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

CHP Auburn WA Tenant Corp
Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

RE: Prestige Senior Living Auburn Meadows License # 2239

Dear Administrator:

This letter addresses Compliance Determination(s) 57531 (Completion Date 04/07/2025) and 53622 (Completion Date 02/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/07/2025 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-2480-1, WAC 388-78A-24642-1, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2100-2-b-iii, WAC 388-78A-2305-1, WAC 388-78A-2350-1, WAC 388-78A-2350-7, WAC 388-78A-2350-7-a, WAC 388-78A-2350-7-b

The Department staff who did the on-site verification:
Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor
Jane Hermano, NCI

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

Sincerely,

Laurie Anderson

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for the unannounced on-site full inspection on 01/28/2025 and 01/31/2025 of:

Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

The following sample was selected for review during the unannounced on-site visit: 9 of 82 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor
Jane Hermano, NCI

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

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

Laurie Anderson — Residential Care Services

02/11/2025 — 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)

2/19/2025 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 6 staff (Staff B, Staff C, and Staff D) were screened for Tuberculosis (TB), as required. This failure placed all 82 residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Review of the facility's undated personnel records showed the facility hired Staff B, Med Tech, on 08/13/2024; Staff C, Patient Care Assistant (PCA) on 04/10/2024; and Staff D, PCA, on 07/02/2024.

Review of the facility's staff schedule showed that from 08/13/2024 through 01/27/2025, Staff B worked at the facility providing care and services for residents. Review of Staff B's personnel records showed no documentation that Staff B completed TB screening and testing within 3 days of the date of hire.

Review of the facility's staff schedule showed that from 04/10/2024 through 01/27/2025, Staff C worked at the facility providing care and services for residents. Review of Staff C's personnel records showed no documentation that Staff C completed TB screening and testing within 3 days of the date of hire.

Review of the facility's staff schedule showed that from 07/02/2024 through

01/27/2025, Staff D worked at the facility providing care and services for residents. Review of Staff D's personnel records showed no documentation that Staff D completed TB screening and testing within 3 days of the date of hire.

During an interview on 01/31/2024 at 1:15 PM, Staff A, Executive Director, stated that they were unaware Staff B, Staff C, and Staff D were not tested for TB upon hire.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 3/27/2025

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

Administrator (or Representative) 2/19/2025 Date

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to submit a request for a national fingerprint background check for 2 of 6 staff (Staff B and Staff D) prior to having unsupervised contact with facility residents. This failure placed all 82 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included...

Review of the facility's staff schedule showed that from 08/13/2024 through 01/27/2025, Staff B, MedTech, worked at the facility providing care and services for residents. Review of Staff B's personnel records showed no documentation that Staff B completed a national fingerprint background check and followed department procedures.

Review of the facility's staff schedule showed that from 07/02/2024 through 01/27/2025, Staff D, Patient Care Assistant (PCA), worked at the facility providing care and services for residents. Review of Staff D's personnel records showed no documentation that Staff D completed a national fingerprint background check and

followed department procedures.

During an interview on 01/31/2025 at 1:10 PM, Staff A, Executive Director, stated that the facility failed to submit the request for a national fingerprint background check for Staff B and Staff D when both were hired.

Plan/Attestation Statement

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

Administrator (or Representative) 2/19/2025 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

(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;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 3 of 9 sampled residents (Resident 1, Resident 4, and Resident 5) assessments that included the required full assessment components. This failure placed Resident 1, Resident 4, and Resident 5 at risk of harm from unidentified care needs and changes in condition.

Findings included...

RESIDENT 1

Review of Resident 1's records showed the facility admitted Resident 1 on [redacted]/2007. The records showed Resident 1 admitted with diagnoses of: [redacted].

Review of Resident 1's assessment, dated 05/29/2024, showed no documentation of Resident 1's current prescribed medications. The assessment showed no documentation of Resident 1's diagnosed [redacted]. There was no documentation of Resident 1's delusional ideations, and no guidance for staff to follow if Resident 1 experienced any delusions, no guidance to notify nursing staff, and no directions related to documenting Resident 1's delusional incidents.
There was no documentation of Resident 1's history of medication over-dose and medication "pocketing" (hiding of medications in the cheek). There were no instructions for staff to follow to ensure Resident 1 swallowed crushed medications at time of administration

RESIDENT 4
Review of Resident 4's records showed the facility admitted Resident 4 on [redacted]/2022. The records showed Resident 4 admitted with diagnoses of: [redacted], and [redacted]. Review of Resident 4's assessment, dated 11/12/2024, showed no documentation of Resident 4's seizure disorder, with information about the type of seizures, the frequency of seizures, and medications used to manage the seizure disorder. There were no instructions for care staff to notify nursing staff and document Resident 4's seizures. There was no documentation of Resident 4's current prescribed seizure medication, Keppra, 500 milligrams, tablet given twice daily by mouth, and any potential side effects of the medications. There was no documentation of Resident 4's other prescribed medications and any potential side effects of the medications .

RESIDENT 5
Review of Resident 5's records showed the facility admitted Resident 5 on [redacted]/2022. The records showed Resident 5 admitted with diagnoses of: [redacted], and [redacted]. Review of Resident 5's assessment, dated 12/27/2024, showed no documentation of Resident 5's observable mannerisms and/or behaviors related to Resident 5's [redacted] diagnosis. There was no guidance for staff to observe and document potential side effects from Resident 5's prescribed antipsychotic medication, Risperidone, three milligrams, tablet given twice daily by mouth, and any potential side effects of the medication. There was no guidance for staff to observe and document potential side effects from Resident 5's prescribed anti-depressant medication, Sertraline, 100 milligrams, capsule, give two capsules once daily by mouth, and any potential side effects of the medication.

During an interview on 01/31/2025 at 1:20 PM, Staff A, Executive Director, stated that they were unaware of the comprehensive elements required in resident assessments.

Staff A stated that the facility utilized an electronic documentation system. Staff A stated that they thought the electronic documentation system met the required assessment comprehensive components.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 3/27/2025

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

Administrator (or Representative) 2/19/2025 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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 kitchen and dining room (main kitchen and dining room) was maintained in compliance with the regulations related to the proper use and testing of sanitization solution. This failure placed all 82 residents at potential risk of contracting food-borne illnesses.

Findings included...

Note: Per WAC 246-215-04575 Equipment—Warewashing equipment, determining chemical sanitizer concentration (FDA Food Code 4-501.116). Concentration of the sanitizing solution must be accurately determined by using a test kit or other device.

Review of the facility's policy titled, "ALF: Food Surface Cleaning and Sanitizing", revised 02/2019, showed that the facility ensured food surfaces were properly cleaned and sanitized to reduce disease-causing bacteria that contaminate food. The policy showed the facility cleaned and sanitized food-contact surfaces between all tasks to prevent cross contamination and used green (washing) and red (sanitizing) buckets. The policy showed the facility kept the chemical sanitizing solutions at the appropriate

concentration and free from food debris and visible soil. The policy showed that the sanitation was maintained as outlined in Chapter 246-215 WA, Food Service Sanitation.

Observation of the main dining room on 01/28/2025 at 1:15 PM, showed an unidentified dining staff removed dirty plates from the tables and stacked them on a cart. The cart contained a green and red bucket. Observation showed that after the dining staff removed all the used dishes, the staff used a dampened cloth from the red bucket to wipe down the tables.

During an interview on 01/29/2025 at 8:56 M, Staff K, Dining Services Manager, stated that they expected the dining staff to keep a green bucket for cleaning solutions and red bucket for sanitizing solutions available when they clean the food services counter and dining room tables. Staff K stated that the dining staff used sanitized wiping cloths during the in-between use and each time they wiped down a different table. Staff K stated that the staff were expected to change the cleaner and sanitizer solutions every two hours or as needed.

Observation in the main kitchen on 01/29/2025 at 9:26 AM, showed an empty red bucket in the dishwashing area and a red bucket half-filled with sanitizing solution under one kitchen counter. During an interview at this time, Staff L, Cook, stated that they just changed the sanitizing solution. Staff L stated that they were unsure when they last tested the sanitizing solution. Observation showed Staff L asked Staff K where the test kit was stored.

During an interview on 01/29/2025 at 9:41 AM, Staff K stated that they were unable to find the test kit. Staff K stated that they used a pre-mixed disinfectant solution, and the red bucket was filled from an auto dispensed hose. Staff K was unaware that that they needed to measure the concentration of the pre-mixed sanitizing solution for effectiveness. Staff K stated that there was no documentation that showed the cleaning and sanitizing solution was checked for safe use.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 3/27/2025.

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

Administrator (or Representative) Date 2/19/2025

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to implement or obtain clarification for 3 of 5 residents (Resident 2, Resident 10, and Resident 11) health care provider orders. This failure placed Resident 2, Resident 10, and Resident 11 at risk for potential medical complication and a decreased quality of life.

Findings included...

Review of facility's policy titled, "Coordination of Services Policy and Procedures," revised 10/2015, showed that the Health Services Director (HSD) or Executive Director (ED) assisted in arranging outside care if needed and coordinated the resident's care with physicians. The policy showed that the outside physician assessed the resident and developed the care plan. The staff, the resident and their family representative discussed and clarified the plan as appropriate and ensured that resident's needs were met.

RESIDENT 2
Review of Resident 2's medical records showed that the facility admitted Resident 2 on [redacted]/2023 with multiple diagnoses which included [redacted].
Review of Resident 2's medical records contained an outside healthcare provider (HCP) summary visit note dated 11/19/2024. The summary note showed an order that requested the staff to notify the HCP if Resident 2's systolic blood pressure (the first number in a blood pressure reading, SBP) was below 100/x or greater than 160/x millimeters of mercury (mmHg) "consistently." The order showed Resident 2's SBP goal between 100 and 140.

During an interview on 01/30/2025 at 10:20 AM, Resident 2 stated that they recorded their own blood glucose reading daily and did not include their blood pressure. Resident 2 stated that they were unaware there was an order to report to the HCP if their SBP was below 100 or greater than 160. Resident 2 stated that they experienced headaches or dizziness on and off most of the days, which could be related to low blood pressure. Resident 2 stated that they did not report the symptoms to the HCP or staff.

Review of Resident 2's November 2024, December 2024, and January 2025 medication administration record (MAR) showed the facility obtained Resident 2's vital signs monthly. The MARs showed an order to notify the HCP if Resident 2's SBP reading was less than 100 or greater than 160. Review of November 2024 MAR showed no documentation that Resident 2's blood pressure was obtained.

During an interview on 01/30/2025 at 1:12 PM, Staff G, Health Services Director, stated that the facility took monthly vital signs as part of residents' routine health monitoring. Staff G was unaware that Resident 2's blood pressure was not obtained for the month of November. Staff G stated that they failed to coordinate or clarify with Resident 2's HCP how frequently the SBP was to be monitored.

RESIDENT 10
Review of Resident 10's medical records showed that the facility admitted Resident 10 on [redacted]/2024 with multiple diagnoses which included [redacted], and [redacted]. Review of Resident 10's medical records contained an outside HCP summary visit note dated 10/14/2024. The summary note showed multiple orders that requested the staff to notify the HCP if Resident 10 had a significant weight gain greater than five pounds in a week or a SBP reading below 100 or complaints of kidney disease complications, such as nausea, vomiting, significant weakness, or decreased urine output.

Review of Resident 10's December 2024 and January 2025 MAR showed documentation of Resident 10's monthly weight. There was no documentation on the MARs of the order that the HCP was to be notified if Resident 10 had a five-pound weight increase in a week. The MARs showed Resident 10 received two blood pressure medications daily in the morning. The MARs showed that the blood pressure readings were taken one hour after the medications were administered. Review of MARs showed that between 12/01/2024 and 01/31/2025, Resident 10's SBP readings were below 100/x mmHg 21 different times. There was no documentation that showed Resident 10's HCP was notified, as ordered.

Review of Resident 10's service plan, dated 11/15/2024, showed no documentation that Resident 10 was diagnosed with [redacted]. There was no guidance that instructed staff to notify the HCP if Resident 10 experienced kidney disease complications, as directed in the HCP's order.

RESIDENT 11
Review of Resident 11's medical records showed that the facility admitted Resident 11 on [redacted]/2022 with multiple diagnoses which included [redacted], and

[redacted]. Review of Resident 11's medical records contained an outside HCP summary visit note dated 01/02/2025. The summary note showed Resident 11 had history of left foot toe amputation of the second to fifth toes. The summary note showed Resident 11 was found to have an open wound to the lateral of the left foot. The summary note provided direction for staff about how to prevent pressure injury and wound treatment on Resident 11's left foot. The note directed staff to report to the HCP of any signs or symptoms of worsening condition or complication of the foot, such as a possible infection.

Review of Resident 11's service plan, dated 12/09/2024, showed no documentation about Resident 11's history of amputated toes on their left foot. The plan showed no documentation Resident 11 received wound treatment on their left foot, as ordered. There were no staff instructions about when to report any signs and symptoms of worsening wound complications, as directed in the HCP's order.

During an interview on 01/31/2025 at 11:15 AM, Staff G stated that the Medication Technicians were trained to use the electronic MAR system to document and to notify the HCPs, as needed. Staff G stated that they were unaware that Resident 10's HCP was not notified when Resident 10's SBP was below 100/x mmHg, as ordered. Staff G stated that they were unable to coordinate or clarify with Resident 10's HCP how frequently the weight needed to be obtained.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 3/27/2025

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

Administrator (or Representative) 2/19/2025 Date

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

02/11/2025

CHP Auburn WA Tenant Corp
Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

RE: Prestige Senior Living Auburn Meadows # 2239

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/10/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

Laurie Anderson, Community Field Manager
Residential Care Services
Region 2, Unit D
Preferred methods:

eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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

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

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

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

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

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

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

(f) Availability of the supervisor, in person, by pager, or by telephone, to respond to residents' needs on the assisted living facility premises as necessary.

(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:

(a) Chapter 18.79 RCW, Nursing care;

(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.

The facility failed to ensure one resident, who required nurse delegation services, had updated documentation and oversight with the facility's current nurse delegation provider. During the inspection, facility staff established and documented the completion of nurse delegation services to meet regulatory requirements.

WAC 388-78A-3040 Laundry.

(5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off site commercial laundry services.

The facility failed to ensure the ventilation system in the facility laundry room worked to vent to the outside. During the inspection, the facility staff repaired the fan to make it operational and ventilate to the outside.

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

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

The facility failed to ensure one staff completed training for mental health. During the licensing visit, the facility enrolled the staff person in the mental health specialty training, conducted on site, by an approved trainer. The staff person completed the training before the end of the licensing inspection.

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

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

Throughout the secured memory care unit within the facility, there was no information posted about the upcoming weeks meal choices. During the full inspection, the facility staff posted the weekly menus in the dining room and in the location where the food was served to meet the regulatory requirements.

You Are Not:

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

You May:

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

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

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

Enclosure