-78A-2150, 388-78A-2140, 388-78A-2100, 388-78A-2090, and 388-78A-2130.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a character, competence, and suitability for 1 of 1 staff member (Staff B) before they were determined they were cleared to work with vulnerable adults. This placed 26 of 26 residents at risk for potentially being cared for by an unauthorized staff member.

Findings included...

“WAC [Washington Administrative Code] 388-113-0060 How and when must a character, competence, and suitability [CCS] determination be conducted by the department or an authorized entity? (1) The department or an authorized entity must conduct a character, competence, and suitability determination of an employee, prospective employee, or other individual who is required to undergo a background check when the applicant has received a "review required" result as defined in WAC 388-113-0101(b). (3) If an applicant is required to have a character, competence, and suitability determination under this section, the applicant may not have unsupervised access to minors or vulnerable adults unless the character, competence, and suitability determination has: (a) Been completed and documented in writing. applicant may have unsupervised access to minors or vulnerable adults.”

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff B’s, Resident Care Coordinator, date of hire was on 09/11/2023.

In an interview on 12/12/2024 at 12:00 PM, Staff A, Executive Director, stated the

employees with a hire date of 09/11/2023 was the date the new management company took over the facility. Staff A stated the employee's original hire date when first worked at the facility would be in their employee file.

Record review of Staff B's General Orientation, dated 02/25/2021, showed Staff B's date of hire for the facility was on 02/23/2021.

Record review of Staff B's interim Washington state name and date of birth and fingerprint background check, dated 02/24/2021, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review". There was no CCS completed for Staff B's interim fingerprint background check results for review.

Record review of Staff B's final Washington state name and date of birth and fingerprint background check, dated 11/18/2021, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review". There was no CCS completed for Staff C's final fingerprint background check results for review.

Record review of Staff B's "Residential Care Services Character, Competence, and Suitability (CCS) Determination for Unsupervised Access to Minors and Vulnerable Adults", dated 12/12/2024, showed it was completed by Staff A, Executive Director, the day the Department requested to review Staff B's CCS.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated Staff C, Business Office Assistant, was in training and responsible for ensuring that all staff had required documentation for their employee files.

In an interview on 12/27/2024 at 12:49 PM, Staff B stated the facility executive director was responsible to review all staff's Washington State name and date of birth background check results. Staff B stated the executive director was responsible to review with the staff member if there were findings resulted on their Washington state name and date of birth and fingerprint background checks and fill out the CCS form.

In an interview on 01/02/2025 at 12:02 PM, Staff O, Senior Executive Director, stated the executive director of the facility was responsible to review the results of any staff members background check results. Staff O stated the executive director would complete the CCS form for the employee if the background check results showed one needed to 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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

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

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

(b) A national fingerprint background check.

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(c) Managers who do not provide direct care to residents; and

(d) Contractors other than the administrator and caregivers who may have unsupervised access to residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a Washington State name and Date of Birth background check and fingerprint background checks completed for 2 of 2 contracted agency caregivers (Staff N and Staff R) prior to them working at the facility. The facility failed to ensure that the 3 of 4 new staff (Staff A, Staff E, and Staff G) had their Washington State name and Date of Birth background check and fingerprints completed within the required time. These failures placed all 26 of 26 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included…

Washington Administrative Code (WAC) 388-06-0530 “When does the 120-day provisional period begin? The 120-day provisional period begins on the date an applicant, long-term care worker, or service provider begins providing care to a vulnerable adult or child.”
WAC 388-78A-2020 Definitions. “"Contractor" means an agency or person who contracts with a licensee to provide resident care, services, or equipment.”

Staff A

Record review of the facility's document titled, "[facility name] Associate Roster", undated, showed Staff A, was the Executive Director. There was no hire date recorded on the document.

In an interview and observation on 12/12/2024 at 4:05 PM, Staff A stated they started employment at the facility on 11/26/2024.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated they worked in Washington state during the year 2020 through 2021. Staff A does not recall completing a new one prior to their start at the facility as the executive director on 11/26/2024.

Staff E

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff E, Medication Technician, was hired at the facility on 01/02/2024

Record review on 12/12/2024 at 3:40 PM, of Staff E's employee file showed there was no Washington State Name and Date of Birth and Fingerprint Background check results or background check authorization form for review.

Staff G

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff G, Care Manager, was hired at the facility on 12/07/2023.

Record review on 12/12/2024 at 3:40 PM of Staff G's employee file showed there was no Washington State Name and Date of Birth and Fingerprint Background check results or background check authorization form for review.

Staff N

Record review of the facility's untitled and undated document titled "December", dated 12/08/2024 through 12/14/2024, was a schedule of the caregivers and medication technicians for the facility. On 12/12/2024 through 12/14/2024 from 10:00 PM until 6:00 AM, Staff N, Medication Technician Agency was scheduled to work.

In an interview and observation on 12/13/2024 at2:15 PM, Staff N, had been observed to be in the chart room on the computer. Staff N said they worked their first shift for the facility the night of 12/12/2024.

Staff R

Record review of the facility's untitled and undated document titled "December", dated 12/08/2024through 12/14/2024, was a schedule of the caregivers and medication technicians for the facility. On 12/12/2024 through 12/13/2024 from 10:00 PM until 6:00 AM and on 12/14/2024 from 11:00 AM until 7:00 PM Staff R, Certified Nursing Assistant Agency was scheduled to work.

On 12/12/2024 at 3:27 PM, the Department requested to review Staff A, Staff E, Staff G's employee file. The Department requested to review Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background check.

In an interview on 12/12/2024 at 3:41 PM, Staff D, Vibrant Life Director, brought in Staff R's background check in for review. Staff D stated Staff A was printing Staff N's background check for the Department to review.

Record review of Staff R's document titled, Washington Access to Criminal History, dated 11/11/2024, showed "web search no record found report". There was no Washington State Name and Date of Birth and Fingerprint Background Checks provided.

In an interview on 12/12/2024 at 4:05 PM, Staff A stated they submitted their request to get their ID code to access background checks in the system on 12/11/2024. Staff A was observed to look through a binder with employee background check results. Staff A stated Staff E, Staff A, Staff G, Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background checks were not in the binder for review.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated they were still unable to access any background check results for review Staff A, Staff E, Staff G, Staff N, and Staff R for the Department to review. Staff A stated they had filled out to have a Washington State Name and Date of Birth and Fingerprint Background completed when they worked in Washington during the year 2020 through 2021. Staff A did not recall completing a new one prior to their start at the facility as the executive director on 11/26/2024. Staff A stated Staff C, Business Office Assistant, was responsible to ensure that all staff had the required background checks completed and filed for review.

As of 12/13/2024 at 5:30 PM, the Department had not received Staff A, Staff E, Staff G, Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background results for review.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1of 2 sampled staff (Staff B) had submitted a new Washington state name and background check every two years. This failure placed 26 of 26 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included…

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff B, Resident Care Coordinator, was hired at the facility on 09/11/2023.

In an interview on 12/12/2024 at 12:00 PM, Staff A, Executive Director, stated the employees with a hire date of 09/11/2023 was the date the new management company took over the facility. Staff A stated the employee’s original hire date when first worked at the facility would be in their employee file.

Record review of Staff B’s General Orientation showed Staff B’s date of hire for the facility was on 02/23/2021.

Record review of Staff B’s interim Washington state Name and Date of Birth Background

check, dated 02/24/2021, showed under background check result “review required as of the date of the background check data search, the applicant has: information reported by one or more background check sources that requires a character, competence, and suitability review.” The background check was the most updated Washington state Name and Date of Birth Background check in Staff B’s employee file for review.

On 12/12/2024 at 5:44 PM, Staff B’s current Washington state Name and Date of Birth Background was requested for review.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated Staff C, Business Office Assistant, was responsible to ensure that all staff had the required Washington state Name and Date of Birth Background checks completed and filed for review. Staff A stated they were still unable to access any background check results for Staff B for the Department to review

As of 12/13/2024 at 5:30 PM, the Department had not received Staff B’s current Washington State Name and Date of Birth Background results for review. Staff B was required to have a Washington State Name and Date of Birth Background check on 02/24/2023 that was 658 days past when it was to 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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2471 Background check Confidentiality Use restricted Retention. The assisted living facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure 3 of 5 sampled staff (Staff A, Staff E, and Staff G) and 2 of 2 sampled agency staff (Staff N and Staff R) had a copy of their Washington State Name and Date of Birth and Fingerprint Background Checks at the facility for the department to review. This failure to ensure a Washington State Background Check was available placed 26 of 26 residents at risk for

being cared for by a staff member with a potentially disqualifying history.

Findings included…

Record review of the facility's document titled, "[facility name] Associate Roster", undated, showed Staff A, was the Executive Director. There was no hire date recorded on the document.

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff E, Medication Technician, was hired at the facility on 01/02/2024 and Staff G, Care Manager, was hired on 12/07/2023.

Record review of the facility's untitled and undated document titled "December", dated 12/08/2024 through 12/14/2024, was a schedule of the caregivers and medication technicians for the facility. On 12/12/2024 through 12/14/2024 from 10:00 PM until 6:00 AM, Staff N, Medication Technician Agency was scheduled to work and Staff R, Certified Nursing Assistant Agency, was scheduled to work 12/12/2024 through 12/13/2024 from 10:00 PM until 6:00 AM and on 12/14/2024 from 11:00 AM until 7:00 PM.

On 12/12/2024 at 3:24 PM, the Department requested to review Staff A, Staff E, Staff G's employee file for review. The Department requested to review Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background check.

In an interview on 12/12/2024 at 3:41 PM, Staff D, Vibrant Life Director, brought in Staff R's background check in for review. Staff D stated Staff A was printing Staff N's background check for the Department to review.

Record review of Staff R's document titled, Washington Access to Criminal History, dated 11/11/2024, showed "web search no record found report". There was no Washington State Name and Date of Birth and Fingerprint Background Checks provided.

As of 12/12/2024 at 4:00 PM, the Department had not received Staff A, Staff E, Staff G, Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background check for review.

In an interview and observation on 12/12/2024 at 4:05 PM, Staff A stated they started employment at the facility on 11/26/2024. Staff A stated they submitted their request to get their ID code to access background checks in the system on 12/11/2024. Staff A was observed to look through a binder with employee background check results. Staff A stated Staff E, Staff A, Staff G, Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background checks were not in the binder for review.

In an interview on 12/12/2024 at 5:27 PM, Staff A acknowledged that there was no Washington State Name and Date of Birth and Fingerprint Background check for review in Staff E and Staff G's employee files for review.

On 12/12/2024 at 5:44 PM, the Department requested to review Staff A's Washington State Name and Date of Birth and Fingerprint Background check.

In an interview on 12/12/2024 at 5:49 PM, Staff A stated the facility only had the Washington Access to Criminal History background check results for Staff R. Staff A acknowledged that the facility did not have a Washington State Name and Date of Birth and Fingerprint Background check for Staff R.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated they were still unable to access any background check results for review Staff A, Staff E, Staff G, Staff N, and Staff R for the Department to review. Staff A stated they had filled out to have a Washington State Name and Date of Birth and Fingerprint Background completed when they worked in Washington during the year 2020 through 2021. Staff A does not recall completing a new one prior to their start at the facility as the executive director on 11/26/2024. Staff A stated Staff C, Business Office Assistant, was responsible to ensure that all staff had the required background checks completed and filed for review.

As of 12/13/2024 at 5:30 PM, the Department had not received Staff A, Staff E, Staff G, Staff N, and Staff R's Washington State Name and Date of Birth and Fingerprint Background results for review.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term

care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

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

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under chapter 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009 .

This requirement was not met as evidenced by:

Based on interview and record review facility failed to ensure 3 of 3 sampled new staff (Staff E, Staff F, and Staff G) had completed their facility orientation. The facility failed to ensure 3 of 3 sampled staff (Staff E, Staff F, and Staff G) had the required Department of Social and Health Services (DSHS) five hour orientation and safety training. The facility failed to ensure 3 of 5 sampled staff (Staff E, Staff F, and Staff H) had the required CPR (cardiopulmonary resuscitation) and First Aid training. The facility failed to ensure that 2 of 2 sampled staff (Staff E and Staff G) had the dementia specialty training certificate as required. The facility failed to ensure 1 of 2 sampled staff (Staff H) completed their continued education units (CEU). The facility failed to ensure 2 of 4 sampled Staff (Staff E and Staff G) had their home care aid certification. These failures resulted in residents being cared for by staff without required trainings and placed 26 of 26 residents at risk of harm in the event of an emergency due to staff not being trained on life saving measures, unaware of the facility's expectations, and risk of unmet care needs by untrained staff.

Findings included…

Washington Administrative Code (WAC) 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility

orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods

and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."

WAC 388-112A-0220 "What is safety training, who must complete it, and when should it be completed? (1) Safety training is part of the long-term care worker requirements. It is a three hour training that must meet the requirements as described in WAC 388-112A-0230, and include basic safety precautions, emergency procedures, and infection control. Safety training must be completed prior to providing care to a resident. (2) All long-term care workers who are not exempt from home care aide certification as described in RCW 18.88B.041 hired after January 7, 2012, must complete three hours of safety training. This safety training must be provided by qualified instructors who meet the requirements in WAC 388-112A-1260. (3) The department must approve safety training curricula and instructors."

WAC 388-112A-0720 "What are the CPR and first-aid training requirements? (2) Assisted living facilities. (a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire. (b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire. (c) The form of the first-aid or CPR card or certificate may be electronic or printed. "

WAC 388-112A-0611 "(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:(i) A certified home care aide;(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);(iii) A certified nursing assistant;(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in RCW 28A.300.010; and(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0060.(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.(c) The continuing education requirements of this section do not apply to a registered nurse, a licensed practical nurse, and an advanced registered nurse practitioner licensed under chapter 18.79 or 18.80 RCW, even if voluntarily certified as a home care aide under chapter 18.88B RCW.(d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete and provide documentation of 12 hours of continuing education within 45 calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; and(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or(ii) If the 45 calendar day time period allows the long-term care worker to complete continuing education in January or February of the following year, the credit hours earned will be applied to the calendar year in which the long-term care worker was hired.(e) If the birthday following initial certification as a home care aide or nursing assistant (NA-C) is less than a full year from the date of initial

certification, no continuing education will be due for the first renewal period.(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed."

WAC 388-112A-0400 "(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450. (b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement. (c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (b) Dementia specialty training as described in WAC 388-112A-0440; (4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (b) Dementia specialty training as described in WAC 388-112A-0440; and (5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire. (6) For long-term care workers who have completed the 75-hour training and do not have a specialty training certificate that indicates completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs."

WAC 388-112A-0490 "What are the specialty training requirements for applicants, resident managers, administrators, and other types of entity representatives in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities. (3) If an assisted living facility serves one or more residents with special needs, the assisted living facility administrator or designee must complete specialty training and demonstrate competency within one hundred twenty days of date of hire. (4) If a resident develops special needs while living in an assisted living facility, the assisted living facility administrator or designee has one hundred twenty days to complete specialty training and demonstrate competency, or demonstrate proof of specialty training."

WAC 388-112A-0300 "(1) The 70-hour home care aide basic training is in addition to orientation and safety training. It is 70 hours and includes: (a) The core competencies

and skills that long-term care workers need in order to provide personal care services effectively and safely; (b) Practice and demonstration of skills; and (c) Population specific competencies. (2) DSHS must approve the 70-hour home care aide basic training curricula. (3) On-the-job training may be applied to the core competencies of 70-hour home care aide basic training for an amount that must be approved by the department. (4) The DSHS developed fundamentals of caregiving (FOC) or another department approved training may be used to teach the core competencies of the 70-hour home care aide basic training but the FOC must include enhancements. Additional student materials are required to ensure the enhancements are well planned and documented for students. Materials must be submitted for approval and approved per WAC 388-112A-1020. Examples of enhancements include, but are not limited to: (a) More time for workers to practice skills including: (i) The mechanics of completing the skill correctly; (ii) Resident centered communication and problem solving associated with performing the skill; (iii) The different levels of care required for each skill including independent, supervision, limited, extensive, and total; (iv) Working with assistive devices associated with a skill; (v) Helpful tips or best practices in working through common resident challenges associated with a skill; and (vi) Disease specific concerns or challenges associated with a skill. (b) Augmenting or adding additional materials, student activities, videos, or guest speakers that: (i) More deeply reinforce and fortify the learning outcomes required for basic training; (ii) Ensure each student integrates and retains the knowledge and skills needed to provide quality basic personal care; and (iii) Prepares workers for the certification testing environment and process. (c) Enhancements are not materials or activities that are one or more of the following: (i) Are out of the scope of practice for a long-term care worker such as content clearly written for registered nurses; (ii) Are identical to, or a direct replacement of, those already included in the FOC; (iii) Fail to reinforce Washington state laws associated with resident rights and resident directed care; (iv) Long-term care workers are not paid to provide; (v) Are written above a high school reading level. (5) The delivery mode of the 70-hour home care aide basic training may be either in-person or virtual classroom instruction, or a hybrid of online and in-person, remote, or virtual classroom instruction. One hour of completed classroom instruction or other form of training (such as a virtual classroom, remote or online course) equals one hour of training. (a) Online and virtual classroom modules must be interactive, provide the student with access to the instructor, and adhere to the DSHS online and virtual classroom standards posted on DSHS's website at https://bit.ly/dshs-online-standards. (b) The in-person skills training or remote skills training portion of hybrid modules must be no less than 16 hours of the total basic training hours and include in-person or remote instruction on the personal care tasks supporting activities of daily living, as described in WAC 388-112A-0320. (6) The long-term care worker must be able to ask the instructor questions during the training. (7) There is no challenge test for the 70-hour home care aide basic training."

WAC 388-112A-0105 "Who is required to obtain home care aide certification and by when? (1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (2) The following individuals must obtain home care aide certification as follows… (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire."

WAC 388-112a-008- "Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC

388-112A-0090… Assisted living facilities. (4) Assisted living facility administrators or their designees within one hundred twenty days of date of hire. (5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training."

Record review of the facility's document titled, "Disclosure of Services Required by RCW 18.20.300", under the section titled, "care for residents with dementia, developmental disabilities, or mental illness", showed the facility that chose to serve resident with dementia, developmental disabilities, or mental health issues must provide their staff with specialized training in those areas. The facility would serve persons with the following needs that included dementia.

Record review of the facility provided, "Census Report", dated 12/12/2024, showed active employees included Staff E, Medication Technician, was hired at the facility on 01/02/2024.

Record review of the facility provided, "Census Report", dated 12/12/2024, showed active employees included Staff F, Care Manager, was hired at the facility on 10/10/2024.

Record review of the facility provided, "Census Report", dated 12/12/2024, showed active employees included Staff G, Care Manager, was hired at the facility on 12/07/2023.

Record review of the facility provided, "Census Report", dated 12/12/2024, showed active employees included Staff H, Medication Technician, was hired at the facility on 09/11/2023.

Facility Orientation

Record review of Staff E's, "General Safety Orientation", undated, showed Staff E had reviewed the following topics that included electrical shut off, water shut off, gas shut off, fire alarm system, location of the fire alarm panel, emergency shut off, security system/door alarms, standby generator, fire alarm response, fire drill procedure, and missing resident/elopement procedure. Staff E signed off that they reviewed the document. Staff E's orientation did not cover all required topics per WAC 388-112A-0210.

Record review of Staff F's, General Safety Orientation", undated, showed Staff F was reviewed the following topics that included electrical shut off, water shut off, gas shut off, fire alarm system, location of the fire alarm panel, emergency shut off, security system/door alarms, standby generator, fire alarm response, fire drill procedure, and missing resident/elopement procedure. Staff F signed off that they reviewed the

document. Staff F's orientation did not cover all required topics per WAC 388-112A-0210.

Record review of Staff G's personnel file, on 12/13/2024, showed Staff G did not have a facility orientation completed for review.

DSHS 5 Hour Orientation and Safety Training

Record review of Staff E's personnel file on 12/13/2024, showed Staff E did not have a five hour DSHS orientation to review. This was not completed as required prior to providing care to a resident.

Record review of Staff F's personnel file on 12/13/2024, showed Staff F did not have a five hour DSHS orientation to review. This was not completed as required prior to providing care to a resident.

Record review of Staff G's personnel file on 12/13/2024, showed Staff G did not have a five hour DSHS orientation to review. This was not completed as required prior to providing care to a resident.

CPR/First Aid Certificate

Record review of Staff E's personnel file on 12/13/2024, showed Staff E did not have a first aid and CPR certificate for review. Staff E was required to obtain their first aid and CPR certificate by 02/01/2024 that was 316 days past due.

Record review of Staff F's, Healthcare Provider American Heart Association, dated 04/11/2011, showed Staff F completed their CPR training on 04/11/2011. Staff F's CPR card showed it had the recommended renewal date was 04/13/2013.

Record review of Staff F's personnel file, on 12/13/2024, showed Staff F did not have a first aid certificate to review and did not have an updated CPR certificate to review.

Record review of Staff H's, Basic Plus Certification Card, dated 11/04/2021, showed Staff H completed their first aid and CPR certificate that was issued on 11/04/2021. Staff H's CPR and first aid card expired on 11/04/2023.

Record review of Staff H's personnel file, on 12/13/2024, showed Staff H did not have an updated first aid and CPR certificate for review.

Dementia Specialty Training

Record review of Staff E's personnel file, on 12/13/2024, showed Staff E did not have a dementia specialty training certificate to review. Staff E should have completed the dementia specialty training by 05/01/2024. Staff E was 226 days past the required time frame to complete the dementia specialty training.

Record review of Staff G's personnel file, on 12/13/2024, showed Staff G did not have a dementia specialty training certificate to review. Staff G should have completed the dementia specialty training by 04/05/2024. Staff G was 252 days past the required time frame to complete the dementia specialty training.

CEU

Record review of Staff H's personnel file on 12/13/2024, showed their date of birth was on [redacted].

In an interview on 12/13/2024 at 10:12 AM, Staff C, Business Office Assistant, provided Staff H's continued education credits for review and stated these were all the CEU's they had for Staff H for review.

Record review of the facility provided document titled, "[Staff H's name] Trainings", undated showed a transcript of their continued education credits. The CEU were for dates [redacted]/2023 through [redacted]/2024, that showed Staff H completed three of 12 required CEU's.

Home Care Certificate

Record review of Staff E's personnel file, on 12/13/2024, showed Staff E did not have any Washington State Department of Health credentials for review.

Record review of Staff G's personnel file, on 12/13/2024, showed Staff G did not have any Washington State Department of Health credentials for review.

In an interview on 12/13/2024 at 11:28 AM, Staff G, said they were in the process to complete their credentials. Staff G said the facility administration never enrolled them into programs to complete their credentials.

In an interview on 12/13/2024 at 11:03 AM, Staff A, Executive Director, stated Staff C, Business Office Assistant were responsible for keeping track of the staffs required training, testing, certificates, all requirements in the staff files. Staff A stated Staff B,

Resident Care Coordinator was still in training and the facility's corporation was assisting Staff C to track that the staff had all the required documents and trainings completed.

In an interview on 12/13/2024 at 11:43 AM, Staff A said that the employee records the Department requested should be in the employee's personnel file. Staff A said Staff C had been responsible to organize the personnel files. Staff A said if a document was not in the personnel file, then the facility did not have it.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 4 of 4 sampled Staff (Staff A, Staff E, Staff F and Staff G) received their Tuberculosis (infectious bacterial disease of the lungs) test within the required time requirements. This failure placed 26 of 26 residents at risk for exposure to Tuberculosis (TB).

Findings included…

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and

the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the Centers for Disease Control and Prevention (CDC) website article titled, "Clinical Testing Guidance for Tuberculosis: Health Care Personnel", dated 12/15/2023, showed TB screening programs for health care personnel were part of TB infection control plans. CDC recommends all United States health care personnel should be screened for TB upon hire.

Record review of the CDC's website article titled, "Baseline Tuberculosis Screening and Testing for Health Care Personnel", dated 12/19/2023, showed All United States health care personnel should be screened for tuberculosis upon hire. The process should include a risk assessment, symptom evaluation, and TB blood test or TB skin test. If the Mantoux tuberculin skin test (TST) used for baseline testing of the health care personnel, they were to get a two-step skin test. The two-step skin test was recommended for the initial TB skin test for adults who may be tested periodically, such as health care personnel. The first step of the skin test should be administered results were negative then the skin test would be repeated with another TB skin test completed one to three weeks after the first TB skin test results read. The TB skin test was to be read within 48-72 hours. If the person failed to return within 72 hours to have the TB skin test read, the TB skin test was to be repeated.

Record review of the facility's policy titled, "Infection Control 14- Tuberculosis- Care Staff", dated 05/13/2022, showed all care staff would be screened for TB infection and disease per state regulations prior to beginning employment. Under the section titled, "screening care staff", showed each newly hired care staff member would be screened for TB infection and disease after employment offer was made but prior to the employee's duty assignment. Each staff person was screened for TB within three days of employment. Per the CDC guidance, test results should be read 48-72 hours after administration by a healthcare worker trained to read TST results. If the staff member does not return within 72 hours, they would need to be rescheduled for another skin test. Unless the staff person meets the requirements for having not 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 that included an initial skin test within three days of employment and a second skin test done one to three weeks after the first step. The assisted living facility must keep records of TB test results in the assisted living facility, make them readily available to the licensing agency, retain the records for at least two years after the staff person either quits or was terminated.

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff E, Medication Technician, was hired at the facility on 01/02/2024.

Record review of Staff E's "Employee TB Test Record", undated, showed Staff E received their first TB skin test on 07/15/2024. That was 192 days after the required time frame it was to be completed.

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff F, Care Manager, was hired at the facility on 10/10/2024.

Record review of Staff F's "Employee TB Test Record", undated, showed Staff F received their first TB skin test on 11/20/2024. That was 29 days after the required time frame it was to be completed. The first skin test was not read and the second skin test was not completed.

Record review of the untitled and undated document that had a list of active employees for the facility showed Staff G, Care Manager, was hired at the facility on 12/07/2023.

Record review of Staff G's "Employee TB Test Record", undated, showed Staff G received their first TB skin test on 07/24/2024. That was 227 days after the required time frame it was to be completed.

Record review of the facility's document titled, "[facility name] Associate Roster", undated, showed Staff A, was the Executive Director. There was no hire date recorded on the document.

In an interview and observation on 12/12/2024 at 4:05 PM, Staff A stated they started employment at the facility on 11/26/2024.

In an interview on 12/13/2024 at 10:14 AM, Staff A stated Staff S, Former Executive Director, had given their TB test and Staff A gave Staff S their TB test and were unable to find the form to show it was completed.

In an interview on 12/13/2024 at 11:03 AM, Staff A stated Staff C, Business office Assistant, was responsible to ensure that all staff employee files had all the required documentation and tests completed and filed.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

WAC 388-78A-2821 Design, construction review, and approval plans.

(2) The assisted living facility will meet the following requirements:

(b) Construction document review. Submit construction documents for proposed new construction to the department for review within ten days of submission to the local authorities. Compliance with these standards and regulations does not relieve the facility of the need to comply with applicable state and local building and zoning codes. The construction documents must include:

(i) A written functional program consistent with WAC 388-78A-2361 containing, but not limited to, the following:

(A) Information concerning services to be provided and the methods to be used;

(B) An interim life safety measures plan to ensure the health and safety of occupants during construction;

(C) An infection control risk assessment indicating appropriate infection control measures, keeping the surrounding area free of dust and fumes, and ensuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors;

(D) An analysis of likely adverse impacts on current assisted living facility residents during construction and the facilities plans to eliminate or mitigate such adverse impacts including ensuring continuity of services;

(c) Resubmittals. The assisted living facility will respond in writing when the department requests additional or corrected construction documents;

(d) Construction. Comply with the following requirements during the construction phase:

(i) The assisted living facility will not begin construction until all of the following items are complete:

(A) Construction review services has approved construction documents or granted authorization to begin construction;

(C) The construction review services will issue an "authorization to begin construction" when the construction documents have been conditionally approved.

(ii) Submit to the department for review any addenda or modifications to the construction documents.

(iii) Assure construction is completed in compliance with the final construction review services approved documents. Compliance with these standards and regulations does not relieve the facility from compliance with applicable state and local building and zoning codes. Where differences in interpretations occur, the facility will follow the most stringent requirement.

(vi) The assisted living facility will allow any necessary inspections for the verification of

compliance with the construction documents, addenda, and modifications.

(e) Project closeout. The facility will not use any new or remodeled areas for resident use of licensed space until:

(i) The department has approved construction documents;

(ii) The local jurisdictions have completed all required inspections and approvals, when applicable or given approval to occupy; and

(iii) The facility notifies the department in writing when construction is completed and includes:

(A) Copy of the local jurisdiction's approval for occupancy;

(B) Copy of reduced floor plans; and

(C) A room schedule.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to submit construction documents to construction review services (CRS) before scheduled construction for 3 of 3 areas (room [redacted], room [redacted], and whirlpool room) within the facility. This placed 26 of 26 residents safety at risk as CRS had not been able to ensure health and safety plans were in place for the residents, staff, and visitors during the construction.

Findings included…

Record review of Washington State Department of Health Construction Review Services (CRS) website article, undated, showed construction and renovation could affect the existing life safety and fire protection systems of the facility. When the facility was occupied by staff and patients during construction, this could present an increased hazard to the occupants. To mitigate the conditions, CRS recommends that all phases of the project to be examined to identify potential hazards. Both life safety code and the fire code provided specific direction to the maintenance of the life safety systems during a fire. Major design elements that must be resolved by CRS before issuing an authorized to begin construction include but not limited to infection control risk assessment and interim life safety measures. An infection control risk assessment should address precautions such as but not limited to patient placement or relocation, standards for barriers or other protective measures required to protect adjacent areas and susceptible patients from airborne contaminants, protection from the products of demolition, and temporary provisions or phasing for construction or modification of heating, ventilation, air conditioning, and water supply system.

Record review on 12/17/2024 at 8:55 AM, of the Washington State Department of Health Construction review search website, showed there were no records found for the facility for review.

Record review of the Washington State Department of Health website article 333-302 titled, “Mold”, dated 09/2022, showed mold was tiny microscopic organisms that digest organic matter and reproduce by releasing spores. Molds were a type of fungi. Mold could become a problem then they go where they were not wanted and digest materials such as homes. Mold could grow on any surfaces and need moisture to begin growing, digesting, and destroying. When molds were distributed, they release spores into the air, that could expose a person by breathing air containing the mold spores. People could be sensitive to the mold spores that could cause a person to experience skin rash, eye irritation, runny nose, cough, nose congestion, and difficult breathing with people that have an underlying breathing condition.

Record review of the facility provided document titled, “Certificate of Mold Analysis”, dated 10/30/2024, showed Priority Lab took a sample location outside of room [redacted] on 10/30/2024. The data had been analyzed on 11/12/2024 and showed under air analysis that there had been a “problem”. There had been three problem fungi identified which included Chaetomium (fungi or mold found in soil, air, and plant debris), penicillium/aspergillus (type of fungi found in the environment that could be a health concern), and stachybotrys (fungi or mold).

Room [redacted] and Room [redacted]

In an interview on 12/12/2024 at 1:18 PM, Resident 4 (R4), said they used to reside in room [redacted]. R4 said they had to relocate rooms when Collateral Contact 1 (CC1), R4’s power of attorney, found mold (a type of fungus that can be dark green or black in color commonly found in damp water damaged areas) underneath their kitchenette sink. R4 said the mold effected the cojoined room attached to room [redacted]. R4 said CC1 took pictures of the mold the day they found it inside of their room.

Record review on 12/12/2024 at 1:36 PM, showed CC1 sent the Department pictures of underneath R4’s former kitchenette in room [redacted]. The picture had been taken on 10/27/2024. In the picture you could see two silver nozzles and underneath the nozzles there had been a curved shape pipe. The picture showed a white wall that had dark green and black varying sizes spots that covered the wall. To the left of the image in the corner there had been dark green and black spots that accumulated heavier on the left and bottom side of the piping fixture.

In an observation on 12/12/2024 at 2:31 PM, inside room [redacted] the kitchenette area had been stripped from the room. There had been exposed piping inside of the wooden panels. Inside of room [redacted] room [redacted] had been visible as the rooms shared a wall. Room [redacted] window had been left opened.

In an observation and interview on 12/13/2024 at 10:55 AM, Staff L, Building Service Director, and Staff K, Housekeeper, were observed to bring in a large piece of drywall into room [redacted]. Inside the room the wall was missing to the left that exposed pipes and 2x4 wood structure boards. Staff L stated there had been water damaged that caused

mold in the area of the wall that required them to remove all of the wall. Staff L stated all the paperwork had been completed and was given to Staff A, Executive Director.

Whirlpool Room

In an observation on 12/12/2024 at 11:19 AM, Staff J, Lead Care Manager, had been observed to exit an unidentified room located next to room 139. Inside the unlocked room showed a bathroom with a whirlpool bathtub. The laminate floor had been torn off and exposed 75 percent of the cement ground. On top of the cement a brown rectangle carpet had been placed. Directly in front of the door was a wall with half of it missing. The wall from the floor to half up had exposed pipes and 2x4 board structure and could see the whirlpool through the area on the other side. The exposed 2x4 wood boards had rusted nails that stuck out of the surface. Two by four individual wood pieces had leaned against the wood panels and exposed pipes.

In an interview on 12/12/2024 at 11:32 AM, Staff K, Housekeeper, said at one point the whirlpool spa inside of the bathroom worked. Staff K said the facility considered repairing the bathroom, but they had been unsure if there had been a current plan in place to fix the exposed piping.

In an interview on 12/13/2024 at 11:43 AM, Staff L did not think the facility performed construction to room [redacted] and room [redacted] when they took out the kitchenette, insulation, and drywall which left exposed pipes and 2x4 wall structure wood boards. Staff L had not been aware if the facility completed construction that they needed to submit paperwork of their plan to Washington state Department of Health CRS. Staff A said the facility should have submitted paperwork to CRS. Staff A confirmed the facility could not provide any documentation that they submitted to CRS for the construction of the whirlpool room, room [redacted], and room [redacted].

In an interview on 12/13/2024 at 11:53 AM, Staff L, said they thought the whirlpool bathtub stopped working and the facility tore the wall apart to see if they could fix it. Staff L said historically they never sent in documentation to CRS to review.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 (inner outside courtyard and common hallways) and areas within the building. The facility failed to keep exterior grounds in good repair. These failures placed 26 of 26 residents as risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included…

Record review of the facility provided document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection, undated, showed 13 of 26 residents had a condition that affected their memory because the column titled, “Dementia [a group of conditions that affects a persons what of thinking and memory]/Alzheimer's [a progressive brain disorder that affects one’s ability to think, judgement, and ability to carry out activities of daily living needs]/Cognitive Impairment [a brain condition affecting thinking, memory, and decision-making], was checked.

Record review of the facility provided document titled, “Disclosure of Services Required by RCW 18.20.300”, undated, showed all assisted living facilities must keep any area a resident used in a safe, clean, and comfortable condition.

Record review of the facility provided document titled, “Integral Senior Living Job Description”, dated 06/01/2005, showed the housekeeper was responsible to clean all public areas to ensure they were clean at all times.

In an observation on 12/12/2024 at 11:02 AM, in the common outside courtyard doorway facing inside the facility, across from room 107 and room 109, on the right side of the doors was a missing light fixture. In the area were there had been a light fixture were black and white wires exposed and extended out of the facility wall. On the left side of the door the light fixture hung off of the wall was not secured to the lights base and hung down. In between the light fixtures base and the top of the light were black and white exposed wires.

In an observation on 12/12/2024 at 11:16 AM, in the hallway just outside of the room 128, the light on the ceiling was observed to have black particles inside. Some of the black particles had shapes that resembled wings of a bug.

In an observation on 12/12/2024 at 11:17 AM, in the hallway just outside of the room 133, the light on the ceiling was observed to have multiple black particles inside. Some of the black particles had shapes that resembled wings of a bug.

In an observation on 12/12/2024 at 11:19 AM, in the hallway just outside of the laundry room, the light on the ceiling was observed to have multiple black particles inside. Some of the black particles had shapes that resembled wings and legs of a bug.

In an interview on 12/12/2024 at 11:32 AM, Staff K, Housekeeper, said the facility did not have a maintenance director. Staff K said the light fixture in the common courtyard fell approximately one month ago and broke. Staff K said the replacement light fixture needed to be ordered. Staff K said they were unsure if the facility could locate a matching fixture. Staff K said they were unaware if the facility had a plan in place to fix the light fixture. Staff K stated they had wrapped the ends of the wire with electrical tape and left the wire protruding out of the wall.

In an interview on 12/13/2024 at 11:52 AM, Staff L, Building Service Director, said they mainly worked at another sister facility nearby. Staff L said the facility did not have a maintenance director, and the facility had went downhill.

In an observation on 12/12/2024 at 11:12 AM, room 120's maroon plaque outside of their door with their room number on it had not been secure to the wall.

In an observation on 12/12/2024 at 2:29 PM, room 137's maroon plaque outside of their door with their room number on it had not been secure to the wall and leaned forward.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain fire safety per the state fire marshal regulations for 1 of 1 outside (inner outside courtyard) areas observed. This failure placed 26 of 26 residents, staff, and visitors' life and safety at risk in the event of a fire.

Findings included…

Revised Code of Washington (RCW) 70.160.075 “Smoking prohibited within twenty-five feet of public places or places of employment - Application to modify presumptively reasonable minimum distance. Smoking is prohibited within a presumptively reasonable minimum distance of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited so as to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means."

International Fire Code 604.4.3 2018, “Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations.

Record review of the document titled, “final bill report Initiative-901”, dated 12/08/2005, showed it was a clean indoor air act amendment, that prohibits smoking in a public place, except within designated smoking areas. “Public place” was the portion of any building or vehicle use by or open to the public, regardless of who owns it and whether or not a fee is charged for entry. The definition of a public place also includes a private residence or home-based business when that residence or business was used to provide licensed adult care or other similar social services care on the premises. Smoking was not allowed within a “presumptively reasonable minimum distance” from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking was prohibited. I-901 defines a “presumptively reasonable distance” as twenty-five feet.

Record review of the facility policy titled, “Smoking”, undated, showed the facility was a smoke-free community. Smoking had been prohibited near entrances or exits. If anyone chose to smoke outside, it would need to be in the designated smoking area. Smoking material must be disposed in containers in the smoking area.

Record review of Resident 6 (R6)’s, “Service Agreement”, dated 04/03/2024, showed R6 had been an independent smoker.

Record review of R6's, "Resident Smoking Appraisal", dated 04/04/2024, showed R6 could move to the designated smoking area without assistance. R6 had been assessed to smoke unsupervised.

In an interview on 12/12/2024 at 10:56 AM, Staff D, Vibrant Life Director, said Resident 6 (R6), smoked and required assistance from staff to smoke. Staff D said they had been unsure where the designated smoking area was for R6.

In an observation on 12/12/2024 at 11:02 AM, R6 had been observed to smoke outside in the common courtyard underneath the doorway that was across from room 107 and 109. R6 had been observed to re-enter the facility when they finished smoking. Under the doorway where R6 had been observed to stand was a white chair and a strong odor of cigarettes. There were cigarette butts and gray ash on the ground seven feet three inches away from the doorway into the facility. Inside of the pet waste bag dispenser area of the green post that was five feet six inches away from the door and the window into the facility, were multiple burned cigarette butts, loose brown leaves and gray ash. On the ground on the soil next to the pet waste post was a Canada dry ginger ale soda can that was five feet eleven inches from a window into the facility. On the rim of the can had ashes and the inside of the can were cigarette butts observed. There had been ash on the cement ground by the white chair.

In an interview on 12/13/2024 at 11:27 AM, Staff G, Care Manager, said the facility medication technicians provided R6 their cigarettes. Staff G said R6's cigarettes and lighter were kept in the medication cart. Staff G said R6's designated smoking area was in the common courtyard in the middle of the facility outside by the green post. Staff G stated that was the designated smoking area for residents only.

In an observation on 12/13/2024 at 4:15 PM, R6 was observed outside by the green pet disposing post smoking. R6 was observed to have white cloud of smoke leave their mouth after their hand was removed from their mouth area.

In an interview on 12/18/2024 at 11:10 AM, Collateral Contact 2 (CC2), Deputy State Fire Marshal, stated that the assisted living facility must have a designated smoking area that was 25 feet away from the facility building, windows, or doors per the state law. CC2 stated the facility was required to have an approved disposing smoking receptacle at all designated smoking areas at the facility. CC2 stated a soda can and the metal post were not designated acceptable smoking disposable receptacles.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure effected all 26 residents and visitors right to be able to have knowledge of the facility's inspection results.

Findings included…

In an observation on 12/12/2024 at 10:33 AM, just inside the front doors of the facility there was no posted signs or binder observed with the facility’s annual inspection results for review.

In an observation on 12/12/2024 at 10:34 AM, inside the facility’s library room, there was no signed posted or a binder publicly available with the facility’s annual inspection results were for review.

In an observation and interview on 12/12/2024 at 10:45 AM, in the receptionist counter and working area there was no binder publicly accessible or signs posted where the facility’s annual state inspection results binder were for review. Staff C, Business Office Assistant, stated the binder was kept on the receptionist desk and provided to the Department to review. When Staff C grabbed the binder, it was stored with multiple other binders.

In an observation on 12/12/2024 at 12:12 PM, Staff C had been observed to retrieve the state survey binder that had been located behind the front desk on the counter.

In an interview on 12/12/2024 at 2:02 PM, Resident 10 (R10) stated they had never seen a binder that was available with the facility’s current annual inspection inside for review.

In an interview and observation on 12/13/2024 at 12:23 PM, Staff C stated they were unsure if there was a sign posted that showed where the facility's state survey annual inspection results were located for the public to review. Staff C then asked Staff D, Vibrant Life Director, if there was a sign posted it would be on the same wall as the state hotline and ombudsman's phone numbers that was to the left upon entering the facility. Staff D looked at the wall and stated there was no signed posted about where the facility's state annual survey binder inspection results were located. Staff C stated they were unsure how any of the residents, family members, visitors would know where the state survey binder annual inspection results were if they did not ask. Staff C stated that it was always kept at the front receptionist desk with the other binders.

In an interview on 12/13/2024 at 4:25 PM, Staff A, Executive Director, acknowledged that the facility's annual state inspection result binder was not publicly available for residents, family, or visitors for review or that there was a sign posted to show where the results were stored to retrieve.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow and implement safe food handling and storing practices for 2 of 2 areas reviewed (the kitchen and activity room) and failed to ensure 1 of 2 long term staff (Staff H) had their food handlers cards. These failures placed 26 of 26 residents at risk of for food-borne illnesses due to receiving improperly handled food.

Findings included…

Washington Administrative Code (WAC) 246-215-04605 “Objective—Equipment food-contact surfaces and utensils (FDA Food Code 4-602.11). (1) EQUIPMENT, FOOD-CONTACT SURFACES, and UTENSILS must be cleaned: (5) Except when dry cleaning methods are used as specified under WAC 246-215-04620, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be cleaned: (a) At any time when contamination might have occurred; (b) At least every twenty-four hours for iced tea dispensers and CONSUMER self-service UTENSILS such as tongs, scoops, or ladles; (c) Before restocking CONSUMER self-service EQUIPMENT and UTENSILS such as condiment dispensers and display containers; and (d) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (i) At a frequency specified by the manufacturer; or (ii) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.”

WAC 246-215-04920 “Storing—Equipment, utensils, linens, and single-service and single-use articles (FDA Food Code 4-903.11). (1) Except as specified in subsection (4) of this section, cleaned EQUIPMENT, UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES must be stored: (a) In a clean, dry location; (b) Where they are not exposed to splash, dust, or other contamination; and (c) At least six inches (15 cm) above the floor. (2) Clean EQUIPMENT and UTENSILS must be stored as specified under subsection (1) of this section and must be stored: (a) In a self-draining position that allows air drying; and (b) Covered or inverted. (3) SINGLE-SERVICE and SINGLE-USE ARTICLES must be stored as specified under subsection (1) of this section and must be kept in the original protective package or stored by using other means that afford protection from contamination until used. (4) Items that are kept in closed packages may be stored less than six inches (15 cm) above the floor on dollies, pallets, racks, and skids that are designed as specified under WAC 246-215-04268.”

WAC 246-215-03306 “Preventing food and ingredient contamination—Packaged and unpackaged food—Separation, packaging, and segregation (FDA Food Code 3-302.11). (1) A food must be protected from cross contamination by: (a) Except as specified in (a)(iv) of this subsection, separating raw animal foods during storage, preparation, holding, and display from: (i) Raw ready-to-eat food including other raw animal food such as fish for sushi or molluscan shellfish, or other raw ready-to-eat food such as fruits and vegetables; (ii) Cooked ready-to-eat food;…”

WAC 246-215-03300 “Preventing contamination by employees—Preventing contamination from hands (FDA Food Code 3-301.11). (1) FOOD EMPLOYEES shall wash their hands as specified under WAC 246-215-02305".

WAC 246-215-02310 Hands and arms—"When to wash (FDA Food Code 2-301.14). FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (1) After touching bare human body

parts other than clean hands and clean, exposed portions of arms; (4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) After handling soiled EQUIPMENT or UTENSILS; (6) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (7) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (8) Before donning gloves for working with READY-TO-EAT FOOD unless a glove change is not the result of contamination; and (9) After engaging in other activities that contaminate the hands or gloves."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."

WAC 246-217-015 "(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

WAC 246-217-025 (1)(8)"(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee… (8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials."

WAC 246-217-035 (1) (5)(c)"(1) All initial cards are valid for two years from the date of issuance…(5) The card shall be approximately three inches by five inches in size and contain the following information: (c) Printed (or typed written) name and signature of the food service worker."

Record review of the facility provided document titled, "Culinary Sanitation", dated "10/2018", showed it was the company policy to ensure all appropriate sanitations measures were followed in the culinary department to prevent food-borne illness. All kitchen equipment just be cleaned regularly in accordance with the cleaning log.

Record review of the facility provided document titled, "Daily Kitchen Cleaning Schedule", undated, showed staff were supposed to clean as they went. Spills were supposed to be cleaned as they occurred.

Record review of the facility provided document titled, "Weekly Kitchen Cleaning Schedule", undated, showed on Tuesdays the doors in the kitchen were supposed to be washed. On Thursdays the utensil area should have been removed and scrubbed. On Friday's the items in the drawers were to be removed and cleaned. On Saturdays the

vents were to be cleaned.

Record review of the facility provided document titled, “Monthly Kitchen Cleaning Schedule”, undated, showed the ice machine cleaning task had been assigned to the culinary service director and the building service director.

Record review of the facility provided, “Census Report”, dated 12/12/2024, was a list of active employees that included Staff H, Medication Technician, showed they were hired at the facility on 09/11/2023.

Kitchen Storage and Cleanliness

In an observation on 12/12/2024 at 10:39 AM, showed the white door into the kitchen had brown markings all around the gold doorknob. There were brown markings to the right and left of the doorknob.

In an interview on 12/12/2024 at 12:51 PM, Staff Q, Traveling Culinary Service Director Corporate Division, said they had worked for the corporation and had been at the facility to help for the last two days. At 12:57 PM, Staff Q said he resided in another state and mainly worked with independent living facilities and had been unfamiliar with assisted living facility regulations. At 2:45 PM, Staff Q said they would only work in the facility until 12/16/2024 and a new temporary cook would come to the facility until the facility could fill the cook’s position.

In an observation on 12/12/2024 at 12:51 PM, the free-standing ice machine showed that the silver surface on the front and side had brown streaks that ran from the top of the machine to the bottom. The front of the machine had black grates at the bottom and each grate contained a grey fuzzy substance inside. Inside of the machine the white wall on the right side had black specks in a large circular pattern. The back side of the machine had a black grate and on the right side of it in the creases contained a thick white substance.

In an observation on 12/12/2024 at 12:57 PM, inside of the “Prep and or Left Over” refrigerator, showed on the second shelf was a cardboard box of raw bacon. Directly under the second shelf of raw bacon on the third shelf was a silver rectangular container with loose foiled on top. Inside of the silver dish was ready to eat macaroni dish. The first shelf above the raw bacon cardboard box was a bag of peaches. When the bag of peaches was touched, liquid came out and dripped through the shelf down onto the cardboard box of raw bacon. The bottom of the refrigerator showed large amounts of bright and darker red liquid that was coming from a package that was wrapped with clear wrapping plastic. The package with red liquid coming from it, had been opened with a label of ground beef. The red liquid touched a cardboard box of chicken thighs that was stored behind the package of ground beef that was not in a container.

In an observation on 12/12/2024 at 1:00 PM, inside the freezer was a brown box with a blue bag inside that was open and draped over the side of the brown box. Inside the blue bag that was open to air were frozen green beans. Some of the green beans were frozen together and formed baseball sized clumps.

In an interview and observation on 12/12/2024 at 1:08 PM, Staff Q stated the cardboard box of raw bacon should not have been stored above the macaroni dish that had been cooked and ready to eat. Staff Q stated the red liquid on the bottom of the refrigerator was blood from the raw hamburger. Staff Q picked up the package of ground beef that was wrapped in clear plastic. When Staff Q picked up the package there was red liquid dripping from the package. There was standing red liquid blood on the bottom of the refrigerator where the package had once sat that continued to touch the cardboard package of chicken thighs.

In an observation on 12/12/2024 at 1:00 PM, the kitchen islands countertop trim had been stripped off the entire perimeter. The side of the island that faced the stove had five of five cabinet drawers that were observed to be soiled with light brown, dark brown, orange, and unknown food substances. Inside of the five drawers showed kitchen utensils that sat on top of light brown, brown, white, red, and other unknown substances. One of the five drawers had 11 kitchen utensils inside of it. There were no kitchen cupboards observed to protect the side of the island that faced the stove. The kitchen island that faced the ice machine had five missing kitchen cupboards and one missing cabinet drawer.

In an observation on 12/12/2024 at 1:02 PM, to the right of the stove the sink had two missing cupboards. Underneath the sink showed the bottom floor had been soiled with a wet unknown substance and was dark in color. The green grate had food particles of macaroni, black beans, and other unidentified substances. There were two white wooden planks that were wet. The left side of the sink closest to the stove had one missing cabinet drawer. The right side of the sink had one missing cabinet drawer. Square pans were observed to sit on top of unknown brown substances. The drawers and cabinets that remained in the area all were soiled with a variety of splatters, markings, and debris.

In an observation on 12/12/2024 at 1:05 PM, above the counter under the window that the electric mixer sat, the vent on the ceiling had large amounts of thick brown fuzzy matter.

In an observation and interview on 12/12/2024 at 1:06 PM, Staff Q acknowledged that the trim that surrounded the kitchen island was not in good repair. Staff Q pulled part of the trim off from the surface to show that it peeled off. Staff Q acknowledged all the kitchen cabinets and drawers were soiled. Staff Q acknowledged that when kitchen drawers were opened that the kitchen utensils sat on top of dirt. Staff Q said they thought the area under the sink that had been observed to be wet was from a leak somewhere or that the sink had overflown and got the floor wet.

In an observation on 12/12/2024 at 1:09 PM, the white air conditioning vent in the kitchen window that faced the parking lot had grey fuzzy substances in every grate.

In an observation on 12/12/2024 at 1:10 PM, two of two vents observed above the kitchen stove showed they had been covered in an unknown brown substance. The brown substance spread to the wall that surrounded the vent.

In an interview on 12/13/2024 at 11:33 AM, Staff G, Care Manager, said care managers helped serve residents their meals, prepared silverware, and did dishes. Staff G said the facility cooks had been responsible to clean the kitchen. Staff G described the kitchen as "dirty and janky."

In an interview and observation on 12/13/2024 at 12:23 PM, Staff Q said the maintenance staff should have cleaned the ice machine monthly. Staff Q had been observed to look inside of the ice machine on the righthand side and said that if black specks accumulated in a wet area, they thought the substance would be mold (a type of fungus that can be dark green or black in color commonly found in damp water damaged areas). Staff Q said they did not think it would be safe or healthy for the residents to consume ice from the machine. Staff Q had been observed to take a white paper towel and wiped the ice machine in multiple areas, which included over the black speckled surface. When Staff Q wiped the machine, a black residue had been left on the white paper towel. Staff G looked inside of the ice machine and said the substance was mold. Staff G said the ice machine had probably never been cleaned. Staff Q said they would bring the ice machine concern up with their supervisor. Staff Q acknowledged the outside of the ice machine had been soiled and said it was “gross”. Staff Q said when they walked into the facility kitchen it had been a nightmare. Staff Q had been observed to perform hand hygiene and said they cannot believe they just touched mold.

In an interview on 12/13/2024 at 4:25 PM, Staff A, Executive Director, stated they had observed the kitchen and that it was not in good condition. Staff A acknowledged the kitchen was not sanitary. Staff A stated there should be a cleaning log of monthly, weekly, and daily items to be completed by the kitchen staff routinely.

Activities Room

In an observation on 12/12/2024 at 11:32 AM, inside of the activity room’s freezer showed an open cardboard box with plastic that contained chocolate chip cookie dough. The cookie dough sat in the plastic and had been opened to air.

Hand Hygiene

In an observation and interview on 12/12/2024 at 1:08 PM, Staff Q stated the red liquid on the bottom of the “Prep and or Left Over” labeled refrigerator was blood from the raw hamburger. Staff Q picked up the package of raw hamburger that was wrapped in

clear plastic with their bare hands. When Staff Q picked it up, the red liquid dripped off of the clear plastic. Staff Q took the package of raw hamburger to the prep sink and rinsed it off. Staff Q placed the package of raw hamburger into a clear plastic bin. Staff Q took a rag and wiped up the red liquid blood from the bottom of the refrigerator with bare hands. Staff Q put the clear container with the raw hamburger into the refrigerator. At 1:11 PM, Staff Q stated they had to complete a computer meeting, left, entered their office, and shut the office door. Prior to Staff Q entering their office, Staff Q was never observed to wash their hands after they touched the package of raw hamburger with red dripping liquid that was identified as blood on it or after cleaning up the red liquid blood from the bottom of the refrigerator.

In an interview on 12/12/2024 at 2:45 PM, Staff Q said the facility staff were to perform hand hygiene when then entered the kitchen and before they donned (put on) a pair of gloves.

In an observation on 12/13/2024 at 12:12 PM, Staff G, Care Manager, entered the kitchen, did not perform hand hygiene before they grabbed two plates with tuna salad sandwiches, Doritos chips, and coleslaw and exited the kitchen. At 12:13 PM, Staff G re-entered the kitchen, did not perform hand hygiene before they grabbed two more plates of food and exited the kitchen. Within the same minute Staff G re-entered the kitchen, did not perform hand hygiene before they grabbed two more plates of food and exited the kitchen. At 12:14 PM, Staff G re-entered the kitchen, did not perform hand hygiene before they grabbed two more plates of food and exited the kitchen.

In an observation on 12/13/2024 at 12:13 PM, Staff J, Lead Care Manager, entered the kitchen, did not perform hand hygiene before they grabbed two plates with tuna salad sandwiches, Doritos chips, and coleslaw and exited the kitchen. At 12:14 PM, Staff J reentered the kitchen, did not perform hand hygiene before they grabbed three plates of food and exited the kitchen.

In an observation on 12/13/2024 at 12:21 PM, Staff G had been observed to not perform hand hygiene before they exited the kitchen with multiple bowls of cookies. Within the minute Staff G returned did not perform hand hygiene before they exited the kitchen with more cookies.

Food Handlers Card

Record review of the facility provided personnel file for Staff H, showed Staff H’s Washington State Food Worker Card, was valid from 09/16/2020 through 09/16/2022.

In an interview on 12/12/2024 at 2:45 PM, Staff Q said all the facility staff food handler cards were posted in their office.

In an interview on 12/13/2024 at 12:08 PM, Staff Q provided the Department all the

facility food handlers cards they had to review. There was not a current food handlers card for Staff H provided. At 12:15 PM, Staff Q said they did not know who Staff H was.

In an interview on 12/13/2024 at 11:43 AM, Staff A said Staff C, Business Office Assistant, organized the employee files and if something was not in the file then the facility did not have it.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

(1) The assisted living facility must:

(c) Ensure all menus:

(iii) Include all food and snacks served that contribute to nutritional requirements;

(v) Provide a variety of foods; and

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(ii) Individual preferences to the extent reasonably possible.

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

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

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

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to accommodate resident diets, provide a variety of food, notify residents when food substitutions were made, failed to document changes to the menu, and failed to have a dietary manual complete and accessible for 1 of 1 kitchens reviewed. These failures placed all 26 of 26 residents at risk of diminished quality of life and not having preferences and nutritional needs met.

Findings included…

Record review of the facility provided document titled, “Menu Guidelines”, dated “07/2023”, showed every community would offer a daily “Always Available” menu which included a minimum of four choices for lunch and dinner and one signature entrée for all resident populations and one daily special which would be updated daily. The purpose was to provide every resident the opportunity to enjoy a positive dining experience with a variety of food choices. The procedure showed the culinary service director had been responsible to ensure residents were aware of the daily special and always available menu. All menus must be reviewed, signed, and dated by a registered dietician. Menu substitutions should be documented in a substitution log and retained in accordance with state specific regulations. The executive director and culinary service director were responsible to ensure adherence to the policy.

Record review of the facility provided menu, dated 11/18/2024 through 12/13/2024, showed no written alterations to the menu. The menu showed the salad of the day was served at lunch and the soup of the day was served at dinner. On 12/12/2024 lunch showed an open face turkey and Swiss sandwich, green beans, salad, and root beer float was to be served. On 12/12/2024 dinner showed Tatar tot casserole, garlic mixed vegetables, role, and poke cake was to be served. On 12/13/2024 lunch showed honey garlic pork loin, baked potato, broccoli, roll, and apple cobbler.

Resident Diet Preferences

In an interview on 12/12/2024 at 12:51 PM, Staff Q, Traveling Culinary Service Director Corporate Division, said they had worked for the corporation and had been at the facility to help for the last two days. At 12:57 PM, Staff Q said he resided in another state and mainly worked with independent living facilities and had been unsure about assisted living facility regulations. At 2:45 PM, Staff Q said they would only work in the facility until 12/16/2024. Staff Q said a new temporary cook would come to the facility until the facility could fill the cook’s position.

In an interview on 12/12/2024 at 1:18 PM, Resident 4 (R4), said they did not think the facility accommodated resident preferences when it came towards meals. R4 said they wanted to have salad with their meals and often times were not served salad.

In an interview and observation on 12/13/2024 at 12:17 PM, Staff G, Care Manager, said R4's request for salad should be accommodated. Staff G had been observed to pick up a facility menu and noted that there was supposed to be a salad served daily with lunch. Staff G said the salad and soups of the day stopped being served a long time ago.

In an interview on 12/13/2024 at 2:52 PM, Resident 9 (R9), said historically when they asked for a poached egg for breakfast, they were told they could not have one because not every resident would want to eat a poached egg. R9 said they were a soup person. R9 said sometimes they would get served soup, but not daily.

Variety of Food

In an interview on 12/12/2024 at 2:45 PM, Staff Q said for lunch on 12/12/2024 the residents had an open face turkey sandwich with green beans and a donut for dessert. Staff Q said they did not have other sandwich options for the residents if they did not like the one that had been served. Staff Q said there were no alternatives for lunch. Staff Q said the company should have an always available menu for the residents to choose from. Staff Q said they hoped the menu would go back to having the always available menu for residents to choose from. Staff Q said that the food in the facility did not correspond to the menu that was supposed to be served.

In an interview on 12/12/2024 at 1:18 PM, R4 said the facility did not offer an alternative meal. R4 said if they did not like what was served then they did not get anything else to eat.

In an interview on 12/13/2024 at 4:25 PM, Staff A, Executive Director, acknowledged the facility was not serving meals as it was showed on the facility posted menus. Staff A stated the facility has a program for elevate meals and an anytime menu that were to be available for all the residents to choose their meal from. Staff A acknowledged that the facility's policy and procedures were not being implemented.

Notification of Food Substitutions and Documentation of Changes to the Menu

In an observation on 12/12/2024 at 12:04 PM, in the dining room, multiple residents sat at the dining room tables. On the plates that were being served had a piece of bread with a substance that resembled meat with brown liquid and green beans on the side. For dessert was a glazed donut.

In an interview on 12/12/2024 at 1:18 PM, R4, said the facility did not have a set menu. R4 said the facility did not follow what was supposed to be on the menu. R4 said the facility did not update the residents when there was a change in the menu. R4 said for lunch on 12/12/2024 they had canned green beans, ham with gravy, and a glazed donut.

In an interview on 12/12/2024 at 2:09 PM, Resident 10 (R10) stated they were served a hot pork sandwich with green beans and a donut for dessert for lunch that day. R10 stated the kitchen staff did not make changes to the menu for the residents to review. R10 stated they get served different food than what the menu showed. R10 stated they never know what they would be served until they were served. R10 stated there were no alternatives other than a sandwich. R10 stated all the residents were served the one dish with not alternatives available.

In an interview on 12/12/2024 at 2:45 PM, Staff Q said for lunch the residents had an open face turkey sandwich with green beans. Staff Q said the dessert had been a donut. Staff Q said the residents suffered due to the food quality and while they were at the facility they tried to make the residents happy. Staff Q said if they made a change to the menu then they verbally told the facility Care Managers who would then let the residents know of the change. Staff Q said for dinner on 12/12/2024 they had to alter the menu from chicken fried steak to chili because they did not have the ingredients. Staff Q said they did not have access to the computer system to alter the menu so the announcement would be verbal. Staff Q stated the facility should be using five-week menu's that were changed out every three months with a separate alternative menu's that the residents could choose from that was per the facility policy and procedure.

In an observation on 12/12/2024 at 5:11 PM, in the common dining room residents were observed to eat chili with a biscuit.

In an observation on 12/13/2024 at 12:06 PM, on the wall just entering the dining room by the library room on the wall was a menu that was posted. On the menu for lunch showed the residents would be served honey garlic pork loin, baked potato, roll, broccoli, and apple cobbler. There was nothing crossed off to indicate there were any changes made to the menu or food items for lunch.

In an interview and observation on 12/13/2024 at 12:08 PM, Staff Q said lunch was a tuna salad sandwich, chips, and cabbage coleslaw. On the kitchen island showed multiple plates that contained tuna salad sandwiches, Dorito chips, and coleslaw.

In an observation on 12/13/2024 at 12:12 PM, Staff G, Care Manager, came out of the kitchen with multiple plates of ready to eat meals. Staff G served the residents the plates and noted that there was a tuna fish sandwich cut in two pieces, a blue bag of Doritos, and a small cup of cabbage coleslaw. At 12:16 PM, Staff G stated the chef informs the care staff of menu food changes. Staff G stated they do not go room to room to tell the residents of the changes and only tell them if the resident inquired or asked.

In an observation on 12/13/2024 at 12:17 PM, Staff Q had been observed to plate cookies in a bowl and put them on the kitchen island.

In an interview on 12/13/2024 at 12:19 PM, Staff Q said they were unsure what was supposed to be served for mealtimes. Staff Q said there were no items in the refrigerator that matched the menu they were supposed to follow. Staff Q expressed understanding that if there had been a change in the menu it should have been written down.

In an interview and observation on 12/13/2024 at 12:19 PM, Staff G and Staff J, Lead Care Manager, said they did not make announcements to the residents to let the residents know when a change in the menu occurred. Staff G and Staff J said they would only tell a resident about the menu change if the resident specifically asked about it. At 12:20 PM Staff G came out of the kitchen and brought one ginger snap cookie out to the residents for dessert.

In an interview on 12/13/2024 at 2:52 PM, R9 and Resident 10 said that the menu that was provided was not what was served.

Dietary Manual Approved by a Dietician

In an interview on 12/13/2024 at 12:19 PM, Staff Q said the facility menus were not approved by a dietician.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2732 Liability insurance required Ongoing. The assisted living facility must:

(1) Obtain liability insurance upon licensure and maintain the insurance as required in WAC 388-78A-2733 and 388-78A-2734 ; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have the required liability insurance for 1 of 1 facility reviewed. This failure placed all 26 of 26 residents at risk of the facility having insufficient insurance coverage in the event of an incident or accident.

Findings included…

Record review of the Department of Social and Health Services (DSHS) document number 2024-032, dated 09/16/2024, that showed as of 02/29/2024 the DSHS risk management office updated the administrative policy 13.13 that established the types and amounts of insurance coverage required for the contracted facilities. The letter showed the facility were required to have liability insurance minimum coverage limits of two million dollars per occurrence and four million dollars general aggregate.

Record review of the facility provided document titled, “Certificate of Liability Insurance”, dated 09/30/2024, showed the policy was effective on 07/15/2024 with a policy expiration of 08/15/2025. The policy’s each occurrent amount was one million dollars and the general aggregate amount was three million dollars.

In an interview on 12/13/2024 at 4:25 PM, Staff A, Executive Director, stated they were unaware that the facility required high amount liability insurance. Staff A stated that they were unaware if the corporation was aware.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 7 of 7 areas (laundry room, Resident 1 [R1] room, Resident 2 [R2] room, Resident 3 [R3] room, Resident 6 [R6] room, Resident 9 [R9] room, and Resident 10 [R10] room). This failure placed all 26 of 26 residents, staff, and visitors at risk for spread of infectious disease or illness.

Findings included…

Record review of the Center of Disease Control and Prevention (CDC) document, titled, “About Hand Hygiene for Patients in Healthcare Settings”, dated 02/27/2024, showed, patients in healthcare setting were at risk of getting infections while receiving treatment for other conditions. Cleaning your hands could prevent the spread of germs, including those that were resistance to antibiotics, and protect healthcare personnel and patients. Under the section titled, “how to clean hands”, showed they were to, wet their hands with warm water, apply a nickel or quarter sized amount of soap to the hand, rub hands together to form a lather, continue to rub for 15 seconds, rinse hands well under running water, and then dry hands using a paper towel and then turn off water with a paper towel.

Record review of CDC’s fact sheet titled, “About Hand Hygiene at Work”, dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to prevent the spread of germs and keep employees healthy. Hand hygiene was one of the best ways to prevent employees from getting sick and spreading germs to others in the workplace. Good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It can also mean using alcohol-based hand sanitizer with at least 60% alcohol if soap and water were not readily available. Employees were to wash their hands use soap and water instead of hand sanitizer when their hands were visibly dirty. Under the section titled, “tips for protecting employee health”, showed provide soap, water, and way to dry hands (for example paper towels or a hand dryer) so employees can wash and dry hands properly. An alcohol-based hand sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Resident/Staff laundry room

In an observation on 12/12/2024 at 10:49 AM, inside the resident and staff used laundry room had only one sink. The paper towel dispenser that hung up on the wall to the right of the sink was empty. The soap dispenser that was below the paper towel dispenser did not dispense soap when activated, this was attempted twice with no soap produced.

In an observation on 12/13/2024 at 9:44 AM, inside the resident and staff used laundry room had only one sink. The paper towel dispenser that hung up on the wall to the right of the sink remained empty.

In an observation on 12/13/2024 at 10:00 AM, Staff J, Lead Care Manager, entered the resident and staff laundry room. Without performing hand hygiene Staff J donned (put on) a pair gloves. Staff J started a load of laundry. Staff J doffed (took off) the gloves and did not perform hand hygiene before they got a laundry tag to identify which resident the load of laundry was associated with. Staff J went to the sink and washed their hands. After staff J washed their hands, they attempted to get a paper towel, and no paper towels dispensed out of the machine. Staff J said there were no paper towels for them to use and was observed to shake their hands in the air multiple times before they left the room.

R1

In an observation on 12/12/2024 at 1:18 PM, in R1's bathroom and kitchen at the sink, there was no soap or paper towels available for staff to use.

R2

In an observation and interview on 12/13/2024 at 10:10 AM in the kitchen area of R2's apartment at the sink there was a bottle of white liquid with a label of soft-soap, a bottle of "Dawn" orange dish soap, and a roll of white paper towels that sat on the counter. In R2's bathroom by the sink, there was no noted soap or paper towels available for staff to use to wash their hands. At 10:16 AM, Staff I, Medication Technician, stated if their hands were soiled when they were in R2's room, they would wash their hands at the sink in R2's bathroom or the kitchen sink. Staff I stated they would use the soap and pointed to the bottle of orange "Dawn" soap and the white liquid soap that was at the kitchen sink when Staff I was asked what supplies they would use to wash their hands with. Staff I stated the soap and paper towels that were available in R2's kitchen sink were R2's personal supply. Staff I stated the facility did not supply soap or paper towels for the staff to use in the residents rooms.

In an interview on 12/13/2024 at 3:31 PM, R2 stated the facility did not supply either their bathroom sink or the kitchen sink with soap or paper towels. R2 stated they supply all the soap and paper towels they have at the sinks. R2 stated the care staff have used their supply of soap and paper towels to wash their hands.

R3

In an observation and interview on 12/13/2024 at 10:37 AM, in R3's bathroom at the sink, showed there was no soap or paper towels available for use other than a pink oval size bar of soap. R3 stated the pink oval bar of soap was their own soap. At 10:39 AM in the kitchen at the sink, there was a roll of white paper towels that was on a wooden holder. There was a bottle of green foam hand soap available for use. R3 stated the soap and paper towels were their own and that the facility staff have used the soap and paper towels to wash their hands.

R6

In an observation on 12/13/2024 at 1:13 PM, inside R6's bathroom at the sink, it was observed that there was no soap or paper towels available for staff to use to wash their hands. At the sink in the kitchen area of R6's room, showed there was no soap or paper towels available for staff to use to wash their hands.

R9

In an interview on 12/13/2024 at 2:52 PM, R9 stated the facility did not provide soap or paper towels for either their bathroom or their kitchen sink for staff to wash their hands with. R9 stated the soap that was at their sinks were their own personal supply.

R10

In an interview on 12/13/2024 at 2:52 PM, R10 said the facility did not provide soap or paper towels for either their bathroom or their kitchen sink. R10 said the soap that was at their sinks were from their own supply.

In an interview on 12/13/2024 at 4:50 PM, Staff A, Executive Director, stated the facility should be providing soap and paper towels for every residents room to make available for all staff to wash their hands.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records for 1 of 1 medication cart computers (Assisted Living medication cart) observed. This failure placed 26 of 26 residents at risk for exposure of confidential records.

Findings included...

Record review of the facility's policy titled, "confidentiality", dated 06/11/2021, showed all resident data and information were considered confidential. Resident records, information, preadmission documentation, etc, were to be kept inaccessible to visitors and individuals not involved in the direct care and admission of the resident. Care and administrative staff given assess to resident-related documentation were trained during orientation to maintain confidentiality.

In an observation on 12/13/2024 at 9:58 AM, Staff I, Medication Technician, was standing at the medication cart and prepping Resident 2's (R2) medication. Staff I locked the medication cart and slightly lowered the medication cart computer top down and left the medication cart to enter into R2's room. The screen was still illuminating light and when observed the screen, it displayed R2's first and last name, R2's picture, R2's medications duloxetine (a prescribed medication to help treat pain and feeling of sadness) and clonazepam (a prescribed medication to help prevent seizures or whole body uncontrollable shaking, to slow down the nervous system) for review.

In an observation on 12/13/2024 at 10:17 AM, on top of the medication cart was the medication computer that had the screen illuminated with R2's and Resident 1's (R1) pictures, first and last names, and room numbers displayed for review.

In an observation and interview on 12/13/2024 at 1:29 PM, on top of the medication cart that was sitting against the wall in the hallway by the charting room's door unattended with the computer's screen illuminated light and was open. On the screen showed multiple pictures of residents that included R2, Resident 9 (R9), Resident 11 (R11), Resident 12 (R12), and Resident 13 (R13). There was all five resident's picture of their face, room number and their first and last name displayed for review. Staff I approached the medication cart at 1:32 PM and stated that anytime the medication cart was left unattended, the medication cart computer was to be closed or the electronic resident records were to be minimized to hide all resident personal information to be displayed or reviewed.

In an interview on 01/02/2025 at 1:02 PM, Staff O, Senior Executive Director, stated the medication technicians were to close out the computer system or close the laptop on the medication cart to ensure that all residents personal information was not able to be observed or reviewed.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

RCW 70.129.060 Grievances. A resident has the right to:

(1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on observation, record review, and interview the facility failed to provide privacy when they walked into resident rooms unannounced for 3 of 3 residents (Resident 10 [R10], Resident 3 [R3], Resident 2 [R2]). The facility failed to have a system in place to address and resolve 2 of 2 residents (Resident 9 [R9] and Resident [R10]) grievances. These failures placed all 26 of 26 residents at risk for not feeling comfortable in their home and decreased quality of life.

Findings included…

Revised Code of Washington (RCW) 70.129.140 Quality of life—Rights. “(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.”

RCW 70.129.060 Grievances “A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as

that which has not been furnished; and
(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Record review of the facility provided document titled, "Receipt of Concern", undated, showed the facility encouraged residents and family members to express their concerns about the community and suggest improvements. The facility staff would try and be as responsive as possible to concern or suggestions. There was a name, date, documentation of concern, documentation of community follow up, a resolution concern section, and a 30 day follow up by the executive director section to fill out on the form.

Record review of the facility provided, "Census Report", dated 12/12/2024, showed Staff D, Vibrant Life Director, was hired at the facility on 09/11/2023.

Dignity

R10

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R9 moved into the facility on [redacted]/2023. R10 moved into the facility on [redacted]/2022.

In an interview on 12/12/2024 at 2:02 PM, R10 stated when staff enter their room, they knock and open the door at the same time. R10 stated the staff do not wait for the resident to answer after they knock. R10 stated the staff just unlock, open the door, and then enter.

R3

In an observation and interview on 12/13/2024 at 10:32 AM, inside R3's living room area, there was a knock at the door and the door opened the same time when Staff G, Care Manager, walked in without R3 telling them it was ok to enter. R3 stated the staff do not wait for them to answer the door and often just walk right in or knock and open the door at the same time.

R2

In an interview on 12/13/2024 at 3:17 PM, R2 stated they wished the staff knock and wait for them to answer the door before entering their room. R2 stated there were times that they had been in the bathroom and the staff knock enter and open the bathroom door and walk right in without giving them privacy. At 3:31 PM, R2 stated all the staff have keys to their room and just unlock the door and enter whenever they want to. R2

stated they didn't have a choice to have the staff come in or not. They Just let themselves into their room whenever.

Grievances

In an interview on 12/13/2024 at 12:30 PM, Staff D said they were unsure about the facility process on how residents or resident representatives would express a grievance. Staff D said they had never seen a receipt of concern form and they had never been asked to fill one out. Staff D said they were unsure if residents were familiar that receipt of concern forms existed.

In an interview on 12/13/2024 at 2:52 PM, R9 and R10 said they had not been aware of the facility receipt of concern forms and where to get the form to express their concerns. R10 said historically if they expressed a concern it was not followed up on.

In an interview and observation on 12/13/2024 at 11:58 AM, Staff A, Executive Director, said there were no receipt of concern forms to provide to review. Staff A said they looked in two binders and could not find any concern forms filled out to provide. Observation of two facility binders showed no completed receipt of concern forms to review. Staff A said completed forms should have been located in the binders.

This is a recurring deficiency previously cited on 08/29/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to store medication properly for 1 of 1 (medication cart) carts observed. This placed 26 of 26 residents at risk of being administered and ingesting medication not for them and health complications.

Findings included…

In an observation and interview on 12/13/2024 at 1:25 PM, inside the top drawer of the medication cart on the right side was a clear cup with nine medications inside. There was a yellow round pill, orange rectangle pill, round red pill, three small round white pills, one small orange pill, and a pink round pill. On the medications cup there was no prescription label, name, room number, or any identification to show what resident's medications were in the cup. Staff I, Medication Technician, stated they were usure who's medications they were. Staff I stated they did not dispense the medication that were in the cup. Staff I stated the cup of medications had been in the medication cart since they started their shift at 6:00 AM. Staff I stated if a resident did not take their medication or were unavailable when the medication technician came to administer the medication then, the medication technician was to label the cup with the residents first and last name and the room number for identification. Staff I stated the medication was to be administered to the resident as soon as possible.

In an interview on 01/02/2025 at 12:02 PM, Staff O, Senior Executive Director, stated all resident medications were to be stored per resident in either a bingo package or another container with the residents name and what the medication was.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2710 Disclosure of services.

(1) The assisted living facility must disclose to residents, the resident's representative, if any, and interested consumers upon request, the scope of care and services it offers, on the department's approved disclosure forms. The disclosure form shall not be construed as an implied or express contract between the assisted living facility and the resident, but is intended to assist consumers in selecting assisted living facility services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide a signed receipt that 6 of 6 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], Resident 5 [R5], Resident 10 [R10]) received a copy of the facility's disclosure of services before they moved in. This failure placed 26 of 26 residents, and resident representatives at risk from not having knowledge of what services the facility provided.

Findings included…

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R1 moved into the facility on [redacted]/2023.

Record review on 12/13/2024 at 1:50 PM, of R1's hard medical chart, showed there was no signed receipt for the disclosure of services for review.

Record review of R1's financial file showed there was no signed receipt for the disclosure of services to review.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [redacted]/2022.

Record review on 12/13/2024 at 1:50 PM, of R2's hard medical chart, showed there was no signed receipt for the disclosure of services for review.

Record review of R2's financial file showed there was no signed receipt for the disclosure of services to review.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R3 moved into the facility on [redacted]/2024.

Record review on 12/13/2024 at 1:50 PM, of R3's hard medical chart, showed there was no signed receipt for the disclosure of services for review.

Record review of R3's financial file showed there was no signed receipt for the disclosure of services to review.

Record review of the facility provided document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R4 moved into the facility on [redacted]/2024.

Record review on 12/13/2024 at 1:50 PM, of R4’s hard medical chart, showed there was no signed receipt for the disclosure of services for review.

Record review of R4’s financial file showed there was no signed receipt for the disclosure of services to review.

Record review of the facility provided document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R5 moved into the facility on [redacted]/2022.

Record review on 12/13/2024 at 1:50 PM, of R5’s hard medical chart, showed there was no signed receipt for the disclosure of services for review.

Record review of R5’s financial file showed there was no signed receipt for the disclosure of services to review.

Record review of the facility provided document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R10 moved into the facility on [redacted]/2022.

Record review on 12/13/2024 at 1:50 PM, of R10’s hard medical chart, showed there was no signed receipt for the disclosure of services for review.

In an interview on 12/12/2024 at 1:50 PM, Staff A, Executive Director, looked through R2’s financial file and in their resident agreement and said they could not locate a signed acknowledgement that the residents received a copy of the facility disclosure of service agreement. Staff A said going forward they would need to incorporate that the residents received the disclosure of services into the resident agreement. Staff A stated if they had a signed receipt that the resident received the disclosure of services it would be in their financial file for review.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid policy for 5 of 5 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], and Resident 5 [R5]) for review. This failure placed 26 of 26 residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included…

Record review of the facility provided document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, undated, showed R1 moved into the facility on [redacted]/2023.

Record review on 12/13/2024 at 1:50 PM, of R1’s hard medical chart, showed there was no signed Medicaid policy completed for review.

Record review of R1's financial file showed there was no signed receipt that the facility did not accept Medicaid or the facility's policy about Medicaid.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [redacted]/2022.

Record review on 12/13/2024 at 1:50 PM, of R2's hard medical chart, showed there was no signed Medicaid policy completed for review.

Record review of R2's financial file showed there was no signed receipt that the facility did not accept Medicaid or the facility's policy about Medicaid.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R3 moved into the facility on [redacted]/2024.

Record review on 12/13/2024 at 1:50 PM, of R3's hard medical chart, showed there was no signed Medicaid policy completed for review.

Record review of R3's financial file showed there was no signed receipt that the facility did not accept Medicaid or the facility's policy about Medicaid.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R4 moved into the facility on [redacted]/2024.

Record review on 12/13/2024 at 1:50 PM, of R4's hard medical chart, showed there was no signed Medicaid policy completed for review.

Record review of R4's financial file showed there was no signed receipt that the facility did not accept Medicaid or the facility's policy about Medicaid.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R5 moved into the facility on [redacted]/2022.

Record review on 12/13/2024 at 1:50 PM, of R5's hard medical chart, showed there was no signed Medicaid policy completed for review.

Record review of R5's financial file showed there was no signed receipt that the facility did not accept Medicaid or the facility's policy about Medicaid.

In an interview on 12/12/2024 at 2:02 PM, R10 stated they had not signed any document that showed the facility did not accept Medicaid as a payment source.

In an interview on 12/12/2024 at 1:50 PM, Staff A, Executive Director, looked through R2's financial file and in their resident agreement and said they could not locate a signed acknowledgement that the residents received a copy of the facility's Medicaid policy. Staff A said going forward they would need to incorporate that the residents received the Medicaid policy into the resident agreement.

In an interview on 12/13/2024 at 9:30 AM, R4 said when they moved into the facility the facility staff never informed them if they could not privately pay and needed to apply for Medicaid that they would have to move out of the facility.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to identify change in residents' condition for 3 of 5 sampled residents (Resident 4 [R4], Resident 5 [R5], and Resident 3 [R3]). The facility failed to implement interventions for 1 of 3 residents (Resident 2 [R2]) when they had six falls in one month. These failures placed all four residents at risk for unmet and unidentified care needs.

Findings included…

Record review of the facility's policy titled, "Alert Charting", dated "05/13/202" (as written on policy), showed alert charting would be implemented for residents who had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Alert charting procedures would be initiated but not limited to, if a resident was new to the community, exhibits a change in condition, has fallen, returned from the hospital, emergency room, or urgent care, if resident was prescribed a new order for antibiotic, and any other reason deemed appropriate by the resident care director. Each resident would be placed on alert charting and would be monitored for at least 48 hours following the initiation of alert charting. The resident care director or designee would assign alert charting responsibilities and monitor the alert charting on a daily basis. There was to be an alert charting entry in the residents record each shift. The resident care director would evaluate the resident prior to determining if the resident would be removed from alert charting. Changes in the residents Negotiated Service Agreement would be made as appropriate.

R4

Record review of R4's, "Face Sheet", dated 12/12/2024, showed R4 moved into the facility on [redacted]/2024. R4 had a diagnosis of [redacted].

Record review of R4's progress notes, dated 10/25/2024 at 6:01 AM, showed an Agency Medication Technician wrote R4 slid out of their chair onto the floor on 10/24/2024 at 11:30 PM. Care staff got R4 off the floor and back into their chair. R4 could not get into bed because it was too high for them.

Record review of R4's progress notes, dated 10/04/2024 through 12/07/2024, showed no further progress notes to review about R4's fall on 10/24/2024.

Record review of R4's progress notes, dated 10/29/2024 at 7:18 PM, showed Staff E, Medication Technician, wrote they would continue to monitor for changes in condition.

Record review of R4's progress notes, dated 10/30/2024 at 9:03 PM, showed Staff I, Medication Technician, wrote R4 seemed to be okay. R4 was very tired when they returned and did not come down to dinner.

Record review of R4's progress notes, dated 10/04/2024 through 12/07/2024, showed no further progress notes to review about why R4 was monitored for a change in condition and where they went when they left the facility.

Record review of R4's progress notes, dated 11/24/2024 at 9:40 PM, showed an Agency Medication Technician wrote R4 thought their port was infected and was sore. R4 went to the emergency room to get evaluated.

Record review of R4's progress notes, dated 11/26/2024 at 1:10 AM, showed Staff I wrote R4 seemed to be fine this shift.

Record review of R4's progress notes, dated 11/26/2024 at 1:45 PM, showed Staff H, Medication Technician wrote R4 had been well today with no complaints or concerns.

Record review of R4's progress notes, dated 11/24/2024 through 11/26/2024, showed no progress notes to review on 11/25/2024 about R4's return from the emergency room.

In an interview on 12/12/2024 at 1:18 PM, R4 said they used to reside in room [redacted]. R4 said they had to relocate rooms when Collateral Contact 1 (CC1), R4's power of attorney, found mold (a type of fungus that can be dark green or black in color commonly found in damp water damaged areas) underneath their kitchenette sink. R4 said CC1 took pictures of the mold the day they found it inside of their room.

In an observation on 12/12/2024 at 1:36 PM, CC1 sent the Department pictures of underneath R4's former kitchenette in room [redacted]. The picture had been taken on 10/27/2024. In the picture you could see two silver nozzles and underneath the nozzles there had been a curved shape pipe. The picture showed a white wall that had dark green and black varying sizes spots that covered the wall. To the left of the image in the corner there had been dark green and black spots that accumulated heavier on the left and bottom side of the piping fixture.

In an interview on 12/13/2024 at 11:10 AM, Staff G, Care Manager, said they had knowledge R4 used to reside in room [redacted]. Staff G said R4 moved because the room had an odor, and the facility staff wanted to clean the room. Staff G said they heard there was black mold inside of R4's room. Staff G said the room move took place approximately one month ago.

In an interview on 12/13/2024 at 1:49 PM, Staff I, Medication Technician, confirmed they had knowledge of R4's room move that took place due to mold in their kitchenette. Staff I said the room move took place approximately in October 2024. Staff I said R4 had not been placed on alert charting for their room move or exposure to mold. Staff I said as far as they knew they were not sure the incident had been documented.

In an interview on 12/27/2024 at 12:49 PM, Staff B, Resident Care Coordinator, confirmed they had knowledge of R4's room move that took place due to mold. Staff B said it was Staff S, Executive Director Former, and corporate were responsible to follow up on the situation.

Record review of R4's progress notes, dated 10/04/2024 through 12/07/2024, showed no progress notes to review related to R4's exposure to mold and room move.

R5

Record review of R5's face sheet, dated 12/12/2024, showed R5 moved into the facility [redacted]/2022. R5 had a diagnosis of [redacted]

Record review of R5's, "Service Agreement", dated 02/27/2024, showed the document had been prepared by Staff B, Resident Care Coordinator. The medication management section showed the facility staff ordered, stored, managed, and assisted with administration of R5's medication twice a day.

Record review of R5's, "After Visit Summary", dated 11/24/2024, showed R5's was seen for a bladder infection and their medication changed. In typed font it showed R5 was to start taking cefuroxime (medication that treats bacterial infections). In handwritten writing it showed the first dosage of medication was given in the emergency room.

Record review of R5's progress notes, dated 11/24/2024 at 9:42 PM, showed an Agency Medication Technician wrote R5 was not at their baseline. R5 had been observed to lean severely to the right and could not sit on their own, R5 could not stay in a sitting position. The facility staff observed R5 to be weaker than normal. R5 said they felt dizzy and it was hard to keep their eyes open. The emergency medical technicians were called and R5 had a temperature. R5 had been transferred to the emergency room. R5 returned to the facility with a urinary tract infection and had started antibiotics. R5's first dosage of medication had been given in the emergency room.

Record review of R5's progress notes, dated 11/26/2024 at 1:11 AM, showed Staff I, Medication Technician, wrote R5 complained of dizziness. R5's new medication did not get delivered today.

Record review of R5's progress notes, dated 11/26/2024 at 1:44 PM, showed Staff H, Medication Technician, wrote R5 started their new antibiotic.

Record review of R5's progress notes, dated 11/09/2024 through 11/26/2024, showed no further progress notes to review about R5's return from the emergency room and if their antibiotic had been effective.

On 12/12/2024 at 12:14 PM, R5's progress and alert notes were requested from October 2024 through 12/12/2024 for review.

R3

Record review of R3's face sheet, dated 12/12/2024, showed R3 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

On 12/12/2024 at 12:14 PM, R3's progress and alert notes were requested from October 2024 through 12/12/2024 for review.

Record review of R3's progress notes, dated 10/01/2024 through 12/12/2024, showed there was no documentation that R3 moved into the facility for dates [redacted]/2024 through [redacted]/2024 completed.

R2

Record review of R2's face sheet, dated 12/12/2024, showed R2 moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted].

Record review of the facility's document titled, "Resident Incident/Accident", undated, showed it was a list of resident's incident/accidents for date range 10/04/2024 through 12/04/2024, showed R2 had six incidents from 10/20/2024 through 11/12/2024.

Record review of R2's level of care appraisal (facility's version of an assessment)- WA (Washington), dated 11/05/2024, showed it was a change of condition assessment. The document showed R2 did not require hospice services. R2 required stand by assistance with dressing, transfers, toileting but could be left alone. R2 may be a fall risk and required eight to 12 checks per day.

Record review of R2's Service Agreement, dated 08/12/2024, showed R2 required stand by assistance for dressing every morning and evening. R2 needed stand by assistance

for all grooming. Staff were to check on R2 every two hours during the day, evening, and night. R2 required stand by assistance with all transfers and was at risk for falls related to weakness in lower legs. Staff were to encourage R2 to use their walker and use a call pendent for assistance and complete frequent checks that were in place since 12/15/2023. R2 required staff to assist them with standing while toileting. There were no updates to the service agreement that showed that the facility took appropriate actions and put in place interventions to assist and prevent R2 from further falls.

In an interview on 12/13/2024 at 11:10 AM, Staff G, Care Manager, said the medication technicians had been responsible to complete progress notes and alert charting for the residents.

In an interview on 12/13/2024 at 1:49 PM, Staff I said if a resident had a fall then they would go on alert charting for at least two days. Staff I said there should be at least one chart note per shift. Staff I said the facility staff worked eight hour shifts, therefore there should be at least three chart notes per day. Staff I said they were unsure if a resident would go on alert charting if they started a new medication or if they missed a medication.

In an interview on 12/13/2024 at 4:42 PM, Staff A, Executive Director, stated all residents if they were placed on alert charting would remain on alert charting for at least two days.

In an interview on 12/27/2024 at 12:49 PM, Staff B stated residents were put on alert charting for a minimum of 48 hours anytime the resident had a fall, change of condition, or any changes to the resident health concerns. Staff B stated the medication technicians were responsible to chart every shift. Staff B stated the medication technicians worked eight hours shifts. Staff B stated despite a medication technician working two shifts in a row, the medication technician was responsible to chart one per shift and not just once per the double shift.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents, or their responsible party's signed the resident Service Agreement (facility's version of the negotiated service agreement [NSA]) for 2 of 5 sampled residents (Resident 3[R3] and Resident 5 [R5]). This failure placed R3 and R5 or their responsible party's at risk for being denied the opportunity to negotiate and agree to the resident's care needs and services being provided.

Findings included…

Record review of the facility policy titled, "Resident Assessment and Negotiated Service Agreement", dated 12/17/2020, showed the resident care director or generations program director would ensure resident assessments were completed. The procedure showed all assisted living resident assessments would be completed prior to move-in, 30 days after move in, every six months, or whenever a significant change in the resident condition occurred.

Record review of the facility policy titled, "Resident Assessment and Negotiated Service Agreement", dated 12/17/2020, showed there were no guidelines for facility staff to review in regard to how often resident NSA's were to be signed.

Record review of R3's, "Face Sheet", dated 12/12/2024, showed R3 moved into the facility on [redacted]/2024.

Record review of R3's medical chart showed there was no signed initial NSA or signed 30 day NSA provided to review.

Record review of R5's, Face Sheet", dated 12/12/2024, showed R5 moved into the facility on [redacted]/2022.

Record review of R5's, "Assessment and Negotiated Service Plan Summary", agreed and signed upon by R5's responsible party and facility staff on 10/12/2023.

Record review of R5's, "Service Agreement", dated 01/30/2024, showed the document had been prepared by Staff B, Resident Care Coordinator. There were no signatures that the document had been agreed upon by the resident, resident representative, or staff who completed the plan.

Record review of R5's, "Service Agreement", dated 02/27/2024, showed the document had been prepared by Staff B, Resident Care Coordinator. There were no signatures that the document had been agreed upon by the resident, resident representative, or staff who completed the plan.

In an interview on 12/13/2024 at 11:58 AM, Staff A, Executive Director, said all resident assessments and NSA's should be stored in the residents medical chart. Staff A said if a document could not be located in a residents medical chart then the facility did not have it.

In an interview on 12/27/2024 at 12:49 PM, Staff B stated they updated the residents service plans. Staff B stated the service plans were updated at variable times. Staff B stated all service plans and assessments when they were completed were reviewed with the resident or the residents representative for review, agreement, and then signed.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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:

(iii) On-going assessments of the resident;

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

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

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

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

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Service Agreements (facility's version of the negotiated service agreement [NSA]) the plan to provide the care and services necessary to support the residents preferences and care needs, the plan to provide assistance with activities of daily living, and appropriate behavioral interventions for 3 of 5 sampled residents (Resident 2 [R2], Resident 4 [R4], and Resident 5 [R5]). This failure placed residents at risk for unmet care needs and decreased quality of life.

Findings included...

R2

Record review of R2's face sheet, dated 12/12/2024, showed R2 moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted].

Record review of R2's medication administration record, dated 12/01/2024 through 12/31/2024, showed R2 took oral medications for multiple medical conditions that included Parkinson's disease (a progressive brain disorder that causes nerve cells in the brain to weaken and die leading to muscle arm and leg stiffness and uncontrollable body tremors), anxiety (a feeling of fear, dread, or uneasiness that can be a reaction to stress or perceived danger), and Alzheimer's disease (a progressive brain disorder that affect the persons memory, judgement, thinking, and ability to carry out activities of daily living needs).

Record review of R2's level of care appraisal (facility's version of an assessment)- WA (Washington), dated 11/05/2024, showed it was a change of condition assessment. The document showed R2 did not require hospice services. R2 required stand by assistance with dressing, transfers, toileting but could be left alone. R2 may be a fall risk and

required eight to 12 checks per day.

Record review of R2's Service Agreement, dated 08/12/2024, showed R2 required stand by assistance for dressing every morning and evening. R2 needed stand by assistance for all grooming. Staff were to check on R2 every two hours during the day, evening, and night. R2 required stand by assistance with all transfers and was at risk for falls related to weakness in lower legs. Staff were to encourage R2 to use their walker and use a call pendent for assistance and complete frequent checks that were in place since 12/15/2023. R2 required staff to assist them with standing while toileting.

Record review of R2's document untitled, dated 11/06/2024, that was filed in the caregivers service plan binder, showed it was a review of the care and services that R2 required. The document did not show that R2 was on hospice services. The document showed R2 only used a walker for an assistive device.

In an observation and interview on 12/13/2024 at 10:00 AM, R2 was lying in their bed with a continuous positive airway pressure (CPAP) machine (a machine that helps push air into the lungs when the person stops or reduces breathing while they sleep) that was on R2's head over their nose and mouth. R2's bed had an air mattress, and a half side rail (a device that is attached to the bed that can be used to help turn over in bed) on the right side of their bed. R2 had a four wheel walker. Staff I, Medication Technician, handed R2 their crushed medication mixed with applesauce for R2 to take. Staff I stated they often spoon fed R2 their medication especially in the evening as R2 has uncontrollable shaking with their hands and head. Staff I stated R2's hand and head tremors were noted to be worse in the evening versus the morning. R2 was observed to take multiple bits and often missing their mouth with spoon related to their uncontrollable head tremors. At 10:13 AM, Staff I was observed to put a brace on R2's right knee. Staff I was unsure what the brace was for, but stated R2 had to wear the brace on the right knee area anytime they were up out of bed. Staff I stated the staff were required to put it on R2 as R2 was unable to.

Record review of R2's Service Agreement, dated 08/12/2024, showed there was no documentation that R2 had uncontrollable head and hand tremors that could contribute to R2 requiring more assistance with their activities of daily living. There was no documentation that R2 required their medications to be crushed and mixed with applesauce and required to be spoon fed their medications because of their hand and head tremors. There was no documentation that R2 used a bed cane (rail) on their bed to help with bed mobility or used an air mattress. The services agreement did not have any documentation of any of R2 medical diagnoses for staff to know and review.

Record review of R2's document untitled, dated 11/06/2024, that was filed in the caregivers service plan binder, showed there was no documentation that R2 required the staff to put their brace on their right knee for them. There was no documentation that staff were required to help them put their CPAP on at night when R2 went to bed. The document did not have any documentation that R2 was on hospice services or had multiple falls in the last month. There was no documentation that R2 took their medication crushed mixed in applesauce that required staff to spoon feed them. There

was no documentation that R2 had uncontrollable hands and head tremors/uncontrollable shaking that could contribute to R2's lack of ability to perform activities of daily living needs. There was no documentation that R2 used an air mattress on their bed to help with skin integrity or the use of the half side rail on the right side of their bed.

R4

Record review of R4's, "Face Sheet", dated 12/12/2024, showed R4 moved into the facility on [redacted]/2024. R4 had a diagnosis of [redacted].

Record review of R4's level of care appraisal- WA (Washington), dated 09/16/2024, showed R4 required stand by assistance with bathing. R4 required a self-administration assessment for medications and used the community pharmacy vendor. Under assistive/adaptive devices section showed R4 required no assistance. The fall risk section showed yes, R4 may be a fall risk. The colostomy/ileostomy section showed resident could manager their care. Nursing needs showed R4 needed colostomy and urology care.

Record review of R4's, "Service Agreement", dated 08/19/2024, showed the document had been prepared by Staff B, Resident Care Coordinator. The agreement showed R4 needed standby assistance for all transfers. The agreement showed the facility staff would help bath R4 once a week with one person stand by assist.

Record review of R4's document untitled, dated 08/19/2024, that was filed in the caregivers service plan binder, showed it was a review of the care and services that R4 required. The document showed R4 used a wheelchair, received stand by assistance for showers once a week, received stand by assistance for all dressing, and needed stand by assistance for all transfers.

Record review of R4's, "Outside Agency Documentation", dated 10/22/2024, showed home health representative visited for physical therapy. R4 ambulated in the hallway with their four wheel walker. Identified concerns indicated R4 had been a fall risk. The next follow up visit would occur on 10/29/2024. The document was signed by the home health representative.

Record review of R4's, "Outside Agency Documentation", dated 10/24/2024, showed home health representative visited R4 for urostomy and ostomy care and medication review. The identified concerns section showed that medications were still not taken as scheduled. The next follow up visit would occur on 10/31/2024. The document was signed by the home health representative.

Record review of R4's, "Progress Notes", dated 11/08/2024 at 12:34 AM, showed Staff I,

Medication Technician, wrote R4 had a fall in their apartment. R4 was found on the floor in their shower. R4 was a one person stand by assistance, but staff had been unaware R4 got into the shower.

In an interview and observation on 12/12/2024 at 1:28 PM, R4 sat in their reclining chair. R4 had been observed to wear a pendant around their neck. R4 had a wheelchair and a four wheeled walker in front of them. R4's colostomy bag (waterproof pouch that collects waste from the body after a surgical procedure) and urostomy bag (a heavy duty pouch that collects urine from an opening in the abdominal wall) showed above their pant line. R4 had a step stool on the left side of their bed. The left side of their bed had a bed rail. R4's bathroom had a shower chair inside of the shower. R4 had free standing medication bottles next to their reclining chair on a tv tray. R4 said they took their own medication. R4 said they did not want the facility staff to help them with their medication. R4 said they kept their medication in a basket on their nightstand where they were within reach. There was a knock at the door and a home health representative entered to start services with R4. R4 said they had dialysis tomorrow.

In an interview and observation on 12/13/2024 at 9:30 AM, R4 had been observed to wear a pendant around their neck. R4 confirmed yesterday there had been a home health representative that came to work with them. R4 said home health came to work with them one to two times weekly for physical therapy and occupational therapy. R4 said they attended dialysis Mondays, Wednesdays, and Fridays. R4 confirmed they used a pendant, a four wheel walker, a wheelchair, a shower chair, a step stool to get into bed, and a bed rail. R4 said they slept in their reclining chair because it was hard for them to get into their bed. R4 said they had to use the step stool to get into bed because they might slip off. R4 confirmed they used a colostomy bag and urostomy bag. R4 said Collateral Contact 1 (CC1), R4's power of attorney, the home health nurse, or themselves changed their colostomy and urostomy bags every couple of days. R4 said sometimes CC1 ordered their medication, sometimes they did it, and sometimes the facility staff ordered their medication, and they would deliver it to them when it arrived. R4 said they have had several falls since their admission into the facility. R4 said after their fall they did not think the facility staff could physically get them up and they had called emergency services to help them.

In an interview on 12/13/2024 at 11:10 AM, Staff G, Care Manager, said they were aware R4 had falls. Staff G said R4 had been heavy, and they thought emergency services had been called to lift the resident back into their chair. Staff G said if emergency services needed to be called for R4 after a fall to help them get off the ground then that should be incorporated into the service agreement. Staff G said they helped R4 empty their bag when it was full. Staff G said if R4 needed help with their bags they helped by gathering medical supplies for R4. Staff G said they thought CC1 came to the facility to help R4 with their colostomy bag. Staff G confirmed R4 had a wheelchair, a walker, and a shower chair. Staff G said R4's medical equipment they used should be incorporated into the service agreement. Staff G said R4 went to dialysis but had been unsure how often they went. Staff G had been under the impression R4's service agreement indicated they went to dialysis. Staff G had been unsure if R4 received home health services. Staff G said R4 refused stand by assistance with showers. Staff G said R4 refused to sleep in their bed because it was up too high.

In an interview on 12/13/2024 at 1:49 PM, Staff I said when R4 had a fall they would not let facility staff help them up. Staff I said R4 insisted to call emergency services. Staff I said R4 had dialysis Monday's, Wednesday's, and Friday's. Staff I had been unsure if R4's dialysis information had been incorporated into R4's service agreement. Staff I said the facility staff did not help with R4's urostomy and colostomy bags. Staff I said they had been unsure if R4 received home health services. Staff I said R4 was supposed to be stand by assistance with showers but often refused staff help. Staff I confirmed R4 used a wheelchair and had a four wheel walker for assistance with standing. Staff I confirmed R4 had a shower chair. Staff I said R4 had a bed rail and said they did not think R4 slept in their bed because the bed was too high. Staff I confirmed at times the facility staff ordered R4's medication and that they were independent with their medication.

Record review of R4's, "Service Agreement", dated 08/19/2024, did not show that R4 required the use of durable medical equipment. The agreement did not show that R4 utilized a pendant. The agreement did not show that R4 had a colostomy and urostomy bag, and at times a home health nurse changed out their needed medical supplies. The agreement did not show R4 had physical therapy and occupational therapy through home health. The agreement did not show that R4 went to dialysis three times a week. The agreement did not show the facility helped R4 obtain their medication. The agreement did not show anything about R4's ability to self administer their medications safely. The agreement did not show that R4 was a fall risk. The agreement did not show that R4 required emergency services to be called to assist with getting R4 up off the ground and transferred back to wheelchair after every fall. The agreement did not indicate R4 refused their showers or that R4 requested to be independent with showers related to maintaining their privacy. The agreement did not indicate R4 received palliative care services.

In an interview on 12/27/2024 at 12:50 PM, Staff B, Resident Care Coordinator, said R4 had been on palliative care services (medical care for people with serious or chronic conditions manage symptoms, improve quality of life, and receive emotional and spiritual support). Staff B said R4 received home health services for physical therapy. Staff B confirmed R4 received dialysis on Monday's, Wednesday's, and Friday's. Staff B said they would put R4's dialysis information under their orders section in their medical chart and not incorporate the information into R4's service agreement. Staff B said R4 had a temporary port in their chest. Staff B said the facility staff knew if there had been a concern with R4's port that they would contact emergency services. Staff B said R4's port information had not been incorporated into R4's service plan because there was not a space for it. Staff B said the facility medication technicians would have knowledge through notes in their electronic system. Staff B confirmed R4 used a wheelchair and had a walker they used inside of their room. Staff B confirmed R4 had and used a shower chair. Staff B said R4 was stand by assistance for showers but R4 refused and at times screamed at facility staff to get out. Staff B said the facility staff were aware R4 refused showers. Staff B said R4 requested that stand by assistance in the shower get taken off their service plan. Staff B said they had been advised by the corporation to leave showers incorporated into R4's care plan. Staff B confirmed R4 had a fall in the shower due to their refusal to have staff provide stand by assistance. Staff B said R4 was not steady on their legs especially on their dialysis days. Staff B confirmed the facility staff had been instructed to call emergency services when R4 fell for lift

assistance. Staff B said the information that emergency services needed to be called after a fall had not been incorporated into R4's service agreement.

R5

Record review of the facility provided document titled, "Washington Plan For Family Assistance with Medications and Treatments", undated, showed the facility allowed family assistance with resident medications and treatments. The family member would need to agree and submit to a community written plan with the assistance to be conducted and the record would be contained in the resident record.

Record review of R5's face sheet, dated 12/12/2024, showed R5 moved into the facility [redacted]/2022. R5 had a diagnosis of [redacted]

Record review of R5's level of care appraisal- WA, dated 11/15/2024, showed R5 required assistance with medication up to two times daily. The pharmacy section showed R5 used an outside pharmacy vendor and required staff assistance with ordering.

Record review of R5's, "Service Agreement", dated 02/27/2024, showed the document had been prepared by Staff B. The medication management section showed the facility staff ordered, stored, managed, and assisted with administration of R5's medication twice a day according to their primary care providers orders.

Record review of R5's document untitled, dated 11/15/2024, that was filed in the caregivers service plan binder, showed it was a review of the care and services that R5 required. The document showed staff ordered, stored, managed, and assist with administration of R5's medications twice daily.

In an interview on 12/13/2024 at 1:49 PM, Staff I, Medication Technician, said the facility did not order R5's medications. Staff I said R5's spouse ordered R5's medications and brought them into the facility.

Record review of R5's, "Service Agreement", dated 02/27/2024, did not indicate that R5's spouse ordered and brought R5's medications into the facility. The service agreement did not indicate an alternative plan if R5's spouse had been unable to provide R5 their medications.

Record review of R5's medical chart showed no "Washington Plan For Family Assistance with Medications and Treatments", plan to review.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete ongoing assessments focused on residents identified problems for 3 of 5 sampled residents (Resident 2 [R2]), Resident 4 [R4], and Resident 5 [R5]). This failure placed the residents at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included…

Record review of the facility’s untitled, and undated, document that showed the facility was to complete on-going assessments specifically focused on a resident’s identified problems and related issues.

Record review of the facility’s document titled, “resident medical device safety assessment", undated, showed it was an assessment that should be completed if the resident used one of the following assistive devices that included walker, cane, wheelchair, seat or chair assist, transfer board, bed enabler, bed rail, and orthopedic device. The form showed per Washington Administrative Code 388-78A-2020 (4) "Physical restraint" means the application of physical force without the use of any device, for the purpose of restraining the free movement of a vulnerable adult's body.

Record review of the United States Food and Drug Administration article titled, “Bed Rails in Hospitals, Nursing Homes, and Home Health Care The Facts”, dated “04/2010”, showed there was a study conducted with frail, elderly or confused residents that showed there were multiple incidents with bed rails that included residents being caught, trapped, entangled, or strangled in bed with the bed rails. Residents that had problems with memory, incontinence, pain, uncontrollable body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the residents health care team would help to determine how best to keep the resident safe. Potential risks of bed rails may include strangling, suffocating, bodily injury or death when patients or part of their body were caught between rails or between the bed rails and mattress, skin bruising, cuts, and scrapes, preventing residents who were able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. Under the section titled, “which ways are reducing risks are best?”, showed a process that required ongoing resident evaluation and monitoring would result in optimizing bed safety. Many residents go through a period of adjustment to become comfortable with new options.

R2

Record review of R2’s face sheet, dated 12/12/2024, showed R2 moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted].

Record review of R2’s medication administration record, dated 12/01/2024 through 12/31/2024, showed R2 took oral medications for multiple medical conditions that included Parkinson’s disease (a progressive brain disorder that causes nerve cells in the brain to weaken and die leading to muscle arm and leg stiffness and uncontrollable body tremors), anxiety (a feeling of fear, dread, or uneasiness that can be a reaction to stress or perceived danger), and Alzheimer’s disease (a progressive brain disorder that affect the persons memory, judgement, thinking, and ability to carry out activities of daily living needs).

Record review of R2’s level of care appraisal (facility’s version of an assessment)- WA (Washington), dated 11/05/2024, showed it was a change of condition assessment. R2 required stand by assistance with dressing, transfers, toileting but could be left alone. R2 may be a fall risk and required eight to 12 checks per day. Under the section titled, “assistive/adaptive devices”, showed R2 required staff assistance with application/removal of device. R2 had current diagnoses that included [redacted] and [redacted]. Under the section titled, “other safety considerations (danger to self and/or others, medical devices, ability to smoke unsupervised”, showed “none”.

Record review of R2’s Service Agreement (facility’s version of the negotiated service agreement), dated 08/12/2024, showed R2 required stand by assistance for dressing every morning and evening. R2 needed stand by assistance for all grooming. Staff were to check on R2 every two hours during the day, evening, and night. R2 required stand

by assistance with all transfers and was at risk for falls related to weakness in lower legs. Staff were to encourage R2 to use their walker and use a call pendent for assistance and complete frequent checks that were in place since 12/15/2023. R2 required staff to assist them with standing while toileting. There was no documentation in the service agreement that showed R2 used any assistive medical devices on their bed or to help with mobility.

In an observation on 12/13/2024 at 10:00 AM, inside R2's room, R2 was lying down in their bed. On the right side of their bed facing the wall, there was a half bed rail. R2 was observed to grab the bar and assisted themselves up with sitting upright. When R2 was attempting to grab the bar, their hand was noted to have an uncontrollable tremor and was shaking that made it difficult for R2 to grab the bar. Staff I, Medication Technician, did assist R2 with guiding their hand to the half grab bar, so R2 could grab and pull themselves up.

In an interview on 12/13/2024 at 12:00 PM, Staff A, Executive Director, stated all assessments and resident documents were filed in the resident's hard medical chart. Staff A stated if the document was no in the hard medical chart, then the facility does not have it for review.

Record review of R2's hard medical cart on 12/13/2024 at 1:50 PM, showed there was no medical device assessment for R2's ½ bed rail for review.

In an interview on 12/13/2024 at 2:01 PM, Staff A stated residents that had a medical device as in bed rail, transfer pole, self-medication, would have a medical device assessment completed. Staff A stated the medical device assessment would be filed in the resident's medical chart. If the medical device assessment was not in the medical chart, then the facility did not have an assessment completed for review.

R4

Record review of R4's, "Face Sheet", dated 12/12/2024, showed R4 moved into the facility on [redacted]/2024. R4 had a diagnosis of [redacted].

Record review of R4's level of care appraisal (facility's version of an assessment)- WA (Washington), dated 09/16/2024, under assistive/adaptive devices section showed R4 required no assistance. The fall risk section showed yes, R4 may be a fall risk.

Record review of R4's, "Service Agreement", dated 08/19/2024, showed the document had been prepared by Staff B, Resident Care Coordinator. The Service Agreement did not show that R4 required the use of durable medical equipment.

In an observation on 12/12/2024 at 1:28 PM, R4 sat in their reclining chair. Behind their reclining chair R4's left side of their bed had a bed rail attached to it.

In an interview and observation on 12/13/2024 at 9:30 AM, R4 confirmed they used a bed rail that had been attached to the left side of their bed. R4 said they slept in their reclining chair because it was hard for them to get into their bed. R4 said they have had several falls since their admission into the facility.

In an interview on 12/13/2024 at 11:10 AM, Staff G, Care Manager, said they were aware R4 had falls. Staff G said R4's medical equipment they used should be incorporated into their service agreement.

In an interview on 12/13/2024 at 1:49 PM, Staff I, Medication Technician, said R4 had a bed rail and said they did not think R4 slept in their bed because the bed was too high.

Record review of R4's medical chart showed there was no resident medical device safety assessment for R4's bed rails to review.

R5

Record review of R5's face sheet, dated 12/12/2024, showed R5 moved into the facility [redacted]/2022. R5 had a diagnosis of [redacted]

Record review of R5's level of care appraisal- WA, dated 11/15/2024, showed R5 was a fall risk. R5's transfer ability section showed R5 required two-person assistance total assistance.

Record review of R5's, "Service Agreement", dated 02/27/2024, showed the document had been prepared by Staff B. R5 had a Hoyer lift (a mechanical device that helped move and lift a person up for people with limited mobility) in their room as they are unable to bear much weight. The facility staff were to provide R5 two-person assistance for all transfers.

In an observation on 12/13/2024 at 10:03 AM, R5's shower had a Hoyer lift inside of it.

In an interview on 12/13/20204 at 11:27 AM, Staff G said R5 had a Hoyer lift, but they personally never used it to help transfer R5. Staff G said they had never had training from the facility on how to use the device.

In an interview on 12/13/2024 at 1:49 PM, Staff I said they never used R5's Hoyer lift

because R5 did not like it, and it scared them.

In an interview on 12/27/2024 at 12:49 PM, Staff B, Resident Care Coordinator, stated they updated all the residents assessments. Staff B stated the pre-admission assessment was reviewed by the executive director or the corporate nurse to review for proper placement. Staff B stated the other assessment were completed by themselves and were tracked in their electronic record.

In an interview on 01/02/2025 at 12:02 PM, Staff O, Senior Executive Director, stated the facility's resident care director was responsible to complete all of the resident's assessments that included the assistive device and smoking assessments.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within 14 days of the resident’s move-in date for 1 of 2 sampled residents (Resident 4 [R4]). This failure placed R4 at risk for their care needs and services not being met.

Findings included…

Record review of the facility policy titled, “Resident Assessment and Negotiated Service Agreement”, dated 12/17/2020, showed the resident care director or generations program director would ensure resident assessments were completed. The procedure showed all assisted living resident assessments would be completed prior to move-in, 30 days after move in, every six months, or whenever a significant change in the resident condition occurred.

Record review of R4’s, “Face Sheet”, dated 12/12/2024, showed R4 moved into the facility on [redacted]/2024.

Record review of R4’s medical chart, showed there was no 14-day assessment in the chart for review.

In an interview on 12/13/2024 at 11:58 AM, Staff A, Executive Director, said all resident assessments should be stored in the residents medical chart. Staff A said if a document

could not be located in a residents medical chart then the facility did not have it.

In an interview on 12/27/2024 at 12:49 PM, Staff B, Resident Care Coordinator, stated they completed all resident's assessments. Staff B stated an assessment at the residents home or where they resided would be completed prior to the resident moving into the facility to ensure they were appropriate level of care. Staff B stated once the resident moved into the facility, they would review the residents assessment one week after move in. Staff B said they would review if there was any changes in the level of care the resident received or did not require to determine if a new assessment was needing to be completed. Staff B stated they would only make a new assessment at that time if there were changes. Staff B state if there were no changes then they would update a new assessment at their 30 days. Staff B stated there was no where to document on the assessment to show that they reviewed the residents assessment one week after move in and that there were no changes and did not document in the progress notes.

Record review of the facility policy titled, "Resident Assessment and Negotiated Service Agreement", dated 12/17/2020, showed the policy did not instruct facility staff to complete a full assessment within 14 days of a residents move-in date.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

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

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete an initial Negotiated Service Agreement (NSA) following admission into the facility for 1 of 2 newly admitted residents (Resident 3 [R3]). The facility failed to update the NSA for 1 of 5 residents (Resident 2 [R2]) when they had a change in condition and multiple falls. The facility failed to complete an NSA within 30 days following admission to the facility for 2 of 2 newly admitted residents (R3 and Resident 4 [R4]). These failures placed all residents at risk of unmet care needs and decreased quality of life.

Findings included…

Record review of the facility policy titled, “Resident Assessment and Negotiated Service Agreement”, dated 12/17/2020, showed the resident care director or generations program director would ensure resident assessments were completed. The procedure showed all assisted living resident assessments would be completed prior to move-in, 30 days after moving in, every six months, or whenever a significant change in the resident condition occurred.

Record review of the facility’s policy titled, “Alert Charting”, dated “05/13/202” (as written on policy), showed alert charting would be implemented for residents who had a recent change in their expected or customary function or other reason that initiated a need for closer monitoring. Changes in the residents Negotiated Service Agreement would be made as appropriate.

R3

Record review of R3’s, “Face Sheet”, dated 12/12/2024, showed R3 moved into the facility on [redacted]/2024.

Record review on 12/13/2024 of R3’s medical chart showed there was no initial NSA or 30-day NSA to review. Under the tab that was labeled “service plan”, showed there was a document titled “level of care appraisal” dated 09/19/2024, that was an assessment and not a service plan.

R4

Record review of R4's, "Face Sheet", dated 12/12/2024, showed R4 moved into the facility on [redacted]/2024.

Record review of R4's medical chart, showed there was no 30-day NSA to review.

R2

Record review of R2's face sheet, dated 12/12/2024, showed R2 moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted].

Record review of R2's level of care appraisal (facility's version of an assessment)- WA (Washington), dated 11/05/2024, showed it was a change of condition assessment. The document showed R2 did not require hospice services. R2 required stand by assistance with dressing, transfers, toileting but could be left alone. R2 may be a fall risk and required eight to 12 checks per day.

Record review of R2's Service Agreement, dated 08/12/2024, showed R2 required stand by assistance for all dressing every morning and evening. R2 needed stand by assistance for all grooming. Staff were to check on R2 every two hours during the day, evening, and night. R2 required stand by assistance with all transfers and was at risk for falls related to weakness in lower legs. Staff were to encourage R2 to use their walker and use a call pendent for assistance and complete frequent checks that were in place since 12/15/2023. R2 required staff to assist them with standing while toileting.

Record review of R2's Initial Record of Incident, dated 10/20/2024 at 11:15 AM, showed R2 had an unwitnessed fall in their own apartment in the bathroom area. R2 stated they had fallen and did not hit their head or have any pain. Staff found R2 on the floor in their bathroom. Under the section titled, "follow up and prevention: general", showed R2 was placed on 48 hour alert charting, family/Power of attorney (POA) was notified, frequent checks, medical doctor (MD) were notified. Under the section "follow up and prevention: fall reduction interventions implemented", showed N/A (not applicable).

Record review of R2's Initial Record of Incident, dated 10/23/2024 at 3:00 PM, showed R2 had an unwitnessed fall in their own apartment in the living room area. R2 stated they complained of pain. Staff found R2 face down in between their chair and couch complaining of pain. Under the section titled, "follow up and prevention: general", showed R2 was placed on 48 hour alert charting, emergency medical services (EMS) was called to evaluation, family/POA was notified, frequent visual checks, MD was notified. Under the section "follow up and prevention: fall reduction interventions implemented", showed area was checked for trip hazards, care conference with family.

Record review of R2's Initial Record of Incident, dated 10/27/2024 at 5:04 PM, showed

R2 had an unwitnessed fall in their own apartment in the kitchen area. R2 stated they lost their balance when they turned around from checking the door and fell and hit their head. Staff found R2 on the floor in front of their door and R2 reported they had hit their head. Under the section titled, “follow up and prevention: general”, showed R2 was placed on 48 hour alert charting, emergency medical services (EMS) was called to evaluation, encourage resident to ask for assistance, family care conference, family/POA was notified, frequent checks, MD were notified. Under the section “follow up and prevention: fall reduction interventions implemented”, showed area was checked for trip hazards, frequent checks, and hospice.

Record review of R2’s Initial Record of Incident, dated 11/04/2024 at 3:30 PM, showed R2 had an unwitnessed fall in their own apartment in the living room area. R2 stated they lost their balance and slid down the chair to the floor. Staff found R2 on the floor in front of their chair sitting on the floor. Under the section titled, “follow up and prevention: general”, showed R2 was placed on 48 hour alert charting, family and POA was notified, frequent checks, hospice were notified. Under the section “follow up and prevention: fall reduction interventions implemented”, showed area was checked for trip hazards, frequent checks, and hospice.

Record review of R2’s Initial Record of Incident, dated 11/09/2024 at 3:00 PM, showed R2 had an unwitnessed fall in their own apartment in their kitchen area. R2 stated they fell and hit their head and was found on the ground by the kitchen with their walker laying next to them. Under the section titled, “follow up and prevention: general”, showed R2 was placed on 48 hour alert charting, EMS was called to evaluation, family/POA was notified, frequent checks, hospice and MD were notified. Under the section “follow up and prevention: fall reduction interventions implemented”, showed area was checked for trip hazards.

Record review of R2’s Initial Record of Incident, dated 11/12/2024 at 1:15 PM, showed R2 had an unwitnessed fall when R2 lost their balance and fell. R2 was found on the floor with their left side with upper half of their body on the shower floor. Under the section titled, “follow up and prevention: general”, showed R2 was placed on 48 hour alert charting, family and POA was notified, frequent checks completed, hospice and MD were notified. Under the section “follow up and prevention: fall reduction interventions implemented”, showed area was checked for trip hazards and resident was educated on using call pendent for assistance.

Record review of R2’s Service Agreement, dated 08/12/2024, showed there were no new interventions or updates implemented after R2’s falls to help reduce the R2’s risk for further falls. The interventions on the service agreement had been in place and updated on 12/15/2023 and 08/12/2024. The service agreement did not show that R2 had been admitted to hospice services.

In an interview on 12/13/2024 at 3:17 PM, R2 stated they were recently admitted to hospice services that started a few weeks ago. R2 stated they had a lot of falls recently. R2 stated they were to use nonslip socks, and encouraged to use either a wheelchair or a walker to get around.

In an interview on 12/13/2024 at 11:58 AM, Staff A, Executive Director, said all resident assessments and NSA's should be stored in the residents medical chart. Staff A said if a document could not be located in a residents medical chart then the facility did not have it.

In an interview on 12/27/2024 at 12:49 PM, Staff B, Resident Care Coordinator, stated they updated the residents service plans. Staff B stated the service plans were updated at variable times. Staff B stated once a resident moved into the facility the initial service plan was made off of the pre-admission assessment. Staff B stated the service plan was again updated on 30 days, 60 days, and 90 days. Staff B stated all service plans and assessments when they were completed were reviewed with the resident or the residents representative for review, agreement, and then signed.

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, Victoria Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date