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 02/25/2025 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following SOD dated: 02/28/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 66 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Emily Boniface, Community Program Nurse Licensor
Celeste Vashey, ALF LTC Licensor
Megan Zerby, Community ALF/AFH 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

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

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.

Jody Just — 03/13/2025

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

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

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

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(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;

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

(a) Exclusively for the individual resident; or

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

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Residential Care Services   Date

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Administrator (or Representative)   Date

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

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

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(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;

(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:

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federal law.

(4) The resident's preferences for activities and how those preferences will be supported;

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 plan the plan to provide the care and services necessary to support the residents for 3 of 4 sampled residents (Resident 1 [R1], Resident 3 [R3], and Resident 4 [R4]. These failures placed the residents at risk for unmet care needs and untrained staff.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 12/03/2024, 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-2140] 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 12/18/2024. 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 01/17/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, showed for citation WAC 388-78A-2140 the immediate action taken included the facility ensured that care plans contained more details regarding outside services such as hospice and walker versus wheelchair usage. Staff B, Resident Care Assistant, and Staff G, Licensed Practical Nurse, would continue to monitor and add details to care plans as needed. The document showed the date by which the correction would be achieved was on 01/17/2025.

Record review of the facility's policy titled, "Negotiated Service Agreements", undated, showed the resident agreements would be based on the assessed needs and would be developed with the input, participation, and agreement of the resident, responsible parties, facility staff and other as appropriate and to the extent possible. The negotiated service agreement (NSA) would be developed building on the resident's strengths and using the full assessment information, pre-admission assessment, and resident service plan. The NSA would be updated to be consistent with residents needs when there was an observed change in the resident's physical, mental, and emotional function. The NSA would be updated when it no longer addressed the residents needs and/or preferences and it would address all reasonable risks and how those risks would be managed.

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Record review of the International Dysphagia Diet Standardisation Initiative (IDDSI) document titled, “6 soft and bite-sized”, dated January 2019, showed level six soft and bite-sized foods was a diet used when a person was not able to bite off pieces of food safely but were able to chew bit-sized pieces down into little pieces that were safe to swallow. Soft and bite-sized good needed a moderate amount of chewing, for the tongue to collect the food into a ball and bring into the back of the mouth for swallowing. The pieces were bite-sized to reduce choking risk. The food was to not be any bigger than 1.5 centimeters and the food was to be soft enough to press down on the fork until the thumbnail blanches to white and when the fork was lifted the food was squashed and did not regain its shape.

R3
Record review of the facility’s Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R3 moved into the facility on [redacted]/2022.

Record review of R3’s, “Washington Health and Service Evaluation Results” (facility’s version of an assessment), dated 09/20/2024, showed R3 received hospice services.

Record review of R3’s, “Service Plan”, dated 09/20/2024, showed that R3 had a diagnosis of [redacted].
The service plan showed no information related to the hospice services that R3 received and did not indicate R3 was on hospice services.

Record review of R3’s, “Observations [facility’s version of alert charting] For [R3]”, dated 02/21/2025, showed Staff H, Medication Technician, wrote that hospice attempted to see the resident today but R3 stated they did not want to see anyone.

In an interview on 02/25/2025 at 3:10 PM, Staff B, Resident Care Assistant, confirmed R3 was on hospice services. Staff G, Nursing, stated they had not updated R3’s service plan.

R1

Record review of the facility’s Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R1 moved into the facility on [redacted]/2024. The characteristic roster section showed resident needed maximum assistance with their ADL’s (activities daily living).

Record review of R1’s, “Washington Health and Service Evaluation Results” (facility’s version of an assessment), dated 04/10/2024, showed it was a 14-day assessment. The mobility and ambulation section showed R1 used a manual and electric wheelchair. R1 was independent with mobility and ambulation and did not require assistance. The

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transfer section showed R1 required routine hands-on assistance with transfers or changes in position.

Record review of R1's, "Service Plan", dated 04/11/2024, showed R1 used a manual and electric wheelchair and was independent with their ambulation and mobility. R1 needed one person to assist with transfers and R1 used a transfer pole (a sturdy vertical pole that helped people stand, sit, and move around safety) to assist with transfers.

Record review of R1's, "Safety Device Evaluation', dated 04/30/2024, showed it was for a transfer pole. On top of the paperwork had been a sticky note and in handwritten letters it showed "currently working on change of cond. (condition) for move to memory care on 02/25/2025. Will not have transfer poles, just sit to stand."

Record review of R1's, "Observations For [R1]", dated 02/24/2025, showed Staff G, Licensed Practical Nurse, wrote R1 arrived by ambulance today. R1's notes from occupational therapy recommended a mechanical lift (a device that helped move people who had limited mobility), R1 was a two-person total assist, and most ADLs were moderate to maximum assistance. R1 was unable to use their current transfer pole.

In an observation on 02/25/2025 at 12:09 PM, Staff L, Resident Care Assistant, had been observed to push R1 in their wheelchair down the hall before they entered R1's room.

In an interview on 02/25/2025 at 2:02 PM, Staff L said they were unsure what R1's care needs were since their move to the memory care unit. Staff L said they assumed R1 needed two-person assistance with a sit to stand lift (a medical device that helped people with limited mobility stand up from a seated position). Staff L said they had not used a sit to stand lift with R1 since they moved into the memory care unit. Staff L said they were unsure if R1's service plan indicated R1 used a sit to stand lift. Staff L said they used one person, themselves, to transfer R1.

In an interview on 02/25/2025 at 2:47 PM, Staff B said R1 just returned from the hospital and the facility had been in the process of updating R1's service plan. Staff B said the hospital nurse said R1 was a two person assist but occupational therapy advised R1 needed a sit to stand. Staff B confirmed R1 was moved to the memory care unit. Staff B said the memory care unit facility staff were advised of R1's care needs.

R4

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R4 moved into the facility on [redacted]/2024.

Record review of R4's document, "fax orders", dated 01/24/2025, showed R4 had a recent swallow evaluation. R4's physician wrote new orders for R4 to have "IDDSI 6 diet,

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bite size with added moisture (please add gravy and/or soup) to each meal. Thin liquids are tolerated with cup sip swallows, no straws and no bottles of water please."

Record review of R4's "Observations for [R4]", dated 01/24/2025, showed "received fax from PCP [primary care physician] with orders for IDDSI 6 diet, "bite size with added moisture (please add gravy and/or soup) to each meal. Thin liquids are tolerated with cup sips swallows, no straws and no bottles of water please" will add to MAR [medication administration record], alert charting, and inform the kitchen."

Record review of R4's Washington Health and Service Evaluation Results, dated 02/17/2025, showed it was a change of condition assessment. Under the section titled, "meal consumption", showed R4 was independent and did not required assistance with meals. R4 was able to determine their preference and was on a regular diet. There was "none apply" documented for additional meal considerations and meal consumption enabling devices and methods on the assessment.

Review of R4's Service Plan, dated 02/17/2025, under section titled, "meal consumption", showed R4 was independent and did not required assistance with meal consumption. R4 determined their own food preferences and was on a regular diet. There was no documentation to show that R4 had specific physician order diet for the caregivers to follow and know what R4 required.

In an interview on 02/25/2025 at 3:20 PM, Staff B stated R4's service plan, dated 02/17/2025 was the updated service plan. Staff B stated they did not complete temporary service plans or write on the current service plans to show what the residents current care and services were for the caregivers and staff to review until the residents service plan was scheduled to be updated.

This is an uncorrected deficiency previously cited on 12/03/2024 for subsections 388-78a-2140 (1)(a)(ii),(iii),(b),(d),(2)(a),(b).

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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) ______________________ 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:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 1 of 4 sampled resident rooms (Resident 1 [R1]). The failure to secure medications placed 18 of 18 memory care residents at risk of access and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/03/2024, 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-2260] 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 12/18/2024. 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 01/17/2025.”

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Record review of the facility's, "Plan of Correction", dated, 12/12/2024, for citation WAC 388-78a-2260 storing, securing, and accounting for medications, showed room audits were conducted by the nursing department staff to ensure proper storage of medications. Room audits would be conducted by the nursing department staff monthly. Any medications in apartments where the resident cannot safely store and/or administer their own medications would be removed for proper storage at the nurses station. Family and friends of the residents would be reminded as needed to not provide medications of any kind to their loved ones that cannot safely store/administer their own medications.

Record review of the facility's policy titled, "Medication Services", dated 02/23/2018, showed residents who were assessed to be capable to self-administrator or self-administration with assistance could store and control their own medications, which should be stored in a way to prevent access by other residents. The facility would store medications for residents who were not capable of safely storing their own medications and who had been assessed as needing medication administration. All medications in the facility would be properly stored in a locked cabinet in a nurse's station where only designated staff had access.

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 02/25/2025, showed 7 of 18 memory care residents were classified to have a diagnosis of .

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R1 moved into the facility on /2024.

Review of R1's Service Plan, dated 04/11/2024, under section titled, "medication", showed R1 was unable to take medication without assistance.

Record review of R1's, "Observations For [R1]", dated 02/24/2025, showed Staff G, Licensed Practical Nurse, wrote R1 returned to the facility with a diagnosis of

In an observation on 02/25/2025 at 12:10 PM, inside R1's room on the top of their dresser was a tube that had a prescription label that showed, "0.05% clostebol propionate 60 grams" (a prescribed medicated steroid cream that was to help treat flare ups of chronic skin conditions) unsecured.

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In an interview on 02/25/2025 at 3:10 PM, Staff A, Marketing, stated they had sent letters to all the resident's family members that explained, that residents were not allowed to have medications stored in their rooms. Staff B, Resident Care Assistant, said the facility took all of R1's medications out of their room when R1 moved from the assisted living unit to the locked memory care unit.

This is an uncorrected deficiency previously cited on 12/03/2024.

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Administrator (or Representative) ________________ Date ________________

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to obtain and administer medications in an appropriate and timely manner for 1 of 4 sampled residents (Resident 2[R2]). This failure resulted in R2 not receiving medications as prescribed and placed R2 at risk for a decreased quality of life.

Findings included…

Record review of the "Department of Social And Health Services" document, completion date 12/03/2024, 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-2240] 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 12/18/2024. Staff A signed the

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“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 01/17/2025.”

Record review of the facility’s, “Plan of Correction”, dated, 12/12/2024, for citation WAC 388-78a-2240 nonavailability of medications, showed in-services were held for medication technician’s to ensure timely administration of medications. Medication technician’s were educated to always follow up on missing medications and to reorder medications with having enough medications remaining for a few days until new medications come in. Medications technicians were also educated on calling or faxing the primary care physician if medications were missed to avoid health complications, or recommendations from the primary care physician. Staff B, Resident Care Assistant, and Staff G, Licensed Practical Nurse, would continue to educate the medication technicians as needed on timely administration of medications and the importance of timely follow up with the pharmacy and the primary care physician by calling and not just faxing. Staff B and Staff G would be notified by the medication technicians if there were any medication availability issues. New medication technicians would receive training on these in-services.

Record review of facility policy “Nonavailability of Medication,” dated 03/27/2018, showed it was the policy of [the facility name] to provide medication to residents in a timeframe and in a manner that promotes health and welfare. Under the section titled, “procedure” showed “1. All medications that are the responsibility of the facility will be re-ordered from the pharmacy at a pre-designated and negotiated time frame with the pharmacy (due to insurance reimbursement requirements, medications cannot be ordered too early, or the insurance will not cover the cost of the medication). 2. If, despite negotiations and plans set between facility and the pharmacy, a medication is not available to a resident at a designated timeframe, the designated staff person will contact the pharmacy to determine when the medication will be delivered. 3. The licensed nurse will evaluate the significance of the medication not being delivered to the resident on time and take the appropriate actions to ensure resident safety and welfare 4. If the medication will not be available to the resident in the timeframe needed the resident's health care provider or prescriber of the medication will be notified 5. If it is the resident's and /or responsible part's responsibility to obtain mediation for the resident, the designated staff person will contact the resident/responsible party and explain concerns regarding medications being unavailable. 6. Medications may be unavailable due to weather conditions, pharmacy availability of the medication etc. If the resident health and safety would be at risk the pharmacy may contact a local pharmacy to fill the medication so that it will be available in a more immediate timeframe."

Record review of the facility’s Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R2 moved into the facility on [redacted]/2024.

Record review of R2’s Washington Health and Service Evaluation Results, dated

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02/17/2025, under the section titled, “medication”, showed qualified staff were responsible to purchase, store, and to assist with medication administration.

Record review of R2’s Service Plan, dated 02/18/2025, under the section titled, “medication”, showed R2 required total assistance with their medications. R2 was unable to take medications without assistance.

Record review R2’s Medication Administration Record, dated 02/01/2025 through 02/25/2025, showed R2 had an order for gabapentin (a medication to help treat nerve pain and or seizures), take one tablet three times daily. Review of the administrations showed on 02/16/2025 in the evening, through 02/19/2025 in evening R2 missed their gabapentin administrations and showed the medication was not available and not administered. On 02/17/2025 at 7:18 AM, showed “contacting PCP [primary care physician] pertaining to refills”. On 02/17/2025 at 12:19 PM, showed R2’s gabapentin was not administered related to “waiting refill”. On 02/17/2025 at 6:15 PM, showed R2’s gabapentin was not administered related to “not available”. On 02/18/2025 at 6:51 AM, showed R2’s gabapentin was not administered related to “residents PCP closed yesterday. Will call again today about refills”. On 02/18/2025 at 11:32 AM, showed R2’s gabapentin was not administered related to “medication not available. Waiting return phone call from PCP”. On 02/19/2025 at 8:37 AM, showed R2’s gabapentin was not administered with no reason or notation documented. On 02/19/2025 at 12:21 PM, showed R2’s gabapentin was not administered related to “waiting on refill”.

Record review of R2’s observations (facility’s version of alert charting), dated 02/16/2025 through 02/19/2025, showed there was no documentation to show that R2’s physician was called and informed that R2 was out of their gabapentin medication and had not received 8 of 10 doses.

Record review of an email sent to the Department on 02/26/2025 at 10:11 AM, showed there was physician fax notifications sent for R2. Review of the documentation showed there was no physician notifications about R2’s gabapentin being out and not available for administration from 02/16/2025 through 02/19/2025 for review.

Record review of an email on 02/26/2025 at 3:09 PM, showed the facility sent all physician notifications about R2’s gabapentin not being administered from 02/16/2025 through 02/19/2025.

In an interview on 02/25/2025 at 3:09 PM, Staff B, Resident Care Assistance, stated the facility was to reorder the residents medication before the medication ran out. The facility would fax the residents physician prior to the medication being out to get the medication refilled.

In an interview on 02/28/2025 at 9:56 AM, Staff A, Marketing, acknowledged the facility did not have any documentation to show that R2’s physician was notified that their gabapentin was out or the attempts to get the medications from the pharmacy for

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review.

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Administrator (or Representative) ____________________ Date ____________________

WAC 388-78A-2210 Medication services.

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

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

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

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility staff failed ensure 1 of 4 residents (Resident 1 [R1]) received medications as prescribed. This failure placed R1 at risk for health complications by failing to follow physician's orders for medication services and patient monitoring.

Findings included…

Record review of the "Department of Social And Health Services" document, completion date 12/03/2024, 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-2210] as stated in the cited deficiencies in the enclosed report. I understand that to

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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 12/18/2024. 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 01/17/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, for citation WAC 388-78a-2210 medication services, showed in-services were held for medication technicians to ensure proper medications services were provided. Medication technicians were educated on documentation, monitoring and timely communication with the primary care physician's. Staff B, Resident Care Assistant, and Staff G, Licensed Practical Nurse, would continue to educate the medication technicians on medication services as needed. New medication technicians would receive training on these in-services. Staff B and Staff G would monitor medication technicians documentation, monitoring, and timely communication with the primary care physicians.

Record review of the facility's policy titled, "Medication Administration", dated 10/18/2024, showed medications were administered as prescribed. Under the section titled, "procedure" showed medications were administered in accordance with written orders of the physician or other authorized prescriber. All current medications and dosage schedules are listed on the residents medication administration record. Staff were to obtain and record any vital signs as ordered by the physician prior to the medication administration. Medication administration was documented on the residents electronic medication administration record at the time the medication was given by the person who administered the medication.

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R1 moved into the facility on ■■■■/2024.

Review of R1's Service Plan, dated 04/11/2024, under section titled, "medication", showed R1 was unable to take medication without assistance.

Record review of R1's Medication Administration Record (MAR), dated 01/01/2025 through 01/31/2025, showed R1 had an order for diltiazem extended-release (long-acting prescribed medication to help control high blood pressure) oral medication to be given for hypertension (medical condition when the blood pressure is high and body unable to regulate). The order showed when R1's systolic blood pressure (top number of blood pressure reading) was less than 110, the diltiazem was to be held. Record review of administrations showed on 01/20/2025 R1 was administered their diltiazem with no document blood pressure reading for review. On 01/31/2025 R1's systolic blood pressure was 94. R1 was administered their diltiazem and was not held per the physician orders.

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Record review of R1's MAR, dated 02/01/2025 through 02/25/2025, showed R1 had the order for diltiazem extended-release oral medication to be given for hypertension. The order showed when R1's systolic blood pressure was less than 110, the diltiazem was to be held. Review of the administrations showed on 02/04/2025, R1 was administered their diltiazem without their systolic blood pressure being checked and documented. On 02/06/2025 R1's systolic blood pressure reading was 139. Under the section of the MAR titled, "scheduled medication notations" on 02/06/2025 at 7:56 AM, showed "no pass per vitals" that showed R1's diltiazem was held and not administered. R1's blood pressure was not below the physician's parameter and should have been administered. On 02/09/2025 R1's diltiazem was administered their diltiazem without their systolic blood pressure being checked and documented. On 02/10/2025 R1's systolic blood pressure reading was 139. Under the section of the MAR titled, "scheduled medication notations" on 02/10/2025 at 7:45 AM, showed "no pass per vitals" that showed R1's diltiazem was held and not administered. R1's systolic blood pressure was above the physician order parameter and should have been administered.

In an interview on 02/28/2025 at 9:56 AM, Staff A, Marketing, stated Staff B, Resident Care Assistant, was to look through the resident MAR's to ensure that all medications were administered as ordered. Staff A stated Staff G, Licensed Practical Nurse, was to assist Staff B in auditing the residents MAR's for accurate administration.

This is an uncorrected deficiency previously cited on 12/03/2024 for subsection 388-78a-2210 (1)(b).

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 3 sampled Staff (Staff D) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within the required time frames. This failure placed 66 of 66 residents and staff at risk for exposure to TB.

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-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 01/31/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, showed for citation WAC 388-78A-2484 the immediate action taken included a TB tracking binder was created to closely monitor that a first step TB test was given on the date of hire, and a second step TB test was given between one and three weeks after the first step TB was read. All new staff received their initial TB test during the new employee orientation on their first day. Staff G, Licensed Practical Nurse would maintain the tracking binder that contained the TB tests until they were completed and would contact the employees directly to make sure timelines were met. Staff K, Payroll Manager, would file the TB tests in the employee's file. The document showed the date by which the correction would be achieved was on 01/17/2025.

Record review of the Centers of Disease Control document titled, "Testing for Tuberculosis: skin test", dated 01/31/2025, showed a TB skin test required two visits with a healthcare provider. If a person received a TB skin test, they would have two visits with the healthcare provider. During the first visit, the healthcare provider would inject a small amount of TB solution just under the skin on the lower part of the inner arm. On the second visit after two or three days, the person would return to the healthcare provider and have the skin test that was injected on the inner arm observed and determine if it was a positive or negative test result. Under the section titled, "two-step TB skin test", showed if someone was a healthcare worker they would have a two-step TB skin test. The two-step TB skin test could lower the chance that boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the first-step TB skin test was classified as negative, a second-step TB skin test would be given one to three weeks after the first test was read.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing

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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 facility policy titled "employee tuberculin testing", dated 09/08/2024, showed at the time of the initial employment showed employees would receive a TB skin test within three days of employment at the facility. The skin test would consist of baseline two-step test. For a two-step test, the second test would be administered one to three weeks following the first test.

Record review of facility's untitled and undated document with a list of employees, showed Staff D, Helper, was hired at the facility on 01/28/2025.

Record review of Staff D's Tuberculosis Skin Test Form, undated, showed Staff D received their step one skin test on 01/28/2025 and was read on 01/30/2025. Review of the step two showed there was no documentation to show that Staff D was administered the step two test. On the form was a sticky note that showed "2nd TB given but not noted. Waiting for reply from LPN [licensed practical nurse]."

Record review of an email sent to the Department on 02/26/2025 at 3:09 PM, showed Staff D did not have another TB skin test result in the last 12 months prior to Staff D starting employment at the facility.

In an interview on 02/25/2025 at 1:49 PM, Staff G stated Staff D had not had their step two TB skin test. Staff G stated they kept missing each other and were unable to administer the TB skin test to Staff D.

This is an uncorrected deficiency previously cited on 12/03/2024 for subsection 388-78a-2484 (2).

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

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, Sherwood Assisted Living 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:

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

(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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a [redacted] Policy for 2 of 4 sampled Residents (Resident 2[R2] and Resident 4 [R4]). This failure placed both 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 12/03/2024, 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 12/18/2024. 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 01/17/2025.”

Record review of the facility’s, “Plan of Correction”, dated, 12/12/2024, showed for citation WAC 388-78A-2665 the immediate action taken included all new residents and

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or their representatives would be provided with a [redacted] policy prior to their move in date. Acknowledgement of the policy would be documented by the resident or their representative and kept in the resident chart. The document showed the date by which the correction would be achieved was on 01/17/2025.

On 02/25/2025 at 11:07 AM, the Department requested R2 and R4's signed [redacted] policy for review.

R2

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R2 moved into the facility on [redacted]/2024.

During an onsite visit on 02/25/2025, the Department received a sticky noted for R2, that showed "new disclosure of services sent. Still waiting to be returned. Same for [redacted] Agreement."

In an interview on 02/25/2025 at 1:03 PM, Staff B, Resident Care Assistant, stated that the facility mailed R2's resident representative a copy of the [redacted] policy to sign and return but the paperwork had not been returned. Staff B noted to the facility's knowledge R2's resident representative had been out of the country and was difficult to get ahold of.

On 02/25/2025 at 2:44 PM, the Department requested to see a copy of the email that showed R2's responsible party was emailed the [redacted] Policy to sign and return to the facility for review.

As of 03/12/2025, the facility did not provide any documentation to show they provided R2 or their responsible party with a [redacted] policy.

R4

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R4 moved into the facility on [redacted]/2024.

Record review of R4's Resident Information, dated 02/26/2025, showed R4's son was the emergency contact for R4. R4's spouse was not listed as R4's responsible party.

Record review of R4's [redacted] Policy, undated, showed it had R4's name written in the top right corner. The policy was signed by R4's spouse and undated. There was no signature from R4 or R4's emergency contact.

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In an interview on 02/25/2025 at 3:09 PM, Staff A, Marketing, stated R4's [redacted] policy signed by R4's spouse that was undated, was the only signed [redacted] policy the facility was able to provide for the Department to review.

This is an uncorrected deficiency previously cited on 12/03/2024.

Plan/Attestation Statement

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Administrator (or Representative) ____________________ Date ____________________

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

(1) The residents' characteristics and needs;

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

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

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to secure potentially hazardous supplies accessible to memory care residents in 1 of 1 location within the facility (South Hampton Memory Care Unit). This failure placed 18 of 18 residents at risk for ingesting potentially toxic materials.

Findings included…

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

Record review of the “Department of Social And Health Services” document, Completion date 12/03/2024, 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-3100] 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 12/18/2024. 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 01/17/2025.”

Record review of the facility’s, “Plan of Correction”, dated, 12/12/2024, showed for citation WAC 388-78A-3100 the immediate action taken included locked keypad doors were installed in the memory care housekeeping closet and supply closet. The facility staff were reminded of proper chemical and equipment storage and not to prop open closet doors. Ongoing sweeps of the building would take place to ensure chemicals and equipment were secured. The document showed the date by which the correction would be achieved was on 01/17/2025.

Record review of the Alzheimer’s Association document titled, “Home Safety”, undated, showed as the Alzheimer dementia disease (a progressive brain disorder that affects one’s ability to think, judgement, and ability to carry out activities of daily living needs) progresses, the person’s abilities would change. Under the section titled, “how dementia affects safety”, showed Alzheimer’s disease caused a number of changes in the brain and body that would affect the person’s safety that included forgetting how to use household items, becoming easily confused, and experiencing changes in vision. Under the section titled, “home safety tips”, showed keep all cleaning products such as bleach out of sight, secured and in the original storage containers to discourage someone from eating or touching harmful chemicals.

Record review of the facility provided policy titled, “Safe Storage of Supplies and Equipment”, dated 10/20/2024, showed the facility would secure potentially hazardous supplies and equipment with the assessed needs of residents and their functional and cognitive abilities. All housekeeping supplies would be locked in housekeeping carts , housekeeping closet at the end of the shift, and in a locked storage area.

Record review of the facility’s, “Assisted Living Facility Resident Characteristic Roster and Sample Selection”, dated 02/25/2025, showed 7 of 18 memory care residents were classified to have a diagnosis of

In an observation on 02/25/2025 at 11:06 AM, in the memory care unit showed near the

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supply and linen closet there was a bottle of hand sanitizer that was on top of an activity table. The dirty linen closet door had been unlocked and inside contained a container of natures way cleaner (cleaning chemical), odor eliminator (a product that helped neutralize unwanted smells), stain remover (a cleaning chemical designed to remove stains or bring marks to the surface), and drain maintainer (a product that helped prevent clogs and odors inside drains). On the labels read keep out of reach of children and personal protective equipment had been recommended such as splash googles when someone used the product. There was a container of spec span disinfecting (cleaning chemical), all-purpose spray (cleaning chemical), and airlift fresh scent air freshener (a product that helped neutralize unwanted smells). In the cabinet showed a container of biohazard cleaning peroxide (disinfectant) and a container of natures way stain remover.

In an observation on 02/25/2025 at 11:10 AM, the memory care shower room was unlocked, and the door was ajar. Inside the room contained disinfecting all-purpose spray (cleaning chemical), odor eliminator, and stain remover. On the shelf were two bottles of Pantene pro V shampoo, Pantene pro V conditioner, mouthwash, crest toothpaste, Olay ultra moisture moisturizing body wash, dove body wash, head and shoulder shampoo, scalp relief conditioner, seven bars of soap, and shaving cream.

In an observation and interview on 02/25/2025 at 11:12 AM, Staff M, Resident Care Assistant, exited room 3 and entered the unlocked linen closet. Staff M said the shower rooms, the linen room, and the dirty linen storage rooms were supposed to be locked. Staff M said at times the shower room and dirty linen storage room were left unlocked because the door locks were difficult to use.

In an interview and observation on 02/25/2025 at 11:50 AM, Staff A, Marketing, said the hand sanitizer in the memory care unit on the activity table should not have been left out. Staff A picked up the hand sanitizer and removed it from the table. Staff A said the other day they removed six bottles of hand sanitizer from the memory care unit.

In an interview on 02/25/2025 at 12:41 PM, Staff L, Resident Care Assistant, said the memory care facility staff were supposed to keep hand sanitizer on their person or at the nurse's station. Staff L said hand sanitizer was not supposed to be left out to ensure the residents did not have access to it.

In an observation on 02/25/2025 at 12:29 PM, Resident 6 had been observed to walk up the hallway and attempted to open every door they passed.

In an observation on 02/25/2025 at 12:02 PM, Resident 2’s (R2) room had four containers of eight fluid ounces of perineal and skin cleanser (a product used to clean the sensitive skin of the perineum). A container of 16.7 fluid ounces of Lysol wipes (cleaning chemical), one eight fluid ounce bottle of hand sanitizer, one point seven fluid ounces of diaper rash spray (a spray on cream that helped prevent skin irritation), and a one-gallon bottle of perineal and skin cleanser.

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This is an uncorrected deficiency previously cited on 12/03/2024.

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) ____________ 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 follow and implement safe food handling and storing practices for 4 of 4 areas reviewed (dry storage, refrigerator, freezer, and South Hampton Memory Care Dining). These failures placed 66 of 66 residents at risk of receiving improperly handled food.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/03/2024, 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 12/18/2024. 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 01/17/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, showed for

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citation WAC 388-78A-2305 the immediate action taken included food delivery would be put away promptly and not left on the floor. Proper hand hygiene had been addressed in the November 2024 and January 2025 all staff meeting. Staff were reminded of proper handwashing guidelines and glove usage. Staff F, Cook, was responsible to make sure food deliveries were promptly put away on the proper shelving. Staff A, Marketing would do random food storage audits. The document showed the date by which the correction would be achieved was on 01/17/2025.

WAC 246-215-03351 "Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location;
(b) Where it is not exposed to splash, dust, or other contamination; and
(c) At least six inches (15 cm) above the floor.
(2) food in packages and working containers may be stored less than six inches (15 cm) above the floor on case lot handling equipment as specified under…"

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 facility's policy titled, "Food and Nutrition Services/Sanitation", dated 09/09/2024, showed the facility would manage food and maintain any on-site food service facilities.

Record review of the facility's policy titled, "Infection Control", dated 03/07/2018,

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showed hand washing should occur before and after aiding residents with personal care task of daily living, before staff handled food, and whenever staff changed from a dirty task to a clean task. Dietary employees must wash their hands at the kitchen sink upon reentry of the kitchen. Staff to wash hands whenever their hands were obviously soiled. Hand washing would be completed by all employee's according to the facility's policy and procedures.

Food Storage

In an interview on 02/25/2025 at 10:40 AM, Staff F stated that there was food boxes on the floor in the dry pantry. Staff F said they had not had time to move the boxes of food off the floor into their designated storage area.

In an observation in the dry pantry storage on 02/25/2025 at 10:41 AM, three separate stacks of boxes with food items were seen. The first stack of food boxes, from bottom to top were canned tomatoes, chocolate cake mixes, and barbeque wing sauce. The second stack of food boxes included shelf stable juice pack of 12, tree top grower owned cans, nestle cocoa mix, beef- based paste, and quaker enriched cream of wheat. The third stack of food boxes included canned peaches, canned pears, marinara sauce, chiquita bananas, pasta, another box of pasta, curly egg noodles, and then coffee.

In an observation on 02/25/2025 at 10:43 AM, in the outside freezer there was a box of mild cocktail sauce on the floor. There were multiple boxes of food that were stacked on top of the cocktail sauce.

In an interview on 02/25/2025 at 10:45 AM Staff F stated that they rushed outside to the refrigerator so they could move boxes off the ground before the Department could observe them.

In an interview on 02/25/2025 at 11:48 AM, Staff A, Marketing, said they talked with Staff F and informed them they needed to keep food off of the ground. Staff A acknowledged that the facility had food on the dry pantry, the freezer, and the refrigerator ground. Staff A said there should not be food stored on the ground.

Hand Hygiene Memory Care

In an observation on 02/25/2025 at 12:03 PM, Staff M, Resident Care Assistant, wore disposable gloves on each of their hands. Staff M dropped a cup that fell to the floor and picked it up. Staff M did not change their gloves or wash their hands before they got a new cup and poured apple juice and cranberry juice into the cup before they served it to a resident who sat in the memory care dining room. Staff M walked to the kitchenette area and retrieved a frozen sherbert and put it on the counter. Staff F doffed (took off)

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their gloves and handed the sherbert to Staff J, Resident Care Assistant. Staff M threw away their gloves and did not perform hand hygiene before they donned (put on) another pair of gloves. Staff M had been observed to go to a nearby table and removed dirty dishes the residents were finished with. At 12:07 PM, Staff M asked a resident if they wanted more to drink and went and obtained a refill for the resident. When Staff M went to drop off the refill, Resident 1 (R1) said they needed their glasses cleaned. Staff M had been observed to remove R1's shirt protector and took R1's glasses. Staff M got a towel and cleaned R1's glasses and brought the glasses back to R1. Staff M took a dirty dish off the table and offered to assist another resident. Staff M dropped off dirty dish in the kitchenette area and then followed the resident out of the dining area. At 12:35 PM, Staff M had been observed to use their teeth to open a hot cocoa packet and put it in a cup before they served it to Resident 6. Staff M did not perform hand hygiene before they went to the microwave and pulled out food that looked like soup, stirred it, and delivered it to a resident.

In an observation on 02/25/2025 at 12:06 PM, Staff J, without performing hand hygiene, pulled a frozen sherbert out of the microwave and brought it a resident. At 12:15 PM, without performing hand hygiene Staff J donned gloves and started to remove dirty dishes from tables.

In an interview on 02/25/2025 at 12:41 PM, Staff J said they were supposed to perform hand hygiene when they touched something dirty. Staff M said they were supposed to perform hand hygiene in between touching anything.

This is an uncorrected deficiency previously cited on 12/03/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sherwood Assisted Living 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-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff

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assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 2 sampled areas (South Hamptons Memory Care) observed had the means to summon on duty staff in the common areas. This failure placed 18 of 18 memory care residents, visitors, and staff at risk of not being able to summon staff when help was needed.

Findings included...

Record review of the “Department of Social And Health Services” document, Completion date 12/03/2024, 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-2930] 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 12/18/2024. 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 01/17/2025.”

Record review of the facility’s, “Plan of Correction”, dated, 12/12/2024, for citation WAC 388-78A-2930 Resident rights showed residents and/or resident representatives of the facility’s memory care were sent pendant waivers stating they understood call pendants were not available in memory care and that a call light system was not available in common areas. Call systems were in each memory care residents room and bathroom. Staff N, Marketing, would provide the call pendent waiver to the new memory care residents and/or resident representative for signature during the admission paperwork meeting and also for any resident that moves from assisted living to memory care.

Record review of the facility’s document titled, “Memory care facility consent form for no call pendants of call system in common areas”, dated 01/16/2025, showed the form was intended to address the use of call pendants and a call system in the common areas of the memory care. Due to the unique environment and specific care needs of

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the residents, we have implemented a policy whereby call pendant would not be available to memory care residents and a call system was not available in designated common areas. Call systems were in each memory care room and bathroom. Under the section titled, “Common areas definition”, showed common areas included, but were not limited to, hallways, lounges, dining rooms, activity rooms, and outdoor spaces. At the bottom of the document shows that by signing the document, the resident or the resident representative have read and understood the information provided regarding no call system in the common areas policy.

The South Hamptons Memory Care

In an interview on 02/25/2025 at 11:59 PM, Staff O, Maintenance, stated the communications system had not been updated in the Memory care unit’s hallways. Staff O stated the communication system devices were ordered and would need to be installed, but was unsure of the date of installation.

In an interview on 02/25/2025 at 12:11 PM, Staff A, Marketing, stated the facility developed a waiver about the common area of the memory care area not having call light devices available for use. Staff A stated the facility did extra in-regards to the common areas of the memory care areas and purchased call light devices to hang up on the hallways. Staff A stated the call light devices would be installed every fifty feet in the common areas of the memory care unit. Staff A stated they just received the call light devices the week prior and were not yet installed but was scheduled to be installed by maintenance on 02/28/2025. Staff A stated they got the guidance to develop the waiver from their corporation as their affiliated facilities in other countries have developed these waivers.

In an observation on 02/25/2025 at 12:27 PM, in all the hallways of the memory care unit, there were no call light or communication system available for staff, residents, and visitors to use.

Record review of the facility’s document titled, “Final Details for Order”, dated 02/13/2025, showed 12 secure magnet pull cord chair and bed alarm for elderly adults bed alarms and fall prevention for dementia patients wheelchair tab clip alert room monitors for seniors, was purchased on 02/14/2025. That was 28 days after the facility’s attestation that they purchased the call system devices.

This is an uncorrected deficiency previously cited on 12/03/2024 for subsection 388-78a-2930 (1)(a)(iii)(b)(i).

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Plan/Attestation Statement

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Administrator (or Representative) Date

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

(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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff C) completed the required continuing education required to provide care to vulnerable adults. This failure placed 66 of 66 residents at risk of receiving care by an unqualified staff member.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/03/2024, 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 12/18/2024. 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 01/17/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, for citation WAC 388-78A-2474 the immediate action taken included employees needed 12 continuing education credits (CEU) each year and were required to turn in at least one CEU per

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month throughout the year. The year spans from the employee's birthday to their next birthday. CEU's were available to employees thought the Relias online training program. The document showed the date by which the correction would be achieved was on 01/17/2025.

WAC 388-112A-0611
"Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?
(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."

Record review of an untitled and undated document showed Staff C, Resident Care Assistant, was hired at the facility on 10/17/2006 and date of birth was February 1st.

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Record review on 02/27/2025 of the Washington State Department of Health database, showed Staff C had an active nursing assistant registration first issue date was on 02/27/2007.

On 02/25/2025 at 11:34 AM, the Department requested Staff C's CEU's for dates 01/24/2024 through 01/24/2025 for review.

In an interview on 02/25/2025 at 1:01 PM, Staff A, Marketing, said the facility did not have Staff C complete CEU's since they were under the impression Staff C had been exempt. Staff B, Resident Care Assistant, said Staff C was not required to completed CEU's as they have been a nurse assistant registration since 2006. Staff B stated Staff C has never completed the CEU's.

This is an uncorrected deficiency previously cited on 12/03/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sherwood Assisted Living 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.

(3) The assisted living facility must provide a minimum of thirty days written notice to the residents and the residents' representatives, if any:

(b) Before the effective date of any voluntary decrease in the scope of care or services provided by the assisted living facility, and any such decrease in the scope of services provided will not result in the discharge of one or more residents.

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This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide an updated copy of their Disclosure of Services when they decreased the scope of care in the services provided for 2 of 4 sampled residents (Resident 1 [R1] and Resident 2 [R2]). These failures impacted 66 of 66 residents, resident representatives, and any visitor at the facility from having knowledge of what services the facility provided.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/03/2024, 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 12/18/2024. 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 01/17/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, for citation WAC 388-78A-2710, under the immediate action taken, showed an updated disclosure of services had been sent to each resident or their resident representative for review and signature. Returned signatures from the resident mailing and future mailings would be tracked by reception. A copy would be kept in the resident's business office file. The document showed the date by which the correction would be achieved was on 01/17/2025.

On 02/25/2025 at 11:07 AM, the Department requested R1 and R2's disclosure of services receipt for review.

R1

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R1 moved into the facility on [redacted]/2024.

During an onsite visit on 02/25/2025, the Department received a sticky note for R1, that showed "new disclosure of services sent. Still waiting to be returned."

R2

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Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 02/25/2025, showed R2 moved into the facility on [redacted]/2024.

During an onsite visit on 02/25/2025, the Department received a sticky note for R2, that showed "new disclosure of services sent."

In an interview on 02/25/2025 at 3:10 PM, Staff A, Marketing, said the facility mailed a copy of the updated disclosure of services to R1 and R2's resident representatives on 12/02/2024. Staff A said they could not provide documentation to show the facility sent out the facility's updated disclosure of services.

This is an uncorrected deficiency previously cited on 12/03/2024 for subsection 388-78a-2710 (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, Sherwood Assisted Living 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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to investigate, document investigative actions, and findings after becoming aware a resident developed a new

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skin impairment for 1 of 3 sampled residents (Resident 5 [R5]). This failure placed R5 at risk for further skin breakdown, infection, and medical complications.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/03/2024, 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-2371] 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 12/18/2024. 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 01/17/2025."

Record review of the facility's, "Plan of Correction", dated, 12/12/2024, for citation WAC 388-78A-2371
the immediate action taken showed an in-service was held for the facility medication technicians about mandatory observations and documentation and reiterated the importance of documentation for incidents. Staff B, Resident Care Assistant, and Staff G, Licensed Practical Nurse, would monitor medication technician incidents. The document showed the date by which the correction would be achieved was on 01/17/2025.

Record review of the facility provided document titled, "incident report policy and procedure", undated, showed the policy was to proactively and continuously track and trend incident reports by type, and to develop plans of action for completion to assure issues were addressed timely and appropriately. The incident report would be filled out by the charge nurses upon any incident including but not limited to skin problems. Documentation would be done at least 48 hours and/or continue until incident or issue resolved. Staff would use the facility "incident report", form to document the incident on. The information would also be documented by the charge nurse on the "24 hours resident census" from and this daily form would be forwarded to the resident manager for statistical information compilation. The incident report from would be forwarded to the resident manager when completed within 24 hours of incident. Resident manager would review statistics, contributing factors, potential causes for the incident and preventative actions to be taken, and discuss with appropriate departments measures needed to resolve problem or potential problem. The incident report would then be given to the assisted living coordinator for review.

Record review of the facility's policy titled, "incident reporting- unusual occurrences", dated 10/09/2024, showed all unusual incidents that occur involving residents shall be documented by facility employees and contract providers with direct knowledge of the event in the electronic computer program. The incident shall be reviewed by the resident care manager and other departments as applicable, and investigated in a

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timely manner with appropriate follow up and/or remedial action steps taken to prevent occurrence. Under the section titled, “procedures”, showed completed incident reports were to be turned into the resident care manager for further review and follow up investigation. All incident reports were to be reviewed and signed by Administrator and documented on the “Resident fall/Incident Report” for tracking and trending purposes. All incident reports were to be reviewed at quarterly quality assurance meetings for purpose of trending and resolution to increase of incident occurrences or review of positive approaches with respect to the decrease of incident occurrences.
Record review of the untitled and undated document, that was a list of residents’ incident and accident reports, showed R5 had an unwitnessed incident on 02/02/2025 at 12:33 PM.

On 02/25/2025 at 11:34 AM, the Department requested to review the incident report and investigation for R5’s unwitnessed incident on 02/02/2025 for review.

Record review of R5’s accident/Incident Report, dated 02/02/2025 at 12:33 PM, showed it was an unwitnessed fall. Under the section titled, “what did resident state happened”, showed R5 stated they did not remember what happened. R5 did not even notice the injury on their hand. Under the section titled, “observations by team member”, showed resident was walking into the dining room when the medication technician noticed the top of the resident’s left hand was bleeding. The medication technician asked the resident what happened and R5 stated they had no idea what happened, did not feel pain in the area on their hand that was bleeding. There was no attached investigation that had been completed to show what could have happened and ruling out abuse and neglect.

In an interview on 02/25/2025 at 1:01 PM, Staff A, Marketing said that Staff N, Registered Nurse, started the process to complete R5’s incident on 02/02/2024 investigation. Staff A said the facility staff did not print out the incident report for staff N to know they were supposed to complete the investigation.

In an interview on 02/25/2025 at 2:47 PM, Staff B, Resident Care Assistant, and Staff G, Licensed Practical Nurse, stated Staff N completed the investigations for the resident incidents within a couple of days. Staff B stated Staff N looked in the electronic system and the hard binder for the incident report and then would complete the investigations for the incidents. Staff B stated the medication technicians would print the incident report they completed and then place them in Staff N’s mailbox for them to review. Staff B stated R5’s incident on 02/02/2025 did not end up in Staff N’s mailbox and the investigation was not completed.

This is an uncorrected deficiency previously cited on 12/03/2024 and previously consulted on 09/09/2024.

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

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, Sherwood Assisted Living 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

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
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 11/12/2024 and 11/14/2024 of:
Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

The following sample was selected for review during the unannounced on-site visit: 9 of 69 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Emily Boniface, Community Program Nurse Licensor
Nikolas Jennings, Community Nurse Complaint Investigator
Megan Zerby, Community ALF/AFH 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.

Staci Oily, IDR PM for Reg 3E
Residential Care Services

January 24, 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.

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

Administrator (or Representative) Date

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, interview, and record review the facility failed to have a system in place to address and resolve 13 of 13 residents and representative (Resident 16 [R16], Resident 15 [R15], Resident 17 [R17], Resident 18 [R18], Resident 8 [R8], Resident 14 [R14], Resident 19 [R19], Resident 11 [R11], Resident 21 [R21], Resident 22 [R22], Resident 23 [R23], , and Collateral Contact 5[CC5], Resident 20's Representative's) grievances. These failures resulted in residents having unresolved concerns and placed the residents at risk for decreased quality of life.

Findings included...

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 246-215-03525
"(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained: (a) At 135°F (57°C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400(2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130°F (54°C) or above; or ..."

Record review of the United States Department of Agriculture (USDA) Food Safety and Inspection Service Safe Minimum Internal Temperature Chart, dated 05/11/2020, showed fish should be served with a minimal internal temperature of 145 degrees Fahrenheit (F).

Record request on 11/12/2024 at 3:50 PM, for the facility policy related to grievances showed the facility did not have a policy available to review.

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Record review of the facility's "Resident Council Minutes", dated, 10/16/2024, showed six residents attended the meeting. R16 expressed concern that after residents were served their meals the servers disappeared. R16 felt as if more servers should be present for dining incase residents needed more food. R15 expressed concern that the servers needed to be trained properly on how to serve. R15 expressed concern about long call wait times and expressed that wait times were as long as 30-60 minutes long. R15 purposed that the facility management should be present for resident council meetings. R17 expressed the need for a lifted bus. R16 expressed that the outside shrubs should be pruned. R18 expressed concern that a glass door needed to be cleaned. R16 expressed concern that the paper towels in the restroom located by the nurse's station should be more accessible.

Record review of the facility's, "Resident Council Minutes", dated, 09/18/2024, showed ten residents attended the meeting. R15 expressed concern that during a mealtime a marketing salesman had approached residents. R15 inquired if facility staff members were assigned to be present for mealtimes to prevent resident to resident bullying. R17 expressed concern about server protocol and etiquette were reported as lacking. R17 stated servers would touch the rims of glasses, would reach over other residents to serve residents their food or remove plates, and long wait times for when it took 58 minutes after they ordered a sandwich. R8 expressed desire for assigned seating during dining to return. R14 second R8's idea for returned assigned seating. R15 expressed concern that a caregiver who they requested not to work with continued to come and provide them care, R15 wanted to know the policy on their concern. R17 and R19 expressed concern that the facility care staff were not answering call lights. R17 expressed concern about lack of hand towels in the bathroom. R18 expressed concern that the residents do not see management staff often or receive communication from them. R14 said the flu shot clinic had been run poorly and there had not been enough communication to the residents about the dates and times. R14 expressed the desire to use the front door over the weekends. R14 requested activity staff proofread boards for spelling or missing information. R14 stated announcements needed to be audible in resident rooms. R17 asked about the bus would be replaced with a vehicle with a wheelchair lift. R17 inquired if the maintenance supervisor would be replaced.

Resident Council/Town Hall

In an interview on 11/12/2024 at 1:30 PM, 22 residents and two resident representatives were present for a group meeting conducted by the Department. R15 expressed concern that one facility staff member had insulted them, R15 requested the facility staff member no longer provide them care, and the facility staff member still entered their room to provide them care. R11 expressed concerns about theft in the building when their pumpkin decorations outside their door went missing. R11 said the extent of the follow up had been the facility staff looked for them and never found them. R11 stated their door lock had not been secure for their room. CC5 stated R20's door lock was not secure. R16 said the key to their room had the ability to open another resident's room. R21 expressed concern that the facility food served had not been hot. R21 expressed concern that the menu was not provided ahead of time, R21 stated the residents had brought this to the facility's attention two months ago. R11 agreed that they do not receive food menus ahead of time and their food had been served cold. CC5 expressed concern that the vegetables served were mush. R22 stated that the facility staff did not always update the residents if they ran out of a menu item and served an alternative. R23 expressed that they would like to know what ingredients were used in the food served. R17 stated the food served was never hot but rather warm or cold. R15

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expressed concern about long call wait times and that sometimes it took over an hour for staff to show up. R19 stated the concern for long call wait times and stated sometimes the facility staff did not show up at all. R11 recalled a time when a caregiver pushed their wheelchair away from their bedside and forgot to move it back before exiting the room. R11 pushed their call light because they needed assistance with going to the bathroom. R11 stated that when care staff showed up half an hour later, they had brought R11 their food because they thought that is why they pushed their call light. CC5 expressed concern for long call wait times. R11 stated not all facility staff members had call light pagers to utilize. R15 stated that when the care staff took breaks they would go in pairs, leaving limited staff available to residents. R11 stated that a facility staff member vented to them about their frustration that facility staff members would go outside on breaks and smoke together. Multiple residents expressed concern with evening and weekend staffing for the facility. R11 expressed concern that when they left the facility on the weekends the backside parking lot had a lot of potholes. R11 stated it was scary to have to get off the sidewalk and use their wheelchair on the uneven surface. Multiple residents expressed concern for the uneven back parking lot. R15 and CC5 expressed that they need a microphone to hear at resident council. Resident Representative stated that last month's town hall had been canceled.

In an interview on 11/12/2024 at 2:24 PM, Staff X, Activities Supervisor, stated that this round of residents had not realized that even if the facility provided them a microphone to use for resident council that they would still have a hard time hearing and have low attendance.

In an interview on 11/12/2024 at 2:46 PM, Staff A, Marketing Director, stated two administrators ago they had a slip system in place where if a resident had a grievance, they would write their concern down and facility staff would follow up. Staff A stated if residents had concerns about dietary concerns that would be addressed in food forum. Staff A stated if residents had concerns about maintenance, they the staff would complete a maintenance housekeeping slip. Staff A stated if anything needed to be addressed from resident council they would address it during town hall. Staff A stated that the resident council meeting notes for 10/16/2024 had not been addressed because they did not have town hall last month due to Staff A being out of town. Staff A confirmed townhall had not been rescheduled but cancelled. The Department read some concerns from the resident council meeting notes on 10/16/2024 that indicated concerns about long call light times and service in the dining room. Staff A acknowledged the concerns had not been followed up on.

In an interview on 11/12/2024 at 3:04 PM, Staff A provided a grievance for staff and resident binder to review. Staff A stated they themselves had not had any grievances that they needed to follow up on. Staff A stated that they would follow up to see if facility staff kept nots related to town hall meetings.

Record review of the grievance for staff and resident binder showed there were no grievances from the 2024 year for review.

In an interview on 11/12/2024 at 3:15 PM, Staff A reiterated they had never received any grievances they had to follow up on. Staff A acknowledged the grievances for staff and resident binder reviewed did not have any concerns from the last year to review. Staff A stated they were sure the facility did have grievances they had to follow up on in the 2024 year. Staff A stated they would follow up if the facility had a policy related to grievances for review.

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In an interview on 11/12/2024 at 3:50 PM, Staff A stated the facility could not provide any food forum or town hall meeting notes to show the facility had followed up on resident council concerns. Staff A confirmed the facility did not have a policy to review related to how the facility must address resident grievances.

Food Forum

In an observation on 11/12/2024 at 11:50 AM, outside of the door in the hallway by the RCC's office showed an "A" frame sign that had the weekly menu posted. The menu posted for the residents to view had the dates 10/20/2024 through 10/26/2024. There had not been a current weekly menu posted for resident to review.

In an interview on 11/13/2024 at 1:30 PM, Staff H, Dietary Manager, stated they were the person responsible to update the facility menus posted on the bulletin board. Staff H acknowledged at times they forgot to update the menus for the residents to review. In an observation on 11/13/2024 at 2:00 PM, the Department attended the facility's food Forum with Staff Hand the facility residents. The residents expressed concern that their food comes out lukewarm. Four residents expressed concern that the taco cornbread was served cold. Staff H stated they had two servers to help bring residents their drinks and meals. Residents expressed concern that lunch and dinner were the coldest meals served. Residents expressed long wait times to be served their meals, sometimes taking 45 minutes. Staff H acknowledged that the ticket system had been first come first served but the servers sometimes mixed up the tickets and they got out of order. Residents expressed concern that the weekly menu had not been updated on the bulletin boards to review. Staff H acknowledged they did not have pickled beets to incorporate into the menu yet per a resident's request.

In an interview on 11/13/2024 at 4:00 PM, Staff H stated they had food forum today with the residents. Staff H stated four residents complained that the food had been served cold.

In an interview on 11/14/2024 at 12:02 PM, Staff H said R15 and the residents who sat with R15 were the only residents at the facility who expressed complaint that the facility food had been cold. The Department informed Staff H that other residents who resided at the facility expressed concern of cold food being served. Staff H acknowledged other residents had similar concerns related to the food temperature.

In an observation on 11/13/2024 at 4:56 PM, Staff A brought the Department a dinner tray. On the tray was a mug of hot chocolate with a lid covering, a bowl of soup with a cover, and a plate with a dome lid. On the plate was saran wrap and under the saran wrap was mashed potatoes with a measured temperature of 133.6 degrees Fahrenheit(F), Cod (a form a fish) with a measured temperature of 111.3 degrees F, Broccoli which measured 109.9 degrees F, and Cauliflower which measured 100.5 degrees F. The soup measured 148.4 degrees F and the hot cocoa measured 130.8 degrees F.

Call Lights

In an interview on 11/14/2024 at 9:01 AM, Staff W, Medication Technician, stated that they were unsure if the facility had an expectation of when call lights were supposed to be answered. Staff W stated that the facility staff tried to be prompt when answering call lights but that it had been hard at times.

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In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Assistant, said they were unsure if the facility had a policy related to expectations on timelines of when staff answered resident call lights. Staff E stated the facility staff tried to answer call lights within 10 minutes. In an interview and observation on 11/14/2024 at 11:02 AM, R15 stated they had ongoing concerns about how long it took to get a response from facility staff members after they had pushed their call light. R15 stated to their understanding the timeframe should not exceed 15 minutes. R15 said sometimes the wait time exceeded one and a half hours. R15 expressed concern if they had a medical emergency, they would be concerned at how fast the facility staff would respond. At 11:06 AM the Department pressed R15's call light and no facility staff had followed up. The Department exited R15's room at 11:32 AM without a staff member responding to the call light system that was pressed at 11:06 AM.

In an interview and observation on 11/14/2024 at 11:30 AM, Staff G, Maintenance, was observed leaning on the assisted living nurses station, near room 223, and loudly told other facility staff that facility staff have no way of knowing when other staff have responded to a call light because the call lights just pinged the staff but there was no further information recorded in the call light system.

In an interview and observation on 11/14/2024 at 11:34 AM, Staff Y, Resident Care Assistant, said if a resident pressed their call light, then it would come up on the screen at the nurse's station. Staff Y noted that the call light showing on the screen did not currently work. At 11:38 AM, observation of the screen at the nurse's station showed no way of knowing when a resident call light had been turned off.

In an interview on 11/14/2024 at 11:40 AM, Staff G stated when a resident pressed their call light button the information showed up on the screen at the nurse's station and the pagers that the facility staff members had. Staff G stated there had been no way to know when the residents call light had been answered. Staff G stated not all the facility staff members carried a pager.

In an interview and observation on 11/14/2024 at 11:44 AM, Staff K, Resident Care Assistant, stated they did not have a call light pager on them. Staff K was observed to check their pockets and sweatshirt pocket and was unable to show the Department a call light pager. Staff K stated it was often that they would work on their shift without a pager as there was never any pagers available to carry. Staff K stated they would have to be at the nurse's station to know when a resident called for assistance if they did not have a pager on them.

In an interview on 11/14/2024 at 11:45 AM, Staff A stated the facility staff responded to resident call lights as quick as they could, but staff should be to the resident within 10 minutes to check in on them.

In an interview on 11/14/2024 at 1:03 PM, Staff A confirmed that the system at the nurse's station did not inform staff how long it took to answer resident call lights.

In an interview on 11/19/2024 at 9:01 AM, Collateral Contact 1 (CC1), Power of Attorney for R8, said residents at the facility had to wait an excessive amount of time before their call lights were answered. CC1 said sometimes call lights were never answered all together.

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Uneven Parking Lot

In an interview on 11/14/2024 at 11:02 AM, R15 stated they had ongoing concerns about their safety when they had to be in the backside of the facility's parking lot. R15 said they used a wheelchair and when they were pushed in the parking lot, they rattled all over. R15 said they had to take extra caution to ensure they did not fall out of their wheelchair.

In an interview and observation on 11/14/2024 at 8:32 AM, Staff G, Maintenance, acknowledged the backside of the facility's parking lot had uneven surfaces throughout the area. Staff G confirmed that the sidewalk next to the disabled parking spot was not level. Staff G confirmed the front entrance door had been closed on Sundays so if residents left the facility they would leave from the backside entrance. Staff G acknowledged that there was discussion to get the back parking lot repaved but was no longer foreseen in the future.

In an interview and observation on 11/14/2024 at 9:34 AM, Staff A acknowledged the backside of the facility's parking lot had uneven surfaces throughout the area. Staff A stated the sidewalk that led to the parking lot had not been level. Staff A stated they had not had any residents report concerns to them about the area but could see how the uneven surface would be a concern. Staff A stated there had not been a timeline of when the parking lot was scheduled to be fixed. Staff A confirmed the front entrance door to the facility had been closed on Sundays.

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, Sherwood Assisted Living 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-2310 Intermittent nursing services.

(4) In providing intermittent nursing services, the assisted living facility must observe the resident for changes in overall functioning and 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:

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Based on interview and record review the facility failed to provide nursing services when an observed changed occurred for 6 of 9 residents (Resident 2 [R2], Resident 4[R4], Resident 6 [R6], Resident 8 [8], Resident 9 [R9], and Resident 5 [R5]). This failure placed all residents at risk for unmet care needs.

Findings included...

"WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident: (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or (4) Is a physician with a valid state license to practice medicine; or (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living".

"WAC 246-980-140 Scope of practice for long-term care workers. (1) A long-term care worker performs activities of daily living or activities of daily living and instrumental activities of daily living. A person performing only instrumental activities of daily living is not acting under the long-term care worker scope of practice. (a) "Activities of daily living" means self-care abilities related to personal care such as bathing, eating, medication assistance, using the toilet, dressing, and transfer. This may include fall prevention, skin and body care. (b) "Instrumental activities of daily living" means activities in the home and community including cooking, shopping, house cleaning, doing laundry, working, and managing personal finances. (2) A long-term care worker documents observations and tasks completed, as well as communicates observations. (3) A long-term care worker may perform medication assistance as described in chapter 246-888 WAC. (4) A long-term care worker may perform nurse delegated tasks, to include medication administration, if he or she meets and follows the requirements in WAC 246-980-130. (5) A long-term care worker may provide skills acquisition training on instrumental activities of daily living and the following activities of daily living tasks: Dressing, application of deodorant, washing hands and face, hair washing, hair combing and styling, application of makeup, menses care, shaving with an electric razor, tooth brushing or denture care, and bathing tasks excluding any transfers in or out of the bathing area. (6) This section applies to all long-term care workers, whether required to be certified or exempt."

"WAC 246-840-700 Standards of nursing conduct or practice.
(2) The nursing process is defined as a systematic problem-solving approach to nursing care which has the goal of facilitating an optimal level of functioning and health for the client, recognizing diversity. It consists of a series of phases: Assessment and planning, intervention and evaluation with each phase building upon the preceding phases. (a) Registered Nurse: (b) Licensed Practical Nurse: Minimum standards for registered nurses include the following: Minimum standards for licensed practical nurses include the following: (i) Standard I Initiating the Nursing Process: (i) Standard I - Implementing

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the Nursing Process: The practical nurse assists in implementing the nursing process; (A) Assessment and Analysis: The registered nurse initiates data collection and analysis that includes pertinent objective and subjective data regarding the health status of the clients. The registered nurse is responsible for ongoing client assessment, including assimilation of data gathered from licensed practical nurses and other members of the health care team; (A) Assessment: The licensed practical nurse makes basic observations, gathers data and assists in identification of needs and problems relevant to the clients, collects specific data as directed, and, communicates outcomes of the data collection process in a timely fashion to the appropriate supervising person; (B) Nursing Diagnosis/ Problem Identification: The registered nurse uses client data and nursing scientific principles to develop nursing diagnosis and to identify client problems in order to deliver effective nursing care; (B) Nursing Diagnosis/ Problem Identification: The licensed practical nurse provides data to assist in the development of nursing diagnoses which are central to the plan of care"

Record review of the Department of Social and Health Services letter number R23-031, dated 03/24/2023, showed the facility staff member conducting an on-going assessment was not necessarily required to be a registered or licensed practical nurse. The facility must analyze the needs of the resident and the ability and scope of practice of the staff member to determine if they were qualified to complete the assessment. If the facility determined the assessment of resident needs go beyond the assessor's scope of practice, the assessment must be referred to an appropriate and qualified person.

Record review of the facility's policy titled, "Resident Assessments", dated last reviewed by facility on 10/17/2024, showed the facility conducted assessments for each resident to ensure that services and care needs were met. The assessments would be conducted by a qualified assessor as defined in WAC 388-78A-2080. Full assessment would be completed at least annually for assisted living residents and every six months for memory care residents. The full reassessment would focus on identified problems and related issues. The reassessment would be consistent with the residents change of condition as identified by a change in mental, physical, or emotional functioning that required an intervention and was a departure from the normal customary range of functioning.

Record review of the facility's policy titled, "Medication Services", dated 02/23/2018, showed if a resident required medication assistance and their service plan indicated as such, then it would be provided. The facility would provide initial and ongoing assessment of a resident's medication management skills at the time of the service plan update at least annually. The final determination of a resident's medication management skill would be made by the facility's licensed staff. The self-administering of medications section showed if the resident status changed, and the physician determined that the resident was no longer able to safely self-administer their medications the resident would be re-evaluated. The medication storage section showed if residents were capable of self-administration they would store and control their own medications which should be stored in a manner to prevent access by other residents. The recording and documenting prescriber's orders section showed medication administration would not be provided to a resident unless one of the following occurred, a written order from the prescriber.

Record review of facility policy titled, "Resident Independent Medication Agreement", dated 10/16/2024, showed self-medication administration residents must be assessed using the form and must be documented on the resident's negotiated service

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agreement. It also stated resident must be monitored by licensed staff for continued self-administration capability.

Record review on 11/12/2024 of the facility provided, "Disclosure of Services Required by RCW 18.20.300", undated, showed the facility administrator was Staff A, Marketing Director. Under the section titled, "intermittent Nursing Services", showed the facility typically had a licensed practical nurse and a registered nurse in the building without anything being documented for the number of days and total number of hours.

R2

Record review of R2's document titled, "resident information", dated 11/12/2024, showed R2 moved into the facility on /2023 with multiple medical diagnoses that included and .

Record review of R2's document titled, family health clinic letter, dated 08/08/2024, showed it was a letter sent to the facility by R2's primary care physicians office. The letter showed R2 had slipped out of bed without any injuries on 05/29/2024, had a non-injury fall on 06/14/2024 when R2's legs gave out, and a fall in the dining room at lunch on 07/21/2024 with R2 experiencing extreme back pain and transferred to local hospital emergency room. The letter showed that R2 returned to the facility from the emergency room on 07/22/2024 at 1:45 AM with a compression fracture (a type of broken bone that occurs when pressure causes a bone to collapse) and a bony lesion to the thoracic 12 vertebrae (an abnormal change or damage to the bone structure at the left of the thoracic area of the back) and mild kidney injury (when the kidney gets slightly damaged). R2 required physical therapy and additional lab work.

Record review of R2's "care plan" dated /2023, showed R2's first assessment and service plan in one document, both completed the day R2 admitted to the facility. The record did not show an evaluation of R2's fall risk. The document showed R2 required 24-hour supervision.

Record review of R2's "Washington health and service evaluation results", dated 09/23/2024, showed it was an annual assessment. The annual assessment did not document R2's recent history of three total falls. The document showed R2 had one, then two falls in the last 90 days. R2 was evaluated to require only minimal transfer assistance. R2 was independent with assistive devices for mobility/ambulation.

Record review on 11/13/2024 of R2's medical chart showed there were only two service plans and two assessments for review. One assessment was dated /2023, completed when R2 admitted to the facility and the second assessment, dated 09/23/2024, listed as resident's annual assessment. There were no change-of-condition assessments for review from the time of R2's admission and the date of record review on 11/13/2024.

In an interview on 11/13/2024 at 12:55 PM, Staff A, Marketing Director, stated an updated assessment and service plan should have been completed for R2 when they had a change of condition from a fall that resulted in R2 requiring medical attention for a compression fracture and follow up pain management and physical therapy services.

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Staff A stated all assessments and service plans were filed in the residents hard medical chart for review.

R4

Record review of R4's, "Smoking Evaluation", dated 12/12/2022, showed R4 smoked cigarettes with a smoke apron and the facility staff escorted them to the designated smoking section. R4 had been evaluated they had been safe to smoke with staff assistance.

Record review of R4's, "Washington Health and Service Evaluation Results", dated 05/01/2024, did not indicate that R4 had been a smoker and required facility staff assistance to get to the designated smoking section at the facility and wore an apron. The documented showed it had been completed by Staff DD Certified Nursing Assistant (CNA).

In an interview on 11/12/2024 at 10:05 AM, Staff A, Marketing Director, said R4 had been a smoker who had been grandfathered in and the facility staff took them outside to smoke as needed.

In an interview on 11/13/2024 at 3:01 PM, R4 said the facility staff escorted them outside to smoke.

R6

Record review of the facility document titled, "assisted living facility resident characteristic roster and sample selection", dated 11/12/2024, showed R6 moved into the facility on [redacted]/2024. It showed "A" in the medication column meaning R6 received medication administration services from the facility and in the column titled "Dementia/Alzheimer's/Cognitive Impairment [brain conditions affecting thinking, memory, and decision-making]", the box was checked indicating R6 had a condition affecting their memory. The roster did not show R6 had recent hospitalizations.

Record review of R6's unsigned Washington Health and Service Evaluation Results assessment, dated [redacted]/2024, showed documentation that staff reviewed R6's diagnoses with a comment that said "The resident's active diagnoses were reviewed. See Service Plan for details."

Record review of R6's unsigned Service Agreement, update date of 04/11/2024, showed R6 had a need for caregiver monitoring related to R6's diagnoses and conditions. The listed responsible party was "caregiver." The column with resident specific details showed no personalized information for R6 under the category of Diagnoses. Under the caregiver key on the last page, there were no caregiver names nor signatures. The document also showed R6 had mild memory impairment that required assistance and cuing from staff, mild long-term memory impairment.

Record review of R6's Washington Health and Service Evaluation Results assessment, dated 05/14/2024, showed the following diagnoses for R6: [redacted] and [redacted]. The record indicated Dementia/Alzheimer's/Cognitive impairment did not apply.

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Record review of document titled “Service Plan,” dated 05/14/2024 showed R6 had a need for caregiver monitoring related to R6’s diagnoses and conditions. The listed responsible party was “caregiver.” The column with resident specific details showed no personalized information for R6 under the category of Diagnoses.

Record review of R6’s Washington Health and Service Evaluation Results assessment dated 05/14/2024 showed R6 required: stand by assistance for toileting, medication services for all medications including medication monitoring, storing, administration, and ordering by staff, stand-by assistance for toileting, emotional support and personal services related to Depression, a walker for ambulation, 10 or more medications including medications affecting balance and alertness, full housekeeping services that included daily laundry service, and a pendant call system.

Record review of R6’s Service Plans, dated 04/11/2024 and 05/14/2024, showed, “Resident Service Plan is based on latest assessment and is subject to revision based upon change in resident's health status.”

Record review of hospital discharge summary dated 09/24/2024 showed an order for R6 to see their doctor on 09/27/2024 for hospital follow-up. Home Health was also ordered at that time.

Record review of the hospital notes for R6, dated [redacted]/2024, showed that R6 was discharged on [redacted]/2024 with orders for azithromycin (an antibiotic) and, according to R6's son, did not think that medication was ever filled nor provided to R6 after their discharge from the hospital. The notes showed that R6 was admitted for "atypical pneumonia after which she may not have received antibiotics [they] were prescribed. [R6] returned to hospital with increasing pain and shortness of breath with new O2 requirement thought to be related to incompletely treated community-acquired pneumonia versus anxiety or some overlap." Discharge orders indicated follow up with outpatient primary care provider in [redacted] days (10/12/2024) and an order for home O2 assessment.
The after-visit summary from [redacted]/2024 showed an order for azithromycin (antibiotic), potassium chloride (used to regulate electrolytes in body and affects heart function).

Record review of R6’s document titled "Observations for R6", dated 09/01/2024 - 11/12/202, showed R6 discharged to the hospital on [redacted]/2024. R6 was hospitalized until their discharge on [redacted]2024. A note from Staff W, medication technician, on [redacted]2024 at 5:45 PM, showed, "Returned to our facility from OMC Hospital via cabulance at 1620. Resident very happy to be back home. B/P 119/87 P 81 T 97.2 02 84% Resident assisted to her recliner and menu filled out for the dinner tray. After dinner resident walked to bathroom and back to recliner, then asked for a PRN [as needed]. PRN given @ 1805. Resident resting comfortably in her recline."

Record review of R6’s document titled "Observations for R6", dated 09/01/2024 - 11/12/2024, showed a note from Staff W, medication technician, on [redacted]2024 at 10:30 AM that showed, “Resident c/o [complaint of] pain-Stabbing mid chest pain-radiating pain to left chest area, V/S [Vital Signs]: 117/77 78 02 sats [oxygen readings]: ranging from 89%-92% on RA [Room Air]. MD [Medical Doctor] notified new order received to send resident to ER [Emergency Room] for evaluation, resident's son notified, EMS [Emergency Medical Services] arrived at 10:50 am-Resident exited facility @10:59.”

Record review of Hospitalist (medical doctor from hospital) assessment, dated

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10/09/2024, showed R6 would require a home oxygen assessment for newly acquired oxygen need.

Record review of progress notes and faxes between R6's doctors and facility staff did not show the oxygen assessment was ever completed.
Resident had cardiology appointment 10/31/2024 order to get 14-day heart monitor, no documentation showed the monitor was obtained or further care was coordinated.

Record review of an observation note for R6, entered by Staff E, Resident Care Assistant, dated /2024 at 10:15 PM, showed staff received a fax from R6's PCP (Primary Care Physician) regarding resident complaint of left sided chest pain. R6 was transported to the ER and no new physician orders.
R6 experienced repeated admissions and discharges from the hospital and the facility staff failed to re-assess R6 and update their negotiated service agreement.

R7

Record review of the facility's document, titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R7 moved into the facility on /2024.

In an interview and observation on 11/13/2024 at 10:56 AM, inside R7's room, showed that R7's right side of the bed was up against the wall with a full siderail on the upper part of their bed on the left side. R7 stated the siderail was on their bed to help prevent them from rolling out of their bed and did not use the siderail to roll over in bed.

Record review of R7's, "Washington Health and Service Evaluation Results", dated 10/25/2024, showed R7 had an open wound area on their toe, had a right , R7 required hands on assistance with a grab bar for transfers, R7 required occasional/monthly nursing services without any outside services.

Record review of R7's Service Plan (facility's version of the negotiated service agreement), dated 10/25/2024, showed R7 used a grab bar for transfers. There was nothing documented that the resident used a transfer pole by their bed, a side rail on the left side of their bed, and the right side of their bed was up against the wall, or that R7 had an and was missing their .

Record review of R7's document titled, "discharge summary and plan", dated 10/01/2024, showed it was discharging orders from the skilled nursing facility R7 discharged from. The document showed R7 was discharged from the skilled nursing facility on /2024 with an order to have home health services for therapy and nursing services. R7 had multiple medical diagnoses that included . There were no orders for R7 to have a siderail on their bed or that their bed was up against the wall.

Record review on 11/13/2024 in R7's hard medical chart, showed there was no assessment or documentation about R7's use of the siderail on their bed and R7's bed being up against the wall and not considered a restraint.

R8

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Record review of R8's, "Resident Information", dated 11/12/2024, showed R8 had a diagnosis of a [redacted]

Record review of R8's, Service Plan, dated 10/31/2024, showed R8 had been independent with medication and did not require assistance with medication administration.

Record review of R8's, "Independent with Medication Self-Administration Evaluation Form", dated 03/20/2024, showed R8 had been assessed to be appropriate to self-administer their medications. Staff DD, Former Certified Nursing Assistant (CNA), signed the document on 03/20/2024.

In an interview on 11/20/2024 at 2:53 PM, Staff A said Staff DD signed R8's "Independent with Medication Self-Administration Evaluation Form", dated 03/20/2024. Staff A stated Staff DD had been a CNA who helped update resident care plans.

Record review of R8's, "Washington Health and Service Evaluation Results", dated 10/31/2024, showed R8 received hospice services. Medication level of assistance section showed R8 had been independent and did not require assistance. Medication responsibilities section showed R8 had medication orders and over the counter medications. R8's representative had been responsible to purchase the medication. R8 had been responsible to store their medications. R8 had been responsible to self-administer their medications. The document showed it had been completed by Staff E, Resident Care Assistant.

In an interview on 11/20/2024 at 2:53 PM, Staff E acknowledged they completed R8's, "Washington Health and Service Evaluation Results", dated 10/31/2024.

Record review of R8's hospice, "Current plan of Care", dated 09/04/2024, showed R8 admitted into hospice services on 05/15/2024.

Record review of R8's, Ongoing Assessment, dated 10/23/2023, showed it had not been signed by a facility staff member to indicate who completed the assessment.

In an observation and interview on 11/13/2024 at 11:13 AM, on top of R8's dresser had been a container of 1.75 ounces of Aquaphor (an ointment used to protect the skin). R8 said they did not have any medication that they took. R8 said they did not have a key to their room, and they never locked their door.

In an interview on 11/14/2024 at 8:50 AM, Staff W, Medication Technician, said R8 had been on hospice services. Staff W said R8 had been a self-administration of medication resident. Staff W said Collateral Contact 1 (CC1) must have brought R8 their medications.

In an interview on 11/14/2024 at 11:00 AM, Staff E, noted that they just updated R8's service plan. Staff E confirmed R8 had been on hospice services. Staff E said R8 had been a self-administration of medication resident. Staff E said they were unsure if CC1 brought R8 their medications. CC1 stated they thought R8 took Tylenol.

In an interview on 11/19/2024 at 9:01 AM, CC1 said they reviewed R8's service plan in

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October with Staff E. CC1 stated they did not think Staff E had been qualified for their position. CC1 confirmed R8 had been on hospice services. CC1 stated that that they supplied R8 a bottle of Tylenol to take as needed. CC1 stated that historically when R8 took medications they were the individual who supplied R8 the medication.

Record review showed there were not any completed assessments to review after R8 admitted into hospice on 05/15/2024.

R9

Record review of R9's, "Healthcare Provider Plan of Care Admission Orders", signed by R9's primary care provider on 7/17/2024, indicated that R9 required staff assistance with medications.

Record review of R9's, "Washington Health and Service Evaluation Results", dated 7/31/2024, stated that R9 was evaluated by Staff S, Previous Director of Nursing Services (DNS), to need "medication and/or over-the-counter medications" and "medication administration" of over-the-counter medications.

Record review of R9's, "Service Plan Detail", dated 07/31/2024, showed no information related to medication services. In the row, titled, "Additional Nursing Services", R9 was listed as "Independent" and "does not require" additional nursing services.

In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Assistant, stated R9 did not have a self-medication assessment as R9 did not take any medications.

In an observation on 11/13/2024 at 2:30 PM of an unlocked cabinet in R10 and R9's bathroom, showed 400 tablets of Kirkland stool softener, 250 tablets of Aleve back muscle (relieve pain and swelling), 600 milligrams of calcium (dietary supplement), 200 milligrams of coq10 (dietary supplement), 125 micrograms of D3 nature's bounty (dietary supplement from nature's bounty brand), Visine dry eye relief (eyedrops to reduce eye redness and dryness), 60 chewable tablets of areds 2 (slows vision loss), 200 milligrams of Advil (relieve pain and swelling), 40 melts of xylimelts (used for dry mouth), three boxes that contained 48 tablets of 25 milligrams of Exlax-brand (treats constipation). On R9 and R10's bathroom counter showed 8 ounces of bag balm (moisturizing ointment), two bottles of 500 milligram Tylenol (treats pain and reduces fevers) that contained 100 gel tablets, 60 Caplets of Super beta prostate dietary supplement (dietary supplement), 400 soft gel tablets of 100 milligram of Kirkland's Docusate Sodium (stool softener), 750 milligrams of Kinoko platinum AHCC veggie caps (dietary supplement), 250 milligrams of beta sitosterol (dietary supplement), 20 micrograms of Vitamin D (dietary supplement), empty container of spring valley CoQ10 200 milligram (dietary supplement), opened tablet of 25 milligram ex-lax sennosides (stool softener) with 6 of the 12 tablets taken out, two bottles of 36 tablets and 83 milligrams of Bayers-brand aspirin (relieves pain and swelling).

In an interview on 11/13/2024 at 2:30 PM, R9 stated that they do not usually take medications, but they have some Tylenol that they take when they need it.

R5

Record review of R5's, "Resident Information", dated 11/12/2024, showed R5 had a diagnosis of

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Record review of R5's, "Washington Health and Service Evaluation Results", dated 09/20/2024, under the medication responsibilities section showed qualified staff were responsible to purchase, store, and help assist R5 with their self-administration of medications or medication administration.

Record review of R5's, "Healthcare Practitioner Plan of Care", dated 10/03/2022, under medication services showed R5 required staff assistance for medication. The facility staff would order and store medication for the resident.

In an observation and interview on 11/13/2024 at 12:52 PM, R5 had a container of soothe xp extra protection advanced eye therapy drops on a nightstand by their bed. On R5's dresser there had been a 0.5 fluid ounce container of soothXP lubricant eye drops. In R5's bathroom there had been a bottle of 5000 micrograms of biotin in a Nature's Bounty container, 2000 internal units of nature's made D3, a container of sooth hydration dry eye therapy drops, one box of preparation H 24 suppositories, one box of gas X 125 milligram 50 soft gel tablets, and 0.5 fluid ounces of Visine eye drops. R5 said they did not take medications. R5 then said they took their eye drops on their nightstand by their bed.

Record review of R5's, "Independent with Medication Self-Administration Evaluation Form", dated 03/12/2024, showed R5 stored medications in a safe location away from other resident access. R5 had been assessed to be appropriate to self-administer their over-the-counter medications. Staff DD, Certified Nursing Assistant (CNA), signed the document on 03/12/2024.

In an interview on 11/20/2024 at 2:53 PM, Staff A said Staff DD signed R5's "Independent with Medication Self-Administration Evaluation Form", dated 03/12/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sherwood Assisted Living 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;

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(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to identify change in residents' condition for 4 of 9 sampled residents (Resident 6 [R6], Resident 5 [R5], Resident 7 [R7], and Resident 3 [R3]). This failure placed R6 at risk for harm and all residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy titled, "Alert Charting Policy", dated 08/26/2024, showed the medication technician or the director of nursing would initiate alert charting if the resident experienced adverse changes in their health, falls, or if there had been a concern about the resident that needed to be communicated to other team members. Examples of alert charting included new admission for at least 72 hours, falls for at least 72 hours, wounds and skin tears for at least 72 hours.

R6

Record review of facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R6 moved into the facility on [redacted] 2024.The Roster showed an "A" in the medication column meaning R6 received medication administration services from the facility and in the column titled "Dementia/Alzheimer's/Cognitive Impairment [brain conditions affecting thinking, memory, and decision-making]", the box was checked indicating R6 had a condition affecting their memory. The document showed R6 had not had any recent hospitalizations.

Record review of R6's unsigned Washington Health and Service Evaluation Results assessment, dated 02/06/2024, showed documentation that staff reviewed R6's diagnoses with a comment that said "The resident's active diagnoses were reviewed. See Service Plan for details."

Record review of R6's "Service Plan," dated 05/14/2024 showed R6 had a need for caregiver monitoring related to R6's diagnoses and conditions. The listed responsible party was "caregiver." The column with resident specific details showed no personalized information for R6 under the category of Diagnoses.

Record review of R6's Service Agreement, update date of 04/11/2024, showed R6 had a need for caregiver monitoring related to R6's diagnoses and conditions. The listed responsible party was "caregiver." The column with resident specific details showed no personalized information for R6 under the category of Diagnoses. Under the caregiver key on the last page, there were no caregiver names nor signatures. The document also showed R6 had mild memory impairment that required assistance and cuing from staff, mild long-term memory impairment.

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Record review of R6's Washington Health and Service Evaluation Results assessment, dated 05/14/2024, showed the following diagnoses for R6: [redacted] and [redacted]. The record indicated Dementia/Alzheimer's/Cognitive impairment did not apply.The assessment showed R6 required: stand by assistance for toileting, medication services for all medications including medication monitoring, storing, administration, and ordering by staff, stand-by assistance for toileting, emotional support and personal services related to Depression, a walker for ambulation, 10 or more medications including medications affecting balance and alertness, full housekeeping services that included daily laundry service, and a pendant call system.

Record review of R6's Service Plans, dated 04/11/2024 and 05/14/2024, showed "Resident Service Plan is based on latest assessment and is subject to revision based upon change in resident's health status."

Record review of R6's hospital discharge summary, dated 09/24/2024, showed an order for R6 to see their doctor on 09/27/2024 for hospital follow-up. Home Health was also ordered at that time.

Record review of hospital notes for R6, dated [redacted]/2024, showed that R6 was discharged on [redacted]/2024 with orders for azithromycin (an antibiotic) and, according to R6's son, did not think that medication was ever filled nor provided to R6 after their discharge from the hospital.The notes showed that R6 was admitted for "atypical pneumonia after which she may not have received antibiotics [they] were prescribed. [R6] returned to hospital with increasing pain and shortness of breath with new O2 [oxygen] requirement through to be related to incompletely treated community-acquired pneumonia versus anxiety or some overlap." Discharge orders indicated follow up with outpatient primary care provider in [redacted] days (10/12/2024) and an order for home O2 assessment.

Record review of a fax sent on 08/27/2024 showed staff notification to R6's physician that stated R6 had a non-injurious fall, [redacted] after R6 returned from a [redacted]-day-long hospitalization

Record review of an "Incident Report" for R6, dated 08/28/2024, showed R6 sustained a fall on 08/27/2024. On Page 2 of the document, under "Additional Comments: Called to room for resident on the floor, entered to find resident kneeling with upper body over bed and feet pointing towards the window. Wheelchair was across the room; lighting was good, and resident was wearing non-skid socks. Resident unable to state what she was trying to do, just that she was "trying to get higher in the bed". Resident assisted up with help of four and a sheet and into wheelchair. Range of motion was within normal limits, Resident stated pain in toes from kneeling on them, Resident had soiled herself. Resident given pain pill @ 15:20. Resident had been dog sitting prior to fall."

Record review of an "Incident Report" for R6, dated 09/02/2024, showed R6 sustained another fall on 09/01/2024. "Additional Comments", showed, "This MedTech [medication technician] was called on phone by another MedTech who was leaving facility stating that she could hear Resident in [redacted] yelling for help. Seconds after her call, Resident in [redacted] used her pendant to call for help. This MedTech and a caregiver arrived into room and found Resident on her knees, elbows on her bed, walker to her left facing the wall/bedside table, multiple bedroom lights on, wheelchair located across

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the room by TV [television]. When asked if Resident was okay, Resident stated no. When asked if Resident was in pain that was not her normal pain, Resident stated yes, her "knees and back were hurting". When asked if resident was okay with a two-person assist to help get her off the floor, Resident stated that she didn't think she was going to be able to be much help during the transfer. Caregiver put on proper footwear (slippers) before transfer. This MedTech and caregiver attempted a two-person lift underneath arms without success. This MedTech then secured gait belt on Residents lower abdomen, being aware and careful of her broken ribs from her recent full code. This MedTech and caregiver attempted to transfer with gait belt unsuccessfully. This MedTech had to call for a male caregiver from SNU (Skilled Nursing Unit) to assist with transfer while another caregiver slid wheelchair underneath Resident. After getting resident into chair, Resident was asked about pain and pain level again. Resident stated it was just her knees that were hurting (level 3). Slight redness with impressions from the carpet were noted on both knees. Resident was transferred from wheelchair and into recliner chair. Afterwards, Resident was brought PRN pain med and this MedTech ensured that both call buttons were within Residents reach. This MedTech reiterated that Resident should call for assistance and not try to transfer herself without help. Resident agreed to use buttons going forward. Voicemail left with POA [Power of Attorney] @ 2155, PCP [Primary Care Physician] notified via fax."

Record review of document titled" "Observations for R6", dated 09/01/2024 - 11/12/202, showed R6 discharged to the hospital on ██████/2024. R6 was hospitalized until their discharge on ██████/2024. A note from Staff W, medication technician, on ██████/2024 at 5:45 PM, showed, "Returned to our facility from OMC Hospital via cabulance at 1620. Resident very happy to be back home. B/P [blood pressure] 119/87 P [pulse] 81 T [temperature] 97.2 02 [oxygen saturation] 84% Resident assisted to her recliner and menu filled out for the dinner tray. After dinner resident walked to bathroom and back to recliner, then asked for a PRN [as needed]. PRN given @ 1805. Resident resting comfortably in her recline."

Record review of document titled "Observations for R6", dated 09/01/2024 - 11/12/2024, showed a note from Staff S , previous Director of Nursing (DNS), on ██████/2024 at 10:30 AM that said "Resident c/o [complained of] pain-Stabbing mid chest pain-radiating pain to left chest area, V/S [vital signs]: 117/77 78 02 sats: ranging from 89%-92% on RA [room air]. MD [medical doctor] notified new order received to send resident to ER [emergency room] for evaluation, resident's son notified, EMS [emergency medical services] arrived at 10: 50 am-Resident exited facility @10:59."

Record review of R6's Hospitalist assessment, dated 10/09/2024, showed R6 would require a home oxygen assessment for newly acquired oxygen need.Record review of After Visit Summary, dated 10/31/2024, showed an order to get 14-day heart monitor, however, review of facility notes "Observations of R6," showed no documentation the monitor was obtained, or further care was coordinated. The facility failed to identify changes in R6's condition that had previously required intervention and as a result, R6 sustained repeated falls and health decline requiring further hospitalization.

R7

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R7 moved into the facility on ██████/2024.

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Record review of R7's document titled, "discharge summary and plan", dated 10/01/2024, showed it was discharge orders from the skilled nursing facility R7 discharged from. The document showed R7 was discharged from the skilled nursing facility on /2024 with order to have home health services for therapy and nursing services. R7 had multiple medical diagnoses that included . Under the section titled, "treatments", showed R7 skin was to be assessed for cellulitis (a bacterial infection that affects the skin and tissue below the skin's surface), had a sore on their left great toe that required to be cleaned with normal saline, antibiotic ointment applied three times daily and kept open to air, and barrier cream to be applied to his buttocks area. Under the section titled, "recapitulation of stay", showed R7 admitted to the skilled nursing facility for cellulitis of the left leg. R7 had an open area on their buttocks that had resolved and only required barrier cream. R7 had an open skin area to their left big toe that required treatment. R7 was to discharge to the facility by the facility's van.

Record review of R7's document titled, "observations", dated 09/01/2024 through 11/12/2024, showed there were no progress notes for dates /2024 through 10/04/2024 that showed R7 had admitted to the facility and how R7 was adjusting to being at the facility. There was a progress note dated 10/03/2024 at 6:15 PM, that showed R7's power of attorney had called and updated the medication technician on specific medical conditions. The note did not have any documentation as to how R7 was doing since R7 admitted to the facility.

Record review of R7's documentation titled, "observations", dated 11/01/2024 at 9:30 PM, showed the medication technician was called into R7's room for a skin check on R7 buttocks. R7 had a bad open sore on their butt cheek. There was no further documentation for dates 11/02/2024 through 11/10/2024 about the open sore on R7 buttocks area for review.

R3

Record review of R3's "Resident Information" document, dated 11/12/2024, showed R3 admitted to the facility on /2024.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R3 had a condition affecting 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. Review of the characteristic roster also showed R3 was a fall risk.

Record review of R3's assessment, dated 08/06/2024, showed R3 had a fall history of two in the previous month.

Record review of a discharge summary for R3, dated 08/14/2024 at 5:36 PM, showed reason for visit listed was falls. Record showed as the primary diagnosis under the health summary section.

Record review of document titled healthcare provider plan of care admission orders,

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signed 08/16/2024 by resident and physician, showed R3's primary diagnosis was with secondary diagnoses of and .

Record review of R3's "Service Plan," dated 09/14/2024, showed no personalized information for R3 under the category of Diagnoses meaning there was no evidence staff had the required information to monitor R3's health care needs and monitor for changes in condition related to R3's diagnoses.

Record review of documented titled "Observations for [R3], 09/01/2024- 11/12/2024" showed R3 moved from the Assisted Living Facility side of the facility to the memory care side of the facility on 09/01/2024. Records indicate alert charting occurred for only 18 hours that same day, at which point it was discontinued. The next note entry for R3 did not occur until 09/15/2024 at 3:45 AM. Records did not reflect R3 was monitored for their transition to an entirely new unit.

Record review of documented titled "Observations for [R3], 09/01/2024- 11/12/2024", showed a note from 09/24/2024 at 10:15PM that said R3 had experienced falls on 09/13/2024 and 09/14/2024, however, there were no notes provided for either of these incidents. Review of all progress notes from 09/01/2024 to 11/12/2024 showed only one note from 09/24/2024 about R3's falls. Record review of document titled "Observations for [R3]," dated 09/01/2024 through 11/12/2024, showed R3 had falls on 09/13/2024, 09/14/2024, 10/06/2024, 10/21/2024, and 10/26/2024. Record review of the assessments provided from the facility did not show the facility identified changes in R3's functioning despite repeated falls.

R5

Record review of R5's, "Service Plan", dated 09/20/2024, under the mobility and ambulation section showed R5 had been independent with their mobility and ambulation. Under fall potential section showed R5 had "fall potential".

Record review of the facility provided document titled, "Observations for R5", dated 09/01/2024 at 4:45 AM, showed Staff AA, Resident Care Assistant (RCA),
wrote R5 had been on alert for a fall and skin tear to their left hand.

Record review of the facility provided document titled, "Observations for [R5]", dated 09/02/2024 at 9:30 AM, showed Staff BB, RCA, wrote R5's skin tear had not been observed to have drainage, warmth, or pain. Record review of the facility provided document titled, "Observations for [R5]", dated 09/02/2024 at 4:15 PM, Staff BB wrote R5 would be taken off alert for their left-hand skin tear.There were no further observation notes to review related to R5's skin tear that took place on 09/01/2024 and that R5 had been monitored for at least 72 hours.

Record review of the facility provided document titled, "Observations for [R5]", dated 09/21/2024 at 3:45 PM, Staff CC, Former Medication Technician, wrote R5 came to the nurse's station and reported a fall that took place outside in the rose bushes when they picked weeds. R5 reported they felt dizzy. R5 had a skin tear on their top left hand with bruising and abrasion on their right hand.

Record review of the facility provided document titled, "Observations for [R5]", dated

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09/22/2024 at 8:15 AM, Staff M, Resident Care Services Registered Nurse, wrote a fall report that indicated R5 had a fall on 09/21/2024 and there had been no evidence of abuse or neglect found.There were no further observation notes to review related to R5's fall that took place on 09/21/2024 and that R5 had been monitored for at least 72 hours.

Record review of the facility provided document titled, "Observations for [R5]", dated 10/09/2024 at 6:30 PM, Staff E, RCA, wrote R5 had been cut when they tried to pick roses. Facility staff cleaned the wounds and bandaged R5 up.There were no further observation notes to review related to R5's wound that occurred when they picked roses and that R5 had been monitored for at least 72 hours.

In an interview on 11/13/2024 at 3:34 PM, Staff O, Resident Care Assistant, said all progress notes and alert charting were entered under the observation tab in the electronic charting system. Staff O said alert charting was supposed to continue for three days from the start time.

In an interview on 11/14/2024 at 8:56 AM, Staff W, Medication Technician, said that the facility medication technicians and the facility management team were capable of adding in resident observations into the system. Staff W noted that R5 liked the rose bushes, they could not keep R5 out of them, and they often would get a medical kit ready because it would be inevitable that R5 would have a fall or some sort of skin tear related to their desire to prune the bushes. Staff W stated if a resident had a skin tear or a fall then they would be on alert charting for at least 72 hours.

In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Attendant, said if a resident needed to be placed on alert charting at minimum it would be for 72 hours or longer depending on the situation. Staff E stated that the facility medication technicians were responsible to complete alert charting. For the assisted living residents, the medication technicians worked 12-hour shifts and there should be a minimum of one chart note per shift equaling at least two chart notes per day. For the South Hampton's memory care residents, the medication technicians worked 8-hour shifts and there should be a minimum of one chart note per shirt equaling at least three chart notes per day. Staff E said if a resident had a skin tear or a fall then they would be on alert charting for at least 72 hours.

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, Sherwood Assisted Living 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

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

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

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

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(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;

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

(a) Exclusively for the individual resident; or

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

(4) The resident's preferences for activities and how those preferences will be supported;

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 plan the plan to provide the care and services necessary to support the resident's preferences and care and services for 7 of 10 sampled residents (Resident 6 [R6], Resident 2 [R2], Resident 7 [R7], Resident 10 [R10], Resident 8 [R8], Resident 5 [R5] and Resident 9 [R9]). These failures placed the residents at risk for unmet care needs and untrained staff.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements", undated, showed the resident agreements would be based on the assessed needs and would be developed with the input, participation, and agreement of the resident, responsible

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parties, facility staff and other as appropriate and to the extent possible. The negotiated service agreement (NSA) would be developed building on the resident's strengths and using the full assessment information, pre-admission assessment, and resident service plan. The NSA would be updated to be consistent with residents needs when there was an observed change in the resident's physical, mental, and emotional function. The NSA would be updated when it no longer addressed the residents needs and/or preferences and it would address all reasonable risks and how those risks would be managed.

R6

Record review of R6's "Service Plan," dated 05/14/2024, showed R6 moved into the facility on /2024.

Record review of R6's "Resident Information Sheet," dated 11/12/2024, showed R6 moved into the facility on /2024. Under the diagnoses section of the document it showed the following diagnoses for R6: .

Record review of the facility documented, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed "A" in the medication column meaning R6 received medication administration services from the facility and in the column titled "Dementia[a progressive brain condition that affects a person's way 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 that affects thinking, memory, and decision-making]", the box was checked which indicated R6 had a condition that affected their memory.

Record review of R6's unsigned Washington Health and Service Evaluation Results assessment, dated /2024, showed documentation that staff reviewed R6's diagnoses with a comment that said "The resident's active diagnoses were reviewed. See Service Plan for details."

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Record review of R6's unsigned Service Agreement, updated date of 04/11/2024, showed R6 had a need for caregiver monitoring related to R6's diagnoses and conditions. The listed responsible party was "caregiver." The column with resident specific details showed no personalized information for R6 under the category of Diagnoses. Under the caregiver key on the last page, there were no caregiver names nor signatures. The document also showed R6 had mild memory impairment that required assistance and cuing from staff, and mild long-term memory impairment.

Record review of R6's Washington Health and Service Evaluation Results assessment, dated 05/14/2024, showed the following diagnoses for R6: and . The record indicated Dementia/Alzheimer's/Cognitive impairment did not apply. The assessment showed R6 required: stand by assistance for toileting, medication services for all medications including medication monitoring, storing, administration, and ordering by staff, stand-by assistance for toileting, emotional support and personal services related to Depression, a walker for ambulation, 10 or more medications including medications affecting balance and alertness, full housekeeping services that included daily laundry service, and a pendant call system.

Record review of R6's "Service Plan," dated 05/14/2024 showed R6 had a need for caregiver monitoring related to R6's diagnoses and conditions. The listed responsible party was "caregiver." The column with resident specific details showed no personalized information for R6 under the category of Diagnoses.

Record review of R6's Service Plans, dated 04/11/2024 and 05/14/2024, showed, "Resident Service Plan is based on latest assessment and is subject to revision based upon change in resident's health status."

In an observation and interview on 11/14/2024 at 11:10 AM, R6 was observed in a wheelchair, stuck in the doorway of the resident's private bathroom. R6 said they do not usually notify staff for assistance. No call light pendant was observed on the resident. Observed across R6's room was a wheeled walker. R6 said they had been using the wheelchair for a long time; however, they could not recall the exact timeframe when they began using it.

Record review of R6's hospital discharge summary, dated 08/27/2024, showed R6 suffered a heart attack in July 2024. R6 was hospitalized 08/01/2024 through 08/26/2024.

Record review of R6's Service Plan from 05/14/2024 showed R6 received nursing services from the facility nurse for ordering of supplies, scheduling of appointments, monthly pacer checks and other services.

In an interview on 11/14/2024 at 11:30 AM, R6 said their medications had not been coordinated very well and they had not received the medications prescribed for a while after their return from the hospital.

R2

Record review of R2's document titled, "resident information", dated 11/12/2024, showed R2 moved into the facility on 2023 with multiple medical diagnoses that included

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and

Record review of R2's document titled, family health clinic letter, dated 08/08/2024, showed it was a letter sent to the facility by R2's primary care physicians office. The letter showed R2 had slipped out of bed without any injuries on 05/29/2024, had a non injury fall on 06/14/2024 when R2's legs gave out, and a fall in the dining room at lunch on 07/21/2024 with R2 experiencing extreme back pain and transferred to local hospital emergency room. The letter showed that R2 returned to the facility from the emergency room on 07/22/2024 at 1:45 AM with a compression fracture (a type of broken bone that occurs when pressure causes a bone to collapse) and a bony lesion to the thoracic 12 vertebrae (an abnormal change or damage to the bone structure at the left of the thoracic area of the back) and mild kidney injury (when the kidney gets slightly damaged).

Record review of R2's document titled, "care plan", dated 07/26/2023, showed it was an ongoing care plan that was reviewed and signed on 07/26/2023.

Record review of R2's document titled, Washington Health and Service Results", dated 09/23/2024, showed it was R2's annual assessment, that was completed on 09/23/2024.

Record review of R2's document titled, "service plan", dated 09/23/2024, showed it was R2's annual updated service plan that was signed and dated on 09/26/2024. The service plan was updated two months past the annual required time frame.

In an interview on 11/13/2024 at 12:55 PM, Staff A, Marketing Director, stated R2's fall with the compression fracture to their back would have been considered a change of conditions and required an update to their NSA.

R7

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R7 moved into the facility on 2024.

Record review of R7's, "Washington Health and Service Evaluation Results", dated 10/25/2024, showed R7 had an open wound area on their toe, had a R7 required hand on assistance with grab far for transfers, R7 required occasional/monthly nursing services without any outside services.

In an interview and observation on 11/13/2024 at 10:56 AM, inside R7's room, it was observed that R7's right side of the bed was up against the wall with a full siderail on the upper part of their bed on the left side and a transfer pole. R7 stated the siderail was on their bed to help prevent them from rolling out of their bed and does not use the siderail to roll over in bed. R7 stated they used the transfer pole and two staff members to stand up from their bed. On R7's bedside table next to the left side of their bed was a CPAP (continuous positive airway pressure- machine that helps keep the airway open to ensure adequate oxygenation occurs when a person sleeps) and a handheld urinal. R7 stated that they used the CPAP at night and did not require oxygen. R7 stated they had

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been working with home health therapy services for strengthening and a nurse came out two times a week to put ointment and a bandage on their buttocks area and left foot wounds. R7 stated during the day the caregivers assisted R7 to use the bathroom and during the night or when they were in bed they would use a handheld urinal. R7 stated they have never used a bedside commode since they admitted to the facility. Observation of R7's room noted there was no bedside commode in the room. R7 was sitting upright in their wheelchair when R7 stated they had their [redacted] and showed their [redacted]. R7 stated they were a diabetic (the bodies unable to regulate high and low blood sugar levels and maintain them in a normal range) that required the medication technicians to check their blood sugar level every morning and eat a low sugar diet.

Record review of R7's Service Plan (facility's version of the negotiated service agreement), dated 10/25/2024, showed R7 required supplemental oxygen and was independent with all aspects of oxygen utilization. R7 used a grab bar for transfers. There was nothing documented that the resident used a transfer pole by their bed, a side rail on the left side of their bed, and the right side of their bed was up against the wall, or that R7 had an [redacted] and was missing their [redacted]. R7 required total assistance for medications. R7 used a bedside commode for toileting. There was no documentation to show that R7 used the toilet during the day and a handheld urinal. R7 ate a regular diet independently. There was no documentation that the resident was a diabetic and required low concentrated sweets diet. Under the section titled, "additional nursing services", showed there was nothing documented about R7's left foot wound or that R7 required barrier cream to their buttocks area related to a prior wound that had healed. There was no documentation about R7 required Registered Nurse (RN) delegation services for their blood sugar checks. The service plan did not show that R7 received home health services for physical and occupational therapy and nursing services for strengthening and wound care management.

R10

Record review of document titled, "Disclosure of Services Required by RCW 18.20.300", dated "01/2023", showed that the facility did not permit family members to provide medication services to residents.

Record review of R10's, "Washington Health and Service Evaluation Results", dated 07/31/2024, showed R10 was assessed to require "family member" to purchase medications.

Record review of R10's, "Service Plan", dated 07/31/2024, showed no one was identified to obtain R10's medication, only that R10 required "total" assistance with medication.

In an interview on 11/14/2024 at 12:36 PM, Collateral Contact 4 (CC4), R10's family member, stated that the facility obtained R10's medications, the family was not responsible. CC4 stated that the family did not live in the area.

In an interview on 11/13/2024 at 2:30 PM, R10 stated one of their children thought they were a doctor and sent R10 medications to stay healthy.

In an observation on 11/13/2024 at 2:30 PM of an unlocked cabinet in R10 and R9's bathroom, showed 400 tablets of Kirkland stool softener, 250 tablets of Aleve back

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muscle (relieve pain and swelling), 600 milligrams of calcium (dietary supplement), 200 milligrams of coq10 (dietary supplement), 125 micrograms of D3 nature's bounty (dietary supplement from nature's bounty brand), Visine dry eye relief (eyedrops to reduce eye redness and dryness), 60 chewable tablets of areds 2 (slows vision loss), 200 milligrams of Advil (relieve pain and swelling), 40 melts of xylimelts (used for dry mouth), three boxes that contained 48 tablets of 25 milligrams of Exlax-brand (treats constipation). On R9 and R10's bathroom counter showed 8 ounces of bag balm (moisturizing ointment), two bottles of 500 milligram Tylenol (treats pain and reduces fevers) that contained 100 gel tablets, 60 Caplets of Super beta prostate dietary supplement (dietary supplement), 400 soft gel tablets of 100 milligram of Kirkland's Docusate Sodium (stool softener), 750 milligrams of Kinoko platinum AHCC veggie caps (dietary supplement), 250 milligrams of beta sitosterol (dietary supplement), 20 micrograms of Vitamin D (dietary supplement), empty container of spring valley CoQ10 200 milligram (dietary supplement), opened tablet of 25 milligram ex-lax sennosides (stool softener) with 6 of the 12 tablets taken out, two bottles of 36 tablets and 83 milligrams of Bayers-brand aspirin (relieves pain and swelling).

Record review of an email sent to the Department on 11/21/2024 at 5:38 PM, showed Staff A, Marketing Director, said that the facility assisted R10 with all their medications, so they did not have a self-medication assessment or family assistance plan.

R8

Record review of R8's, "Resident Information", dated 11/12/2024, showed R8 moved into the facility on [redacted]/2010.

Record review of R8's, "Washington Health and Service Evaluation Results", dated 10/31/2024, showed R8 received hospice services. The vision deficit section showed resident had been blind or had severe vision deficits. The involvement of resident's family section showed R8's family had been involved with their physical and emotional needs. Medication level of assistance section showed R8 had been independent and did not require assistance. Medication responsibilities section showed R8 had medication orders and over the counter medications. R8's representative had been responsible to purchase the medication. R8 had been responsible to store their medications. R8 had been responsible to self-administer their medications.

Record review of R8's, "Service Plan", dated 10/31/2024, showed no information related to the hospice services that R8 received and did not indicate R8 was on hospice services. The vision section showed R8 had severe visual impairments. The medication section showed R8 had been independent and did not require assistance with medication administration.

Record review of R8's hospice, "Current plan of Care", dated 09/04/2024, showed R8 admitted into hospice services on 05/15/2024.

In an observation and interview on 11/13/2024 at 11:13 AM, on top of R8's dresser had been a container of 1.75 ounces of Aquaphor (a skin protectant that treats a variety of skin conditions) . R8 said they did not have any medication that they took. R8 stated they did not always remember when they were supposed to go down to the dining hall for lunch and dinner. R8 asked the Department if they could inform them when they were supposed to go to the dining hall for lunch. At 11:25 AM, R8's phone rang, it had been Collateral Contact 1 (CC1), Power of Attorney for R8, who called the resident to

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inform them they needed to go to the dining hall for lunch.

In an interview on 11/14/2024 at 8:50 AM, Staff W, Medication Technician, said R8 had been on hospice services. Staff W said they thought if a resident received hospice services that it should be incorporated into the care plan because if not how would the facility staff know the resident received hospice services or who to call in an emergency. Staff W said R8 had been a self-administration of medication resident. Staff W said CC1 must have brought R8 their medications. Staff W said R8 did not need reminders to go to meals because CC1 called R8 before every meal daily. Staff W said the information that CC1 called R8 before every meal to remind them to go to the dining hall would not be incorporated into R8's Service plan.

In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Attendant, noted that they just updated R8's service plan and that CC1 had been very involved in R8's care and coordinated all of R8's care. Staff E confirmed R8 had been on hospice services. Staff E said R8 had been a self-administration of medication resident. Staff E said they had been unsure what CC1 did for R8 because they were new to the position. Staff E said they were unsure if CC1 brought R8 their medications. Staff E stated they thought R8 took Tylenol. Staff E said the information would not be incorporated into R8's service plan because the facility service plan system had not been set up for that.

In an interview on 11/19/2024 at 9:01 AM, CC1 said they reviewed R8's service plan in October with Staff E. CC1 stated R8 had been on hospice services. CC1 stated R8, themselves, and the hospice team had monthly meetings about R8. CC1 stated R8 did not want to take medication. CC1 stated that that they supplied R8 a bottle of Tylenol to take as needed. CC1 stated that historically when R8 took medications they were the individual who supplied R8 the medication. CC1 stated R8 had resided at the facility for 15 years and within that time the facility had never requested an alternative plan related to if they could not supply R8 their medication who would be responsible to do so. CC1 stated themselves or another family member checked on R8 multiple times throughout the day. CC1 stated they called R8 before each meal to remind R8 when they needed to go to the dining room.

Record review of R8's, "Service Plan", dated 10/31/2024, not indicate R8 was on hospice services. The service plan did not indicate that CC1 supplied R8 their as needed medication. The service plan did not incorporate that CC1 called R8 before mealtimes to notify them they needed to go to the dining room to eat.

R5

Record review of R5's, "Washington Health and Service Evaluation Results", dated 09/20/2024, showed R5 received hospice services. Under mobility and ambulation section showed R5 had been independent, R5 balance had been normal, their gate had been normal, and they did not have a mobility device. The activities section showed R5 had been independent and did not require assistance. General activity preferences included reading, writing, and watching television.

Record review of R5's, "Service Plan", dated 09/20/2024, showed that R5 had a diagnosis of

The service plan showed no information related to the hospice services that R5 received and did not indicate R5 was on hospice services. The mobility and ambulation section showed R5 had been independent. The fall potential section

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showed R5 had been a fall potential. The activities section showed R5 had been independent with activities, and they liked to read, write, and watch television.

Record review of an untitled document, dated 03/08/2024, showed R5 had been a patient of (hospice provider) services and to call their number if R5 had difficulties with symptom management, change in condition, or any other information that pertained to R5.

Record review of an untitled and undated document, showed R5 had been a patient of (hospice provider) and their staff were available for consultation of palliative and hospice topics and symptom management needs, they provided R5 and R5's family support such as respite, grief, and spiritual support. They could provide certified nursing services. They evaluated and followed through with funeral home preference arrangements. They added the death to pronounce when the facility did not have a registered nurse on duty.

Record review of the facility provided document titled, "Observations for [R5]", dated 09/01/2024 at 4:45 AM, showed Staff AA, Resident Care Assistant, wrote R5 had been on alert for a fall and skin tear to their left hand.

Record review of the facility provided document titled, "Observations for [R5]", dated 09/21/2024 at 3:45 PM, Staff CC, Former Medication Technician, wrote R5 came to the nurse's station and reported a fall that took place outside in the rose bushes when they picked weeds. R5 reported they felt dizzy. R5 had a skin tear on their top left hand with bruising and abrasion on their right hand.

Record review of the facility provided document titled, "Observations for [R5]", dated 10/09/2024 at 6:30 PM, Staff E, Resident Care Assistant, wrote R5 had been cut when they tried to pick roses. Facility staff cleaned the wounds and bandaged R5 up.

In an interview on 11/14/2024 at 8:50 AM, Staff W confirmed R5 had been on hospice services and that information should be incorporated in the service plan. Staff W said Staff E, Resident Care Assistant, updated resident service plans. Staff W said R5 enjoyed pruning the rose and rhododendrons and the facility staff could not keep R5 out of them. Staff W said when they saw R5 out in the courtyard that they anticipated a possible skin tear or fall.

In an interview on 11/14/2024 at 11:00 AM, Staff E confirmed R5 had been on hospice services. Staff E said they incorporated that R5 had been on hospice services in their assessment. Staff E said that the system did not incorporate R5's hospice services into their service plan. Staff E stated R5 loved the rose bushes and had fallen into them. Staff E stated the information that R5 enjoyed the rose bushes and had fallen in them multiple times had not been incorporated into their service plan.

In an observation on 11/14/2024 at 10:53 AM, R5 had been observed to go out of the backside of the facility and started to pick the rose bushes. R5 had been observed to go off the sidewalk and walk along the white lattice fence. R5 started to pick at the rhododendron bush.

Record review of R5's, "Service Plan", dated 09/20/2024, showed no information related to the hospice services that R5 received and did not indicate R5 was on hospice services. The service plan did not incorporate their interest of going outside and pruning

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the rose and rhododendron bushes and how the facility supported R5's preference to do so.

R9

Record review of R9's, “Service Plan Detail”, dated 07/31/2024, showed no information related to medication services. In the row, titled, “Additional Nursing Services”, R9 was listed as “Independent” and “does not require” additional nursing services.

Record review of R9's, “Washington Health and Service Evaluation Results”, dated 07/31/2024 showed medication responsibilities assessed as “resident needs to have medication administration” of over-the-counter meds. R9 was also assessed as “qualified staff” responsible to assist with self-administration of medication or medication administration.

Record review of R9's medical chart showed R9 did not have a self-medication administration assessment in their chart to review.

In an interview on 11/14/2024 at 11:00 AM, Staff E stated R9 did not have a self-medication assessment as R9 did not take any medications.
Record review of R9's, “Healthcare Provider Plan of Care Admission Orders”, signed by R9's primary care provider on 7/17/2024, indicated that R9 required staff assistance with medications.

Record review of R9's document titled, “Medication Services”, dated 02/23/2018, showed that facility policy stated if resident was having difficulty with medication management, then they would be reevaluated with “documentation to the resident's negotiated service agreement.”

Record review of R9's document titled, “Resident Independent Medication Agreement”, dated 10/16/2024, showed that residents identified as self-medication administration must be assessed using the “Self-administration assessment form” and it must be documented on the resident's negotiated service agreement. The document also showed that the resident must be monitored by licensed staff for continued self-administration capability.

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, Sherwood Assisted Living 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

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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:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 5 of 9 sampled resident rooms (Resident 9 [R9], Resident 10 [R10], Resident 5[R5], Resident 8[R8] and Resident 3[R3,). The failure to secure medications placed 69 of 69 residents at risk of access and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility's policy titled, "Medication Services", dated 02/23/2018, showed residents who were assessed to be capable to self-administrator or self-administration with assistance could store and control their own medications, which should be stored in a way to prevent access by other residents. The facility would store medications for residents who were not capable of safely storing their own medications and who had been assessed as needing medication administration. All medications in the facility would be properly stored in a locked cabinet in a nurse's station where only designated staff had access.

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R3 resided in the South Hampton memory care unit and was classified to have a diagnoses of [redacted]. Review of the assisted living residents showed 13 of 50 were classified to have a diagnosis of [redacted] that included R9, R8, and R5.

R9

Record review of R9's, "Service Plan Detail", dated 07/31/2024, showed R9 was independent and did not require nursing services and that R9 could manage services on their own. R9's "Service Plan Detail" did not indicate if R9 took medication and who was responsible to provide R9 with their medications.

Record review of R9's, "Washington Health and Service Evaluation Results", dated 07/31/2024, showed, under the medication section, that R9 would not take medication without assistance and that they took between four to six medications.

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In an observation on 11/13/2024 at 2:30 PM, showed that in an unlocked cabinet inside of R9 and R10’s bathroom there was 400 tablets of Kirkland stool softener, 250 tablets of Aleve back muscle (relieve pain and swelling), 600 milligrams of calcium (dietary supplement), 200 milligrams of coq10 (dietary supplement), 125 micrograms of D3 nature’s bounty (dietary supplement from nature’s bounty brand), Visine dry eye relief (eyedrops to reduce eye redness and dryness), 60 chewable tablets of areds 2 (slows vision loss), 200 milligrams of Advil (relieve pain and swelling), 40 melts of xylimelts (used for dry mouth), three boxes that contained 48 tablets of 25 milligrams of Exlax-brand (treats constipation). On R9 and R10’s bathroom counter showed 8 ounces of bag balm (moisturizing ointment), two bottles of 500 milligram Tylenol (treats pain and reduces fevers) that contained 100 gel tablets, 60 Capulets of Super beta prostate dietary supplement (dietary supplement), 400 soft gel tablets of 100 milligram of Kirkland's Docusate Sodium (stool softener), 750 milligrams of Kinoko platinum AHCC veggie caps (dietary supplement), 250 milligrams of beta sitosterol (dietary supplement), 20 micrograms of Vitamin D (dietary supplement), empty container of spring valley CoQ10 200 milligram (dietary supplement), opened tablet of 25 milligram ex-lax sennosides (stool softener) with 6 of the 12 tablets taken out, two bottles of 36 tablets and 83 milligrams of Bayers-brand aspirin (relieves pain and swelling)

R10

Record review of R10’s, “Service Plan Detail”, dated 07/31/2024, showed R10 needed total medication assistance and could not take medication without assistance.

In an observation and interview on 11/13/2024 at 2:30 PM, R9 said the reason why themselves and R10, their spouse, was admitted into the facility had been because R10 had diabetes and R10 needed medication management. R10 said when the medication technician brought them their medication, they took the medications without inquiring what the medication was. R10 said previously the facility staff entered R9 and R10’s room and took all their medications out of their room. R10 said they talked to a facility staff member who gave R9’s and R10’s Tylenol bottles back. R9 confirmed they took Tylenol as needed. R10 said one of their children thought they were a doctor and sent R10 medication to stay healthy. R9 and R10 stated they did not lock their door. In an unlocked cabinet inside of R9 and R10’s bathroom showed 400 tablets of Kirkland stool softener, 250 tablets of Aleve back muscle (relieve pain and swelling), 600 milligrams of calcium (dietary supplement), 200 milligrams of coq10 (dietary supplement), 125 micrograms of D3 nature’s bounty (dietary supplement from nature’s bounty brand), Visine dry eye relief (eyedrops to reduce eye redness and dryness), 60 chewable tablets of areds 2 (slows vision loss), 200 milligrams of Advil (relieve pain and swelling), 40 melts of xylimelts (used for dry mouth), three boxes that contained 48 tablets of 25 milligrams of Exlax-brand (treats constipation). On R9 and R10’s bathroom counter showed 8 ounces of bag balm (moisturizing ointment), two bottles of 500 milligram Tylenol (treats pain and reduces fevers) that contained 100 gel tablets, 60 Capulets of Super beta prostate dietary supplement (dietary supplement), 400 soft gel tablets of 100 milligram of Kirkland's Docusate Sodium (stool softener), 750 milligrams of Kinoko platinum AHCC veggie caps (dietary supplement), 250 milligrams of beta sitosterol (dietary supplement), 20 micrograms of Vitamin D (dietary supplement), empty container of spring valley CoQ10 200 milligram (dietary supplement), opened tablet of 25 milligram ex-lax sennosides (stool softener) with 6 of the 12 tablets taken out, two bottles of 36 tablets and 83 milligrams of Bayers-brand aspirin (relieves pain and swelling).

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R5

Record review of R5's, "Resident Information", dated 11/12/2024, showed R5 had a diagnosis of

Record review of R5's, "Service Plan", dated 09/20/2024, showed R5 needed total assistance and could not take medication without assistance.

Record review of R5's, "Independent with Medication Self-Administration Evaluation Form", dated 03/12/2024, showed R5 stored medications in a safe location away from other resident access. R5 could administer their medications accurately and self-administered over the counter medications.

In an observation and interview on 11/13/2024 at 12:52 PM, R5 had a container of soothe xp extra protection advanced eye therapy drops sitting on top of their nightstand by their bed. On R5's dresser there had been a 0.5 fluid ounce container of soothXP lubricant eye drops not secured. In R5's bathroom there had been a bottle of 5000 micrograms of biotin in a Nature's Bounty container, 2000 internal units of nature's made D3, a container of sooth hydration dry eye therapy drops, one box of preparation H 24 suppositories, one box of gas X 125 milligram 50 soft gel tablets, and 0.5 fluid ounces of Visine eye drops that were all not locked up and accessible. R5 said they did not take medications. R5 said they took their eye drops that were on top of their nightstand by their bed.

R8

Record review of R8's, "Resident Information", dated 11/12/2024, showed R8 had multiple medical diagnoses that included

Record review of R8's, Service Plan, dated 10/31/2024, showed R8 had been independent with medication and did not require assistance with medication administration.

Record review of R8's, "Independent with Medication Self-Administration Evaluation Form", dated 03/20/2024, showed R8 stored medications in a safe location away from other resident access.

In an observation and interview on 11/13/2024 at 11:13 AM, on top of R8's dresser had been a container of 1.75 ounces of Aquaphor (a skin protectant that treats a variety of skin conditions) . R8 said they did not have any medication that they took. R8 said they did not have a key to their room, and they never locked their door.

R3

Record review of R3's document titled; "Resident Information" dated 11/12/2024 showed R3 admitted to the facility on 2024.

Record review of the facility document, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed "A" in the medication column

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meaning R3 received medication administration services from the facility and in the column titled "Dementia[a progressive brain condition that affects a person's way 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 conditions affecting thinking, memory, and decision-making]" the box was checked that indicated R3 had a condition affecting their memory.

Record review of R3's "Pre-admission assessment," completed on [redacted]/2024, showed R3 had a mild memory impairment issue in the afternoon.

In an observation on 11/12/2024 at 11:16 AM in the memory care inside R3's bathroom, was a black metal shelf with a container that said mouthwash antiseptic, a tube of Total brand toothpaste, and a tube of diclofenac sodium 1% (ointment that reduces pain). Below, behind the cabinet door was a bottle of baby oil, mouthwash, Cerave cream (skin lotion), Aveeno brand cream (skin lotion), and Mucinex DM MAX (cough medicine).

In an observation on 11/13/2024 at 3:16 PM in the memory care unit, inside R3's bathroom, was a black metal shelf with a container that said mouthwash antiseptic, a tube of Total brand toothpaste, and a tube of diclofenac sodium 1% (a medicated ointment that reduces pain). Below, behind the cabinet door was a bottle of baby oil, mouthwash, Cerave cream, Aveeno cream, Mucinex DM MAX (a medication to help reduce cough and congestion). On the wall above the toilet was a white cabinet. Inside the unlocked cabinet on the bottom shelf was a bottle of Nivea brand shaving cream, and a perianal skin cleanser. On the top shelf was a plastic bag with two tubes inside; one tube was Mupirocin brand antibiotic ointment (used to treat skin infections) and the other tube was a travel-sized tube of toothpaste. On the sink was a bottle of Gillette brand shaving gel and a shaving razor.

In observation on 11/14/2024 at 10:20 AM in the memory care unit, inside R3's bathroom, was a black metal shelf with a container that said mouthwash antiseptic, a tube of Total brand toothpaste, and a tube of diclofenac sodium 1% (ointment that reduces pain). Below, behind the cabinet door was a bottle of baby oil, mouthwash, Cerave cream, Aveeno cream, Mucinex DM MAX (cough medicine). On the wall above the toilet was a white cabinet. Inside the unlocked cabinet on the bottom shelf was a bottle of Nivea brand shaving cream, and a perianal skin cleanser. On the top shelf was a plastic bag with two tubes inside; one tube was Mupirocin brand antibiotic ointment (used to treat skin infections) and the other tube was a travel-sized tube of toothpaste. On the sink was a bottle of Gillette brand shaving gel and a shaving razor.

In an interview on 11/13/2024 at 3:24 PM, Staff N, Caregiver, said medications should not be left out in resident rooms in the memory care unit and Staff N said all medications should be locked up and stored in the medication room.

In an interview on 11/13/2024 at 3:35 PM, Staff O, Resident Care Assistant, said medications could be in the resident room if it was out of reach of the resident.

In an interview on 11/13/2024 at 3:51 PM, Staff E, Resident Care Assistant, said if the residents received medication administration services, then there should not be any medications in their room. This included over the counter medications. Staff E said for R9 and R10 that their medications should be locked up because they were both in the same room.

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In an interview on 11/14/2024 at 8:50 AM, Staff W, Med Tech (medication technician) said residents who administered their own medications should have the medications in a locked drawer inside of their room.

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, Sherwood Assisted Living 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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to obtain and administer medications in an appropriate and timely manner for 3 of 9 sampled residents (Resident 2[R2], Resident 4 [R4], and Resident 6 [R6]) who were dependent on the facility for their medication services. This failure resulted in R6 not receiving necessary medications to treat a medical condition and placed all residents at risk for medical complications from not receiving medications as prescribed and placed the residents at risk for a decreased quality of life.

Findings included ...

Record review of facility policy "Non-availability of Medications," dated 03/18/2018, showed "it is the policy of Sherwood Assisted Living to provide medication to residents in a timeframe and in a manner that promotes health and welfare." The procedure showed that: "1. All medications that are the responsibility of the facility will be re-ordered from the pharmacy at a pre-designated and negotiated time frame with the pharmacy (due to insurance reimbursement requirements, medications cannot be ordered too early, or the insurance will not cover the cost of the medication). 2. If, despite negotiations and plans set between facility and the pharmacy, a medication is not available to a resident at a designated timeframe, the designated staff person will contact the pharmacy to determine when the medication will be delivered. 3. The licensed nurse will evaluate the significance of the medication not being delivered to the resident on time and take the appropriate actions to ensure resident safety and welfare 4. If the medication will not be available to the resident in the timeframe

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needed the resident's health care provider or prescriber of the medication will be notified 5. If it is the resident's and /or responsible part's responsibility to obtain mediation for the resident, the designated staff person will contact the resident/responsible party and explain concerns regarding medications being unavailable. 6. Medications may be unavailable due to weather conditions, pharmacy availability of the medication etc. If the resident health and safety would be at risk the pharmacy may contact a local pharmacy to fill the medication so that it will be available in a more immediate timeframe."

R2

Record review of R2's document titled, "resident information", dated 11/12/2024, showed R2 moved into the facility on [redacted]/2023, with multiple medical diagnoses that included [redacted].

Record review of R2's Medication Administration Record (MAR) dated 09/01/2024 through 09/30/2024, showed that the medication Risperidone (a medication given for psychiatric disorders) was noted as "not in stock" on 09/11/2024 and "can't find in cart" on 09/12/2024.

R4

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R4 admitted to the facility [redacted]/2016.

Record review of R4's MAR, dated 09/01/2024-09/30/2024, showed R4 did not receive the prescribed medication Norco (A medication given for pain management) on 09/16/2024 due to medication non-availability. Staff notes included "Not available" and "Awaiting delivery." This resulted in two missed doses.

R6

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R6 moved into the facility on [redacted]/2024. The roster showed "A" in the medication column meaning R6 received medication administration services from the facility and in the column titled "Dementia/Alzheimer's/Cognitive Impairment [brain conditions affecting thinking, memory, and decision-making]", the box was checked indicating R6 had a condition affecting their memory.

Record review of R6's Washington Health and Service Evaluation Results assessment, dated 05/14/2024, showed the following diagnoses for R6: [redacted] and [redacted]. The assessment showed R6 required medication services for all medications including medication monitoring, storing, administration, and ordering by staff for 10+ medications.

Record review of R6's Service Plan, effective 05/14/2024, showed R6 received total assistance with medication and could not manage medications without full staff assistance and administration. The Service Plan showed R6 took 10+ medications and

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used the preferred facility pharmacy to have their medications filled and provided.

Record review of R6's MAR, dated 09/01/2024 to 09/30/2024, showed R6 was prescribed Buspirone (a medication for anxiety), atorvastatin (medication used to control cholesterol), spironolactone (medication used to get rid of extra water in the body to lower blood pressure), Eliquis (medication used to treat and prevent blood from clotting or known as a blood thinner), losartan (a medication used to treat high blood pressure), insulin glargine (medication to regulate blood sugar), levothyroxine (thyroid medication), furosemide (medication used to get rid of extra water in the body to help lower blood pressure), protonix (medication used to protect the stomach and reduce stomach acid).

Record review of R6's MAR, dated 09/01/2024 to 09/30/2024 showed R6 did not receive buspirone (medication for anxiety) on 09/02/2024 AM, 09/03/2024 PM, 09/04/2024 AM and PM, 09/05/2024 AM and PM, 09/06/2024 AM and PM, 09/07/2024 AM and PM, 09/08/2024 AM and PM, 09/09/2024 AM and PM, 09/24/2024 PM, and 09/25/2024 AM and PM. The record showed R6 missed 17 doses of buspirone in September 2024 due to medication non-availability as the reason for not receiving the medication. The MAR showed R6 did not receive atorvastatin (medication used to control cholesterol) on 09/03/2024 due to medication non-availability. The MAR showed R6 did not receive their scheduled medication spironolactone (medication used to get rid of extra water in the body to lower blood pressure) on 09/08/2024, 09/09/2024, 09/10/2024, 09/25/2024, and 09/26/2024 due to medication non-availability which resulted in five missed doses of spironolactone in September 2024. The MAR showed R6 did not receive their scheduled medication Eliquis (medication used to treat and prevent blood from clotting or known as a blood thinner) on 09/08/2024 AM and PM and 09/10/2024 PM which resulted in three missed doses due to medication non-availability in September 2024. The MARR6 did not receive their scheduled medication Losartan (a medication used to treat high blood pressure) on 09/08/2024, 09/10/2024 and 09/25/2024, 09/26/2024, 09/27/2024, and 09/28/2024 which resulted in six missed doses due to medication non-availability in September 2024. The MAR showed R6 did not receive their scheduled medication Insulin Glargine on 09/10/2024 due to medication non-availability. The MAR showed R6 did not receive their scheduled medication furosemide (medication used to get rid of extra water in the body to help lower blood pressure) on 09/26/2024, 09/27/2024 and 09/28/2024 which resulted in three missed doses due to medication non-availability. The MAR showed R6 did not receive their scheduled medication protonix (medication used to protect the stomach and reduce stomach acid) 09/25/2024, 09/26/2024, 09/27/2024 and 09/28/2024 which resulted in four missed doses due to medication non-availability.

Record review of R6's MAR, dated 10/01/2024 to 10/31/2024 showed R6 did not receive their furosemide, losartan, or protonix on 10/03/2024 due to medication non-availability.

Record review of the Reason for Admission section in the hospital visit summary for R6, dated ██/2024, showed that R6 was again hospitalized on ██2024. The note said R6 was discharged on ██/2024 with orders for azithromycin (antibiotic) and, as detailed in the physician's note, R6's POA did not think that the ordered medication from the previous hospitalization was ever filled nor provided to R6 after their discharge from the hospital on ██2024.

Record review of the "Hospital course, including complications" section in the document containing hospital notes for R6, dated ██2024, showed that R6 was admitted for

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"atypical pneumonia after which [R6] may not have received antibiotics [they] were prescribed. [R6] returned to hospital with increasing pain and shortness of breath with new O2 requirement thought to be related to incompletely treated community-acquired pneumonia versus anxiety or some overlap."

Record review of document titled "Observations for R6", dated 09/01/2024 - 11/12/2024, showed a note from Staff S, previous Director of Nursing (DNS) on [redacted]2024 at 10:30 AM that said " Resident c/o pain-Stabbing mid chest pain-radiating pain to left chest area, V/S: 117/77 78 02 sats: ranging from 89%-92% on RA. MD notified new order received to send resident to ER for evaluation, resident's son notified, EMS arrived at 10: 50 am-Resident exited facility @10:59."

Record review of Hospitalist assessment from 10/09/2024 showed R6 would require a home oxygen assessment for a newly acquired oxygen need.

Record review of R6's MAR, dated 11/01/2024 through 11/12/2024 showed R6 missed their levothyroxine (thyroid medication) on 11/08/2024 PM dose, 11/09/2024 AM and PM doses, 11/10/2024 AM and PM doses, 11/11/2024 AM and PM doses, and 11/12/2024 AM dose. The record showed R6 missed 8 doses over 12 days due to medication non-availability.

Record review of document titled "Observations for R6" showed a note from Staff E , Resident Care Assistant (RCA), on [redacted]/2024 at 10:15 PM that showed how staff received a fax from R6s PCP (primary care physician) regarding the original fax from staff that the resident complained of left sided chest pain. The response from R6's PCP resulted in the transport of R6 to the emergency department for evaluation and treatment.

Record review of R6's progress notes and MAR did not show consistent nor on-going attempts to obtain resident medication.

In an interview on 11/13/2024 at 3:40 PM, Staff O, Resident Care Assistant, said if resident medications were not in the cart, then staff were supposed to check the back- up supplies and then report to Staff E the missing or needed medication. Staff O said staff are then expected to document in the resident chart, however, Staff O also said staff are not consistent in this area if they have already notified the pharmacy. Staff O said staff are also expected to notify the provider of medication non-availability and to check with the pharmacy to confirm medication information.

In an interview on 11/13/2024 at 3:45 PM Staff E said staff should have been documenting interventions taken when medications were not available to administer to a resident. Staff E said the previous interim administrator educated staff on the medication non-available process and staff were instructed to call the pharmacy, ensure the prescription was correct and not expired, and document their attempts each time a medication was not available at the time of administration. Staff E said staff should document in the resident chart under observations for all attempts made.

In an interview on 11/13/2024 at 3:50 PM, Staff E said there had been times R6 has not received prescribed medications after R6 was discharged from the hospital.

In an interview on 11/14/2024 at 11:30 AM, R6 said their medications had not been coordinated very well and they had not received the medications prescribed for a while

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after their return from the hospital but did not know what staff it would do about if they said something.

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) Date

WAC 388-78A-2210 Medication services.

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

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

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

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility staff failed to follow physician orders for 3 of 9 residents (Resident 3 [R3], Resident 9 [R9], and Resident 7 [R7]). This failure placed R3, R7, and R9 at risk for falls and health complications by failing to follow physician's orders for medication services and patient monitoring.

Findings included...

Record review of the facility's policy titled, "medication services", dated 02/23/2018, showed no medication assistance or administration would be provided to the resident unless they had a written order from the prescribed physician or an electronic transmission of the order from the prescriber.

R3

Record review of R3's "Resident Information" document, dated 11/12/2024, showed R3 admitted to the facility on [redacted]/2024 and showed R3 had diagnoses of multiple

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and .

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R3 had a condition affecting 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 a discharge summary for R3, dated 08/14/2024, showed the reason for visit listed was falls. Record showed as the primary diagnosis under the health summary section.

Record review of R3's healthcare provider plan of care admission orders, signed 08/16/2024 by resident and physician, showed R3's primary diagnosis was with secondary diagnoses of and . The notes showed an order for staff to inform the PCP [Primary Care Physician] if SBP (systolic blood pressure, the top number on a blood pressure reading) was less than 100 or greater than 160 and if R3's pulse was less than 60 or greater than 110 beats per minute. The document listed primary diagnosis as with secondary diagnoses of and . The document showed R3 required staff assistance for medication and that staff will order and store medication for the resident, document in the eMAR (electronic medication administration record) and that only trained staff may assist R3 with medication administration.

In observations on 11/12/2024 at 11:16 AM, on 11/13/2024 at 3:16 PM, and 11/14/2024 at 10:20 AM, medications including diclofenac sodium 1% (a medicated ointment that reduces pain), Mucinex DM Max (cough medicine) and mupirocin antibiotic ointment (used to treat skin infections) were in R3's bathroom, accessible to anyone who entered R3's bathroom. This showed the facility did not store all of R3's medication as indicated in the provider's orders.

Record review of a fax from staff to R3's physician on 08/13/2024 at 8:25 PM, showed R3 had a reported pulse (heart rate) of 120. The physician reply to the fax was not sent until 09/23/2024 (41 days after it was sent) and there were no documented follow-up notes from staff after the initial fax was sent. At the bottom of the document, staff signature was dated 09/24/2024 (42 days after fax transmittal) and 09/28/2024(46 days after fax transmittal).

Record review of R3's Medication Administration Record, dated 10/01/2024 through 10/31/2024, showed R3's pulse on 10/23/2024 as 123 in the AM and 121 in the PM, on 10/24/2024 120 in the AM and 120 in the PM, on 10/25/2024 as 121 in the AM and 123 in the PM, on 10/26/2024 as 125 in the AM and 124 in the PM, on 10/28/2024 as 122 in the AM and 122in the PM, on 10/29/2024 as 122 in the AM and 127 in the PM, on 10/30/2024 as 123 in the AM and 122 in the PM and on 10/31/2024 as 124 in the AM and 124 in the PM.

Record review of R3's Medication Administration Record, dated 11/01/2024 through

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11/12/2024, showed R3's pulse readings on 11/01/2024 was 124 in the AM, on 11/02/2024 was 123 in the AM, on 11/03/2024 was 123 in the AM and 125 in the PM, on 11/04/2024 was 120 in the AM and 125 in the PM, on 11/05/2024 was 125 in the AM, on 11/06/2024 was 121 in the AM, and 124 in the PM, on 11/07/2024 was 122 in the AM and PM, on 11/08/2024 was 120 in the AM, 124 in the afternoon, and 123 in the PM, on 11/09/2024 was 123 in the AM and PM, on 11/10/2024 as 124 in the AM and 121 in the PM, on 11/11 was 121 in the AM and 123 in the PM, and on 11/12/2024 was 121 in the AM.

Record review of document titled medical record start date 10/11/2024 at 2:42 PM showed a note from 10/16/2024 at 10:55 AM that said, " HR remains greater than 120."

Record review of document titled "Observations for [R3]", dated 09/01/2024 through 11/12/2024, did not show documentation to support staff made efforts to notify R3's physician each time R3's pulse rate (heart rate) was above 110 beats per minute.

In an interview on 11/132024 at 3:55 PM, Staff E, Resident Care Assistant said they were the staff person who signed off on new orders for residents. Staff E also said they were not aware R3 had an order to notify the provider when R3's pulse was above 110.

In an interview on 11/13/2024 at 3:45 PM, Staff E, Resident Care Assistant, said staff were expected to follow all physician orders filed in the residents' charts when Staff E was asked about R3 admission orders that showed staff were to document and report to R3's physician when R3's heart rate was above 110 beats per minute.

Facility staff failed to follow orders to secure R3's medication and to report R3's elevated pulse rate to the physician, as ordered, resulting in unsecured medications in a memory care unit and at least 20 times during a 21-day period between 10/23/2024 and 11/12/2024 failure to report R3's elevated heart rate placing R3 at risk for poor health outcomes.

R7

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R7 moved into the facility on [redacted]2024.

Record review of R7's document, "resident information", dated 11/12/2024, showed R7 had multiple medical diagnoses that included [redacted]

Record review of R7's Service Plan, dated 10/25/2024, under the section titled, "medication", showed R7 was not able to take medication without assistance. Under the section titled, "additional nursing services", showed R7 required occasional/monthly nursing services such as scheduling of appointments and other services.

Record review of R7's After Visit Summary, dated 10/11/2024, showed R7's physician documented for R7 to continue to take their metformin (medication to help the body reduce the amount of sugar in the blood when a person has diabetes) 500 milligrams (mg) three times daily. R7's blood sugar was to be checked daily one time. If R7's blood sugar was consistently above 150 then R7's metformin would increase to 1000 mg two times daily.

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Record review of R7's Medication Administration Record (MAR), dated 10/01/2024 through 10/31/2024, showed R7 had an order for metformin 500 mg take three times daily before meals. R7's had an order to check their blood sugar daily before breakfast. If the blood sugar was over 150, the metformin was to increase to 1000 mg two times daily and fax the primary care physician. Review of R7's blood sugar readings for dates 10/12/2024 through 10/31/2024, showed R7's blood sugar was above 150 for 10 of the 19 readings. Under the section titled, "additional values gathered" on the MAR, showed on the days R7's blood sugar was above 150, R7 was administered an additional metformin. Review of the MAR showed there was no increase to the metformin to reflect the physicians order to administer 1000 mg two times daily. Review of the MAR showed there was no order to administer any additional dose of metformin if R7's blood sugar was above a certain parameter documented for review.

Record review of R7's MAR, dated 11/01/2024 through 11/12/2024, showed R7 had an order for metformin 500 mg three times daily given before each meal. R7 had an order for their blood sugar to be checked every day before breakfast. If R7's blood sugar was over 150 to increase metformin to 1000 mg two times a day and fax primary care physician. Review of R7's blood sugar readings showed nine of 12 blood sugar readings were over 150. Under the section titled, "additional values gathered" on the MAR, showed on the days R7's blood sugar was above 150, R7 was administered an additional metformin. Review of the MAR showed there was no increase to the metformin to reflect the physicians order to administer 1000 mg two times daily. There was no order to administer any additional dose of metformin if R7's blood sugar was above a certain parameter for review. Under the section titled, "additional values gathered" dated 11/03/2024, showed R7's blood sugar reading on 11/01/2024 was 155 and R7 did not require an additional metformin. R7's blood sugar reading on 11/03/2024 was 230 and showed R7 did not require an additional metformin. R7's blood sugar reading on 11/07/2024 was 160 and showed R7 did not require an additional metformin. R7's blood sugar reading on 11/13/2024 was 151 and showed R7 did not require an additional metformin. Review of the MAR showed there was no order to administer any additional dose of metformin if R7's blood sugar was above a certain parameter documented for review.

In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Assistant, stated R7's blood sugar checks every morning started on 10/12/2024. Staff E stated the medication technicians were administering an addition 500 mg of the medication metformin if R7's blood sugar was above 150. Staff E stated R7's metformin order that the medication technicians were administering was metformin 500 mg three times daily with meals with no parameters attached to the order. Staff E acknowledged that R7's metformin order needed to be clarified and R7's physician needed to be notified about R7's blood sugars being over 150.

In an interview and observation on 11/14/2024 at 11:39 AM, Staff Y, Resident Care Assistant stated they checked R7's blood sugar every morning before breakfast. Staff Y stated if R7's blood sugar was above 150, they would administer an additional 500 mg of metformin to R7 to take. Staff Y stated it was documented like that on the MAR. Staff Y showed the MAR on the medication computer and showed the metformin order was to administer 500 mg three times daily and another order to check R7's their blood sugar to be checked every day before breakfast. If R7's blood sugar was over 150 to increase metformin to 1000 mg two times a day and fax primary care physician. Observed the bottle of R7's metformin medication with a prescription label showed metformin 500 mg

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three times daily. There was no documentation to administer an additional dose of metformin if R7's blood sugar was over a specific number documented for review.

R9

Record review of R9's, "Healthcare Provider Plan of Care Admission Orders", signed by R9's primary care provider on 7/17/2024, indicated that R9 required staff assistance with medications.

Record review of R9's, "Washington Health and Service Evaluation Results", dated 7/31/2024, stated that R9 was evaluated to need "medication and/or over-the-counter medications" and "medication administration" of over-the-counter medications.

Record review of the facility provided document titled, "Observations for [R9]," dated 07/17/2024 at 4:45 PM, showed Staff E, Resident Care Assistant logged, "received admission orders and standing orders".

In an interview on 11/13/2024 at 4:42 PM, Staff E, stated the physician orders were how the facility staff tracked self-assessments for the residents.

Record review of R9 document titled, "Healthcare Provider Plan of Care Admission Orders" signed by R9's primary care provider on 7/17/2024, indicated that resident requires monthly weight and vital signs measurements to be conducted, along with specific parameters on when to notify primary care provider.

Record review of R9's MAR, dated 09/01/2024 - 09/31/2024, showed that R9's temperature was recorded from 09/18/2024 - 09/21/2024 but no other vital signs or weight measurements were present.

Record review of R9 MAR, dated 10/01/2024 - 10/31/2024, had no vital sign measurements recorded.

Record review of R9 MAR, dated 11/01/2024 - 11/12/2024, had no vital sign measurements recorded.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report to the Complaint Resolution Unit (CRU) for 1 of 9 sampled residents (Resident 2 [R2]). This failure to notify CRU placed all 69 of 69 Residents at risk of unreported abuse and prevented the department from evaluating facility systems in place to protect residents.

Findings included...

Record review of the facility's policy titled, "Incident Reporting – Unusual Occurrences", dated 03/30/2018, showed incidents would be reviewed by the resident care manager and other departments as applicable, investigated in a timely manner, with appropriate follow up or action steps taken to prevent reoccurrence. The documentation including the incident report forms would be kept confidential other than the facility mandated reporting agencies. Incident report examples included suspected abuse or neglect, any accident or injury of a resident that required an emergency room visit or admission to a hospital, significant injuries of unknown origin, and falls with or without injury. The procedures section showed incident reports which were determined to require DSHS (Department of Social and Health Services) notification would be done so by any staff member as a mandated reporter.

Record review of the Department of Social and Health Services book, "Assisted Living Facility Guidebook", dated February 2018, showed facilities were required to report 24 hours a day, seven days a week to the Departments CRU hotline via phone or online for any reasonable cause to believe violations that possibly involved abuse, neglect, or misappropriation. The document showed injuries of unknown source meant any injury sustained by a resident where the source of the injury was not observed directly by a staff, or not identified through a progress of a thorough investigation for a substantial injury, and the resident is not able to report/inform how the injury occurred. All injuries (regardless of the extent) occur in non-vulnerable areas of the body would be considered substantial injuries. Some examples of substantial injuries may include bruise of deep color, or those occurring in areas not generally vulnerable to trauma, such as the chest, breast, groin, and more. Review of the "reporting guidelines for assisted living facilities appendix d", showed injuries of unknown source either substantial, substantial reasonably related, and superficial, unknown was to be reported to CRU.

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R2

Record review of R2's document titled, "resident information", dated 11/12/2024, showed R2 moved into the facility on [redacted]/2023, with multiple medical diagnoses that included [redacted].

Record review of R2's fall report, dated 07/21/2024, showed R2 had a fall in the dining room. There were other residents present but were not good witnesses due to their various stages of dementia/memory issues. R2 was unable to clearly state what happened. The report under the section titled, "was other notified", showed there was nothing documented.

Record review of R2's incident investigation, dated 07/23/2024, under summary findings, showed R2 had multiple medical diagnoses but not limited to [redacted], was found in the dining room by a table. R2 was unable to state what happened or other people in the area due to their level of cognition. R2 appeared to hit their head and complained of severe pain that required the emergency medical services to come and evaluate R2. R2 was transported to the local emergency room for further evaluation. R2 returned to the facility the next day with a diagnosis of [redacted] and lab work.

In an interview on 11/20/2024 at 2:53 PM, Staff A, Marketing Director, said if a resident had a fall that resulted in a serious injury such as a fracture they would report it to CRU. Staff A said the facility would report the incident to CRU within 24 hours.

Record review of the Departments data base on 11/14/2024, showed the facility did not report the incident to the Department.

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________________________________ ____________________
Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

This requirement was not met as evidenced by:

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Based on observation, interviews, and record review, the facility failed to implement infection control practices by staff not performing hand hygiene during resident care for 2 of 2 staff (Staff E and Staff F) observed. This failure placed 69 of 69 residents at risk for cross contamination and infection when care and services were provided

Findings included...

Record review of the Centers of Disease Control (CDC) document titled, “about handwashing”, dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other person’s hands or common objects. Hands were to be washed often.

Record review of the CDC’s document titled, “clinical safety: hand hygiene for healthcare workers”, dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare personnel from being infected from germs received from the patient. Healthcare workers were to clean their hands before touching a patient, before moving from work from soiled to clean, after touching a patient or patient’s surrounding, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare works were to wash their hands with soap and water when their hands were visibly soiled.

Record review of the facility’s policy titled, “infection control”, dated 03/07/2018, showed staff were to wash their hands before handling medications, whenever staff change from doing a “dirty” task to a “clean” task. Staff could wash their hands with soap and water or with waterless cleaner.

Record review of the facility’s document titled, “infection control manual”, undated, under the section titled, “standard precautions”, showed standard precautions were treating all patients in the health care facility with the same basic level of “standard” precautions to involve work practices that were essential to provide a high level of protection to patients, healthcare workers and visitors. Some standard precautions included hand washing and antisepsis (hand hygiene) practices.

In an observation on 11/13/2024 at 11:51 AM, in the assisted living dining room Staff W, Medication Technician, was observed at a dining room table administering medications to Resident 29. Staff W, returned to the medications cart at 11:53 am, when they reached in their pocket pulled out the medication cart keys and unlocked the medication cart. Staff W unlocked the computer on top of the medication cart and pulled up a resident’s medication administration record (MAR). Staff W popped a residents’ medication in a medication cup and then closed the computer and the medication cart. Staff W left the medication cart and administered the medication to the resident. Staff W, was not observed to wash their hands or use waterless cleaner during that entire time. At 11:55 AM, Staff W, returned to the medication cart. Staff W turned

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the computer on and then reached into their pocket and pulled out the medication cart keys and unlocked the medication cart. Staff W pulled up Resident 20's [R20] MAR. Staff W, opened the locked narcotic box, popped out R20's tramadol (a prescribed pain medication). Staff W, then signed out the tramadol out of the narcotic box and locked up the computer and medication cart. Staff W, left at 11:57 AM and administered the medication to R20. Staff W was not observed to wash their hands or use waterless cleaner during that entire observation. When Staff W, was providing R20 their medication, Staff W, was observed to touch the handle of R20's wheelchair. Staff W, returned to the medication cart and unlocked the computer and pulled up Resident 30's [R30] MAR and clicked to administer their Tylenol (medication to help alleviate pain and discomfort) and oxycodone (a prescribed regulated pain medication). Staff W, reached into their pocket and pulled out the medication cart keys at 11:59 AM and unlocked the medication cart. Staff W opened the narcotic box and pulled out R30's oxycodone and popped it out into the medication cup. The oxycodone tablet fell onto the top of the medication cart. Staff W attempted to pick up the pill with the medication cup and then was observed to pick up the oxycodone tablet with their bar hands and placed it in the medication cup. Staff W grabbed a binder and signed out R30's oxycodone. At 12:01 PM, Staff W left the medication cart to administer the medication to R30. Staff W was not observed to wash their hand or use waterless cleaner during the observation. Staff W returned to the medication cart at 12:03 PM and opened the computer electronic system to administer Resident 7's [R7] medication metformin (prescribed medication to help lower high blood sugar levels). Staff W reached into their pocket and pulled out the medication cart keys and unlocked the medication cart. Staff W pulled out R7's medication bottles and put their metformin tablet in the medication cup. Staff W left to administer R7's medication to them at the dining room table. Staff W returned to the medication cart and opened the medication cart computer and pulled up Resident 4's [R4] MAR. Staff W reached into their pocket and pulled out R4's gabapentin (prescribed medication to help treat pain) and Norco (prescribed narcotic pain medication). Staff W opened the narcotic box and pulled out R4's Norco and signed the medication out of the narcotic binder. At 12:08 PM, Staff W left the medication cart to administer the medications to R4. Staff W grabbed R4's plate of ready to eat food to position it in front of the resident and then handed the medication to R4. At 12:13 PM, Staff W was observed to use waterless cleaner the first time since 11:51 AM and administered six residents their medications.

In an observation on 11/14/2024 at 11:52 AM, Staff F, Resident Care Assistant, was observed to serve residents trays with food while wearing gloves. Staff F then took off their gloves. Without performing hand hygiene, Staff F went over near the back window to position a resident in their wheelchair and adjusted the wheelchair wheel brakes. At that same time, R30 waved their empty glass to request a refill of their drink. Without performing hand hygiene nor putting on new gloves, Staff F went and took R30's empty glass and asked them if they wanted lemonade and went to retrieve more. When Staff F arrived at the juice machine, there was no lemonade in the machine, so Staff F went over to the cabinet, opened some cabinets and appeared to look for something, then returned to the juice machine and attempted to refill R30's cup with lemonade. Staff F adjusted the cup and held it by the very rim and returned the full cup to R30. After Staff F delivered the refilled beverage to R30, Staff F returned to the cart with trays and donned another pair of gloves without sanitizing nor washing their hands. With the new gloves on, Staff F then adjusted their clothing and subsequently opened the food cart and pulled out resident food to continue meal delivery amongst the residents.

In an interview on 11/4/2024 at 8:53 AM, Staff Y, Resident Care Assistant, stated they

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were to wash their hands before and after they administer any resident their medications.

In an interview on 11/14/2024 at 10:06 AM, Staff A, Marketing Director, stated the facility nurses oversighted the medication technicians to ensure that they were completing proper hand hygiene during medication administration to the residents.

Plan/Attestation Statement

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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 2 of 5 sampled Staff (Staff D and Staff P) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within the required time frames. This failure placed 69 of 69 residents and staff at risk for exposure to TB.

Findings included...

Record review of the Centers of Disease Control document titled, “Testing for Tuberculosis: skin test”, dated 04/22/2024, showed a TB skin test required two visits with a healthcare provider. If a person received a TB skin test, they would have two visits with the healthcare provider. During the first visit, the healthcare provider would inject a small amount of TB solution just under the skin on the lower part of the inner arm. On the second visit after two or three days, the person would return to the healthcare provider and have the skin test that was injected on the inner arm observed and determine if it was a positive or negative test result. Under the section titled, “two-step TB skin test”, showed if someone was a healthcare worker they would have a two-

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step TB skin test. The two-step TB skin test could lower the chance that boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the first-step TB skin test was classified as negative, a second-step TB skin test would be given one to three weeks after the first test was read.

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 facility policy titled " TB Test Policy," last updated "02/2010", said it was the responsibility of the Assisted Living Coordinator to ensure policies and procedures were carried out and the responsibility of the Human Resources Director and Supervisors to ensure testing process was started and completed. The policy further showed, "TB tests must be given no less than one and no more than three weeks apart, and 13. The test was read between forty-eight- and seventy-two-hours following administration by trained personnel and recorded in millimeters of induration. "

In an interview on 11/12/2024 at 9:45 AM, Staff A, Marketing Director, was introduced as the facility administrator.

Record review of the untitled and undated, document that was a list of the facility employees showed Staff A was hired 10/02/2017. Listed department category was 200-Admin.

Staff D

Record review of the untitled and undated, document that was a list of the facility employees showed Staff D, Housekeeper, was hired 10/01/2024.

Record review of facility provided documents of tuberculosis testing showed Staff D received a TB by Mantoux tuberculin skin test (TST) method on 10/02/2024. Record provided showed the remainder of the form was not filled out reflecting that the initial test was not read.
No other TB testing records were provided to review.

Records for Staff D showed that the TB testing series was not completed.

In an interview on 11/13/2024 at 12:31 PM, Staff L, Payroll Manager, acknowledged Staff D did not receive a completed TB testing series. Staff L said Staff D initiated a new TB testing series on 11/13/2024 with the plan that Staff M, Resident Care Services Registered Nurse (RN), would return to the facility on Friday 11/15/2024 to read Staff D's step one in the Mantoux tuberculin test series.

In an interview on 11/13/2024 at 12:35 PM, Staff L said Staff M was a nurse who worked at the facility with residents and served as the RN who conducted new employee TB

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testing.

In an interview on 11/13/2024 at 12:37 PM, Staff L said the facility had been updating their facility policy on TB testing as they had realized there were some employees that missed TB testing during the on-boarding process. Staff L said Staff M planned to administer TB testing Friday, 11/14/2024 to catch up some of those employees. Staff L said Staff D was included in the employee group for TB testing follow-up Friday, 11/15/2024.

In an interview on 11/13/2024 at 12:40 PM Staff L said they were responsible for most of the new employee on-boarding, however, once their portion was completed, new staff were referred to their respective supervisor who coordinated with Staff M to complete employee TB testing. Staff L said new employee supervisors shared responsibility with Staff L to ensure TB testing was completed for new staff.

In an interview on 11/13/2024 at 12:55 PM, Staff A said Staff D restarted their first series on 11/13/2024.

Staff P

Record review of the untitled and undated, document that was a list of the facility employees showed Staff P, Housekeeper, was hired 10/17/2024.

Record review of facility provided tuberculosis testing showed Staff P received a Mantoux tuberculin skin test (TST) on 10/21/2024 given on the right forearm.

Record showed the test was read on 10/23/2024 and was negative. Record showed the second test was administered on 11/13/2024 to right forearm and at time of the review the reading of that test was pending.

Records for Staff P showed that TB testing was initiated one day late (four days after start of employment).

In an interview on 11/13/2024 at 12:55 PM, Staff A said Staff P would receive their next series of TB testing on Friday 11/15/2024.

In an interview on 11/14/2024 at 2:20 PM, Staff A and Staff L acknowledged there were staff not in compliance with the TB testing regulations.

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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 keep resident records confidential for 1 of 1 facility reviewed. This failure placed all 69 of 69 residents at risk and allowed the public, visitors, and other residents to review private medical information without the resident's consent and a breach of confidentiality.

Findings included...

RCW 70.129.050 "Privacy and confidentiality of personal and medical records. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records."

Record review of the facility policy titled, "HIPPA [Health Insurance Portability and Accountability Act- a requirement to protect patients' sensitive information]", dated 10/09/2024 showed the facility respected the privacy of the resident's personal health information and were committed to maintain their confidentiality. The policy applied to all information and records related to the residents' care that the facility received or created. It also extended to information that was received and created by employees, staff, volunteers, and physicians. The facility was required by law to maintain resident privacy of their protected health information. The policy covered all resident that reside at the facility.

In an observation and record review on 11/12/2024 at 10:16 AM, in the Assisted Living dining room, on the two doors of the refrigerator that was beside a resident table were two white pieces of paper, posted on the outside of the doors. Record review of the piece of paper that was on the left side door showed in red bold print "Diabetics", dated 03/12/2024. Under the title "diabetics", showed Resident 24's [R24], Resident 25's [R25], Resident 28's [R28], Resident 11's [R11], Resident 6's [R6], Resident 16's [R16], Resident 26's [R26], Resident 27's [R27] first and last names were posted. R25's, R26's, and R27's name was crossed off with a black marker but was still able to read the first and last name. Below the list of resident names showed "please do not give concentrated sweets to these residents (oreo cookies, grandmas cookies etc.)" in red print. On the door to the right that had the second piece of paper had a title, "diabetic snacks", the showed there were two columns titled, 3:00 PM and 8:00 PM. Under both lists were a list of snacks for the diabetic residents. In red print it showed that no sugar was to be given for the diabetics. The document showed the caregivers were responsible to pass out snacks at 3:00 PM and 8:00 PM to the following residents that were listed that included R25, R24, R16, R27, R26, R28, and R15. R25, R24, R27, R26,

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and R15's names had been crossed off with a black marker, but were still able to read the room number, first, and last names.

In an observation on 11/12/2024 at 10:22 AM, behind the nurse's station showed multiple residents' medical charts that displayed residents first and last names and room numbers that were able to be read.

In an observation on 11/12/2024 at 10:31 AM, the "Smile" room door located by the nurse's station showed it had been propped open with a white bucket. There was no facility staff present inside of the room. On white typed sheets of paper that hung from the shelving unit showed there were care plan updates for R11, R12, R13, and R14.

In an observation on 11/13/2024 at 10:52 AM, inside the assisted living dining room, on the two doors of the refrigerators, the same pieces of paper with the nine resident's first and last names that identified they were diabetic were still posted for all resident, visitors, and staff to review.

In an observation on 11/13/2024 at 11:09 AM, the "Smile" room door located by the nurse's station showed it had been propped open with a white bucket. There had been no facility staff present inside of the room. On white typed sheets of paper there hung from the shelving unit showed there were care plan updates for R11, R12, R13, and R14.

In an observation on 11/13/2024 at 11:51 AM, in the assisted living dining room by the public accessible sink closest to the nurses' station and door of the dining room, was the medication technician's medication cart left unattended. The computer on top of the medication cart was open with the screen illuminating a picture of Resident 29 [R29] with their 12:00 PM medications calcium carbonate (a supplement taken to help replace calcium in the body's bones) and tums (a medication to help reduce stomach acid) medications listed for administration.

In an observation on 11/13/2024 at 4:43 PM, in Staff E's, Resident Care Assistant, office had been observed to tell Collateral Contact 3 (CC3), their child, to grab a hard medical chart for a resident from the nurse's station. CC3 left the room and returned to the office with a binder that resembled one of the resident's medical charts.

In an observation on 11/14/2024 at 8:24 AM, the "Smile" room door located by the nurse's station showed it had been propped open with a white bucket. There had been no facility staff present inside of the room. On white typed sheets of paper there hung from the shelving unit showed there were care plan updates for R11, R12, R13, and R14.

In an observation on 11/14/2024 at 8:40 AM, at the nurses' station counter, was a teal binder that was open with a page that showed it was prescription label, dated 11/14/2024 at 3:44 AM with R6's name. The prescription showed R6's first and last name, date of birth, R6's allergies to wasp venom protein, Ivig [immune globulins (a concentrated amount of antibodies to prevent infection or treat conditions)] and talwain [pentazocine (a medication to help relieve severe pain)], and an order for oxycodone 5 milligram tablet take one tablet by mouth every six house as needed for pain for up to three days, with a quantity of 12 tablets and no refills. The prescription was signed and dated by the physician on 11/14/2024.

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In an interview on 11/13/2024 at 1:32 PM, Staff H, Dietary Manager, said resident information should not be publicly posted or accessible to ensure confidentiality of resident records. Staff H stated to their knowledge the only information about diabetic residents had been inside of an unlocked drawer inside of the dining room. Staff H acknowledged that if a resident or visitor opened the drawer then they would be able to access residents' confidential information.

In an interview and observation on 11/14/2024 at 8:28 AM, Staff H was shown the outside of the refrigerator in the dining room that had a typed piece of paper of diabetic residents first and last names on it. Staff H acknowledged that the paper contained residents' confidential information on it.

In an interview on 11/14/2024 at 8:53 AM, Staff Y, Resident Care Assistant, stated anytime they left the medication cart unattended, they were expected to hit the minimize button on the medication cart computer screen to hide all resident's personal information on the electronic health record. Staff Y stated they were not to leave any resident's health record out and available for any other resident, family member, or visitor to review.

In an interview on 11/14/2024 at 9:05 AM, Staff E stated that one of the Licensors had asked a question about R9's medications when they asked CC3 to go and get R9's medical chart from the nurses' stations. Staff E acknowledged that CC3 should have not gotten R9's medical chart as CC3 was not an employee of the facility or a volunteer.

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, Sherwood Assisted Living 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:

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

(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

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to ensure residents were provided a ██████ Policy for 2 of 9 sampled Residents (Resident 3[R3] and Resident 9 [R9]). This failure placed both 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 R9's document titled, "Resident information", dated 11/12/2024, showed R9 moved into the facility on ████/2024.

On 11/12/2024 at 12:23 PM, the Department requested to review R9's signed ██████ policy. As of 5:00 PM, the Department had not received R9's ██████ policy for review.

On 11/13/2024 at 10:07 AM, the Department requested to review R9's signed ██████ policy.

Record review of an email sent to the Department on 11/13/2024 at 2:58 PM, the facility was unable to locate R9's signed ██████ agreement for the Department to review.

Record review of R3's document titled " Resident Information," dated 11/12/2024, showed R3 admitted to the facility on ████/2024.

Record review of R3's document titled "Sherwood Assisted Living ██████ Policy," dated 05/01/2017, showed R3 signed the form on ████/2024.
No other documents reflecting R3 received a ██████ policy prior to admission were provided to the Department for review.

In an interview on 11/13/2024 at 11:19 AM, Staff A, Marketing Director, said the ██████ policy agreements that were provided reflected the only ██████ policies on file signed by the residents or resident representatives.

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, Sherwood Assisted Living 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.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

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This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to meet the minimum requirements for fire safety per the state fire marshal regulations in 3 of 3 areas (Assisted living, South Hampton Memory Care, and staff utilized areas) within the facility with not having fire doors obstructed open. This failure placed 69 of 69 residents, staff, and visitors' life and safety at risk in the event of a fire.

Findings included...

Washington State Fire "Code IFC 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

Record review of a letter the facility provided titled, "To: the technical advisory group of the Washington state Building Code Council", dated 04/21/2009, showed it was a letter as to why the facility would be allowed to keep their doors propped open. The letter showed that the building built under nursing home specifications. The facility also provided a higher number of staffing other Assisted Living Facilities. The facility staff was equal and often higher than most nursing homes especially during the day and evening hours with 24-hour licensed nurses working. The letter showed that the current fire code regulation in 2009 was that resident rooms were to be closed at all times if not equipped with automatic door closures. At that time in 2009 the nursing homes were allowed to leave their doors open because of their staffing and building requirements. The letter showed they were asking the Washington state building code council to consider the facilities request to amend the building code and allow doors to resident's rooms be open in the assisted living building if staffing and building specifications met those required by nursing homes. There was no attached or provided letter of the determination from the Washington State Building Code Council decision for review.

Record review of the facility provided untitled and undated document that was provided on 11/12/2024, showed it was a list of employees that currently worked at the facility, and showed there was only one licensed nurse that was employed.

Record review of the facility provided Disclosure of Services, undated, that was provided to the Department on 11/12/2024, under the section titled, "intermittent nursing services", showed the facility typically had a registered nurse and a licensed practical nurse with no number of days or hours listed for review.

Record review on 11/12/2024 of the Departments databases, showed the facility did not have any documented exemptions or waivers listed for the facility being allowed to have fire doors propped open by an object against fire marshal standards.

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Assisted Living Unit

In an observation on 11/12/2024 at 10:05 AM, room 204's door had been propped open with a housekeeping cart. There was no facility staff present inside of the room.

In an observation on 11/12/2024 at 10:23 AM, room 214's door had been propped open with a stuffed teddy bear.

In an observation on 11/12/2024 at 10:23 AM, room 211's door had been propped open with a multicolor stuffed animal. There was no magnet on the back of the door that was holding the door open on the wall observed.

In an observation on 11/12/2024 at 10:34 AM, room 126's door had been propped open with a white stuffed teddy bear.

In an observation on 11/12/2024 at 10:34 AM, room 127's door had been propped open with no magnetic lock.

In an observation on 11/12/2024 at 10:40 AM, room 142's door had been propped open with a stuffed white teddy bear.

In an observation on 11/12/2024 at 11:00 AM, room 124's door had been propped open with a barney stuffed animal in a red shirt and blue pants.

In an observation and interview on 11/13/2024 at 10:56 AM, room ███ door was propped open with a brown stuffed animal. There was no magnet on the back of the door that was holding the door open. Resident 7 [R7], stated when they moved into the facility, they were provided the stuffed animal that had a bean bag sewed inside of it to keep the door propped open.

In an observation on 11/14/2024 at 8:23 AM, room 124's door had been propped open with a barney stuffed animal in a red shirt and blue pants.

In an observation on 11/14/2024 at 9:02 AM, room 217's door had been propped open with a red stuffed animal. At 10:23 AM the door remained propped open.

In an observation on 11/14/2024 at 9:02 AM, room 211's door had been propped open with a plaid plushie.

In an observation on 11/14/2024 at 9:03 AM, room 201's door had been propped open with a white bunny in a red sweater.

South Hampton Memory Care

In an observation on 11/12/2024 at 11:03 AM, room 112's door had been propped open with a stuffed panda bear.

In an observation on 11/12/2024 at 11:03 AM, room 109's door had been propped open with a stuffed bunny. There was no magnet on the door that was connected to the wall holding the door open observed.

In an observation on 11/12/2024 at 11:03 AM, room 108's door had been propped open

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with a brown stuffed bear. There was no magnet on the door that was connected to the wall holding the door open observed.

In an observation on 11/12/2024 at 11:04 AM, room 102, 103, 105, and 106 doors had been propped open with stuffed animals.

In an observation on 11/12/2024 at 11:08 AM, room A's (suite A per the facility document Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 11/12/2024) door had been propped open with a stuffed animal.

In an observation on 11/12/2024 at 11:10 AM, rooms 4, 6, and 8 doors had been propped open with stuffed animals.

In an observation on 11/12/2024 at 11:13 AM, room 8's door had been propped open with a multicolored stuffed animal.

In an observation on 11/12/2024 at 11:13 AM, the housekeeping closet door that was across from room 8, was not latched shut as there was a green towel that was on the ground in between the door and the door frame preventing it from shutting closed.

In an observation on 11/12/2024 at 11:16 AM, room 8's door had been propped open with an owl stuffed animal.

In observation on 11/13/2024 at 3:16 PM, room 8's door had been propped open with an owl stuffed animal.

In an observation on 11/14/2024 at 8:23 AM, room 124's door was observed to be propped own with a white teddy bear with a red shirt and blue pants.
There was no magnet on the door that held it open to the wall observed.

In observation on 11/14/2024 at 10:20 AM, room 8's door had been propped open with an owl stuffed animal.

In an observation on 11/14/2024 at 1:15 PM, room 8's door had been propped open with an owl stuffed animal.

Staff Offices/Areas

In an observation on 11/12/2024 at 10:22 AM, the staff lounge door had been propped open with a grey can with a green lid on top of it. There were no
employees inside the staff lounge area. There was no magnet on the door to hold the door open on the wall observed.

In an observation on 11/12/2024 at 10:31 AM, the "Smile" room door located by the nurse's station showed it had been propped open with a white bucket. There was no facility staff present inside of the room. At 11:13 AM, the "Smile" room door showed it still had been propped open with no staff present.

In an observation on 11/12/2024 at 10:56 AM, the activities room door had been propped open with a brown bear.

In an observation on 11/12/2024 at 10:56 AM, the activities director office door had

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been propped open with a green plastic fixture. There was no facility staff present inside of the room.

In an observation on 11/12/2024 at 12:16 PM, an unlabeled door located by the nurse's station showed it had been propped open with a wooden wedge. Behind the door it showed the oxygen storage room and the resident care manager office. Another unlabeled door located to the right next to the state survey binder showed it had also been propped open with a wooden wedge.

In an observation on 11/12/2024 at 12:45 PM, the outside of the facility towards the back parking lot showed the door that opened the refrigerator had been propped open with a black rubber crate. The door that opened the freezer had been propped open with a black rubber crate.

In an observation on 11/13/2024 at 10:48 AM, the "billing/payroll" office doors were propped open with a wedge that had red shoes and legs with black and white striped socks that was wedged under the bottom of the door. There were no employees inside the room at the time of the observation.

In an observation on 11/13/2024 at 11:09 AM, the "Smile" room door located by the nurse's station showed it had been propped open with a white bucket. There was no facility staff present inside of the room.

In an observation on 11/13/2024 at 11:32 AM, the broiler rooms door had been propped open with a wooden wedge.

In an observation on 11/13/2024 at 4:13 PM, the outside of the facility towards the back parking lot showed the door that opened the refrigerator had been propped open with a black rubber crate. The door that opened the freezer had been propped open with a black rubber crate.

In an observation on 11/14/2024 at 8:21 AM, the "billing/payroll" office doors was propped open with a wedge that had red shoes and legs with black and white striped socks that was wedged under the bottom of the door. There was no magnet on the door that was attached to the wall that held the door open.
There were no employees inside the room at the time of the observation.

In an observation on 11/14/2024 at 8:24 AM, the "Smile" room door located by the nurse's station showed it had been propped open with a white bucket. There was no facility staff present inside of the room.

In an observation on 11/14/2024 at 8:31 AM, the outside of the facility towards the back parking lot showed the door that opened the refrigerator had been propped open with a black rubber crate. The door that opened the freezer had been propped open with a black rubber crate.

In an observation on 11/14/2024 at 9:05 AM, the staff lounge door had been propped open with a grey can with a green lid on top of it. There was no magnet on the back of the door that was holding the door open.

In an interview and observation on 11/13/2024 at 10:11 AM, Staff G, Maintenance, stated all the doors in the facility were fire doors. Staff G stated the stuffed animals that

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were in front of the doors were provided by the activity department. Staff G stated the residents would sew a bean bag inside the stuffed
animals to help prop the doors open. Staff G at that time picked up the black teddy bear that was propping Staff A, Marketing Director's, office door open and the door began to close on its own. Staff G stated the hinges had springs in them that made the door closed automatically. Staff G pointed out that the door did not have a magnet that was connected to the fire system and had to be propped open with the stuffed animal. Staff G was then observed to replace the black stuffed teddy bear back in front of the door that held the door open. Staff G stated they were unaware if the fire doors were to be propped open. Staff G stated their supervisor that had been terminated from employment at the facility over two months prior, and they had they been the person to walk and complete the fire marshal inspections.

In an interview on 11/14/2024 at 8:44 AM, Staff G stated the state fire marshal when they came to visit every year mention and comment about the doors of the facility being propped open. Staff G did not elaborate as to what the fire marshal said about the doors being propped open. Staff G stated all doors were 60-to-90-minute fire doors.

In an interview on 11/14/2024 at 9:45 AM, Staff T, Housekeeper, stated they thought the doors in the facility were supposed to remain shut related to fire safety. Staff T stated they propped open resident room doors with the housekeeping cart when they were inside of a room to clean. Staff T said if the housekeeping cart propped open a door facility staff were supposed to be inside of the room. Staff T stated the stuffed animals that propped open doors within the facility were supplied by the activities department.

In an interview on 11/21/2024 at 1:33 PM, Collateral Contact 2 (CC2), State Fire Marshall, stated the facility was an Assisted Living Facility and nursing home guidelines did not apply. CC2 stated the letter provided from 2009 was irrelevant. CC2 stated the facility was not to use any object to prop any fire door open unless the facility had the magnet system that was connected to the fire system.

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, Sherwood Assisted Living 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-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and

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cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

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

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

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to secure potentially hazardous supplies accessible to memory care residents in 1 of 1 location within the facility (South Hampton Memory Care Unit). This failure placed 19 of 19 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the Alzheimer's Association document titled, "Home Safety", undated, showed as the Alzheimer dementia disease progresses, the person's abilities would change. Under the section titled, "how dementia affects safety", showed Alzheimer's disease caused a number of changes in the brain and body that would affect the person's safety that included forgetting how to use household items, becoming easily confused, and experiencing changes in vision. Under the section titled, "home safety tips", showed keep all cleaning products such as bleach out of sight, secured and in the original storage containers to discourage someone from eating or touching harmful chemicals.

Record review of the facility's policy titled, "Proper Cleaning Chemical Storage and Safety", undated, showed chemicals should be stored in unbreakable or double contained packaging, the storage cabinet should be able to hold the contents if the container broke, chemicals should be stored no higher than eye level and never on the top shelf of a storage unit.

Record review of the facility provided policy titled, "Safe Storage of Supplies and Equipment", dated 10/20/2024, showed the facility would secure potentially hazardous supplies and equipment with the assessed needs of residents and their functional and cognitive abilities. All housekeeping supplies would be locked in housekeeping carts when in used and housekeeping closet at the end of the shift and in a locked storage area.

Record review of the document titled, "Material Safety Data Sheet for Goo Gone", dated 08/14/2024, showed it had "warning, combustible liquid. Harmful if swallowed". The chemical could cause eye and skin irritation and could cause skin sensitization. The document showed should the chemical be swallowed it was harmful and could cause stomach distress, nausea or vomiting. The chemical had the following ingredients that included distillates petroleum (a complex mixture of hydrocarbons that were separated

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from crude oil or mild gasoline).

Record review of the document titled, "Material Safety Data Sheet", dated October 2011, for Gillette Series Shave Foam Sensitive Skin showed ingestion could cause stomach irritation, nausea, vomiting, and diarrhea. The list of hazardous ingredients showed there was propane (a colorless, flammable, and odorless gas), and 2-Methylpropane (a colorless, odorless gas that can burn and irritate the skin and eyes).

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed 16 of 19 residents who resided in the South Hampton memory care unit, were classified to have a diagnoses of

In an interview on 11/12/2024 at 11:03 AM, Staff A, Marketing Director, said there were 19 residents who resided in the South Hampton Memory Care Unit.

In an observation on 11/12/2024 at 11:07 AM, the South Hampton dining room showed on top of the refrigerator had been a bottle of one pound air list air freshener and a bottle of hand sanitizer. There were multiple residents observed to be inside of the dining room.

In an observation on 11/12/2024 at 11:08 AM, in the South Hampton's Jacuzzi room, the door was not latched shut and was unlocked. Inside the Jacuzzi room, in the unlocked cabinet were a tub of Clorox wipes (a disinfectant antimicrobial cleaning wipe), Gillette foamy sensitive skin sensible shave foam (a cream applied to the skin to shave/remove hair). Staff A acknowledged that the Department was able to get into the Jacuzzi room without the use of a key.

In an observation on 11/12/2024 at 11:13 AM, in the South Hampton hallway across from R3's room the hallway closet had been propped open with a green rag that was on the ground in between the door and the door frame. The hallway closet was able to be opened and inside the closet unlocked was a spray air freshener can that showed, "warning content under pressure, keep out of reach of children". There was an open bottle of consume nature's way cleaner, a spray bottle and a one gallon jug of "Spic and Span" odor eliminator and stain remover, one opened bottle that was half full of orange liquid and another opened bottle that was a quarter full of orange liquid, both that had a label of "goo gone"(a chemical that can remove grease, sticky messes, and stains from various types of surfaces).

R3

Record review of "Resident Information" document dated 11/12/2024 showed R3 admitted to the facility on /2024

Record review of the facility resident Characteristic roster, dated 11/12/2024, showed "A" in the medication column meaning R3 received medication administration services from the facility and in the column titled "Dementia/Alzheimer's/Cognitive Impairment", the box was checked that indicated R3 had a condition affecting their memory.

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Record review of R3's document titled "Pre-admission assessment," completed on [redacted]/2024, showed R3 had a mild memory impairment issue in the afternoon.

In an observation on 11/12/2024 at 11:16 AM, inside R3's bathroom, there had been a black metal shelf with a container that said mouthwash antiseptic, a tube of total toothpaste, and a tube of diclofenac sodium 1% (ointment that reduces pain). Below, behind the cabinet door was a bottle of baby oil, mouthwash, Cerave cream, Aveeno cream, and Mucinex DM MAX (cough medicine). On the wall above the toilet was a white cabinet. Inside the unlocked cabinet was a cleanse spray cleaner.

In an observation on 11/13/2024 at 3:16 PM inside R3's bathroom, there had been a black metal shelf with a container that said mouthwash antiseptic, a tube of total toothpaste, and a tube of diclofenac sodium 1% (ointment that reduces pain). Below, behind the cabinet door was a bottle of baby oil, mouthwash, Cerave cream, Aveeno cream, and Mucinex DM MAX. On the wall above the toilet was a white cabinet. Inside the unlocked cabinet on the bottom shelf was a cleanse spray cleaner, a bottle of nivea brand shaving cream, and a perianal skin cleanser. On the top shelf was a plastic bag with two tubes inside; one tube was mupirocin ointment (used to treat skin infections) and the other tube was toothpaste. On the sink was a bottle of Gillette brand shaving gel and a shaving razor.

In observation on 11/14/2024 at 10:20 AM inside R3's bathroom there had been a black metal shelf with a container that said mouthwash antiseptic, a tube of total toothpaste, and a tube of diclofenac sodium 1%. Below, behind the cabinet door was a bottle of baby oil, mouthwash, Cerave cream, Aveeno cream, and Mucinex DM MAX. On the wall above the toilet was a white cabinet. Inside the unlocked cabinet on the bottom shelf was a cleanse spray cleaner, a bottle of nivea brand shaving cream, and a perianal skin cleanser. On the top shelf was a plastic bag with two tubes inside; one tube was mupirocin ointment and the other tube was toothpaste. On the sink was a bottle of Gillette brand shaving gel and a shaving razor.

In an interview on 11/14/2024 at 9:45 AM, Staff T, Housekeeper, said no chemicals should be left throughout the facility. Staff T said all chemicals should be behind locked doors or in sight on the housekeeping cart. Staff T acknowledged that residents with Alzheimer's and dementia resided at 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, Sherwood Assisted Living 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

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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 follow and implement safe food handling and storing practices for 6 of 6 areas reviewed (kitchen, dry storage, refrigerator, freezer, Assisted Living Dinging, and South Hampton Memory Care Dining). These failures placed 69 of 69 residents at risk of receiving improperly handled food that was at risk for food-borne illnesses.

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 246-215-03351 "Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location;
(b) Where it is not exposed to splash, dust, or other contamination; and
(c) At least six inches (15 cm) above the floor.
(2) food in packages and working containers may be stored less than six inches (15 cm) above the floor on case lot handling equipment as specified under... "

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

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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 facility's policy titled, "Food Services Sanitation and Storing Food", undated, showed the facility policy was to provide residents with wholesome food prepared in a clean and sanitary environment. Food would be stored above the floor level to prevent contamination and permit easy cleaning. Food must be easily moveable so the floor underneath could be cleaned. Equipment and utensils would be maintained, cleaned, and sanitized.
Facility floors would be clean and in good repair.

Record review of the facility's policy titled, "Equipment Cleaning and Sanitizing", undated, showed the food service manager would conduct visual inspection of all equipment to be certain that it had been cleaned properly and follow up as necessary.

Record review of the facility's policy titled, "Infection Control", dated 03/07/2018, showed hand washing should occur before and after aiding residents with personal care task of daily living, before staff handled food, and whenever staff changed from a dirty task to a clean task. Dietary employees must wash their hands at the kitchen sink upon reentry of the kitchen.

Record review of the facility's policy titled, "Infection Control Manual", undated, showed staff were to change gloves between contacts with different residents. Staff were to wash their hands immediately after gloves were removed.

Cleanliness of the Kitchen and Freezer

In an observation and interview on 11/12/2024 at 12:24 PM four of four white bins in the kitchen were soiled with brown and orange substances. The bins had an unknown crusted substance that covered parts of the surfaces. Brown and orange substances were found embedded into the cracks of the container where the lid laid. Staff H, Dietary Manager, said when the bins were emptied was when they were last cleaned before they had been restocked. Staff H said the bins labeled oats and sugar had been cleaned and refilled one week ago, the bin labeled panko had been cleaned and refilled three weeks ago, and the bin labeled flour had been longer than three weeks because it had almost been emptied and needed to be restocked.

In an observation and interview on 11/12/2024 at 12:35 PM, the ice machine inside of the kitchen showed on the outside of the container had white crusted substance on the machine. The white powered substances congregated in the cracks and crevices of the machine. When the bottom half of the ice machine had been opened the back side of

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the white wall showed brown and orange substances. There had been an inside lip in the machine where yellow and orange substances built up and accumulated brown debris. The ice in the machine had been filled to where the ice had touched the unknown substances. Staff H said the machine had been cleaned approximately one month ago. Staff H said the kitchen staff did not keep records of when the machine had been cleaned to provide. Staff H had been observed to open the top half of the ice machine and that also contained orange and brown substances inside of it. Staff H opened the bottom half of the ice machine and used a paper towel to wipe the backside of the white wall. After Staff H wiped the white wall there had been yellow and brown residue on the paper towel. Staff H acknowledged that the ice machine had been soiled.

In an observation on 11/12/2024 at 12:41 PM, the freezer located outside of the building showed 7 of 7 wire racks had dirt, debris, and food particles underneath them. There had been a black mat that had horizontal indentations. Inside of the indentations had dirt, debris, unknown food particles, and a thick layer of ice that had food embedded into it. Pieces of clear tape had been observed on the freezer floor.

In an observation and interview on 11/13/2024 at 1:29 PM, four of four white bins in the kitchen remained soiled. Staff H stated the kitchen staff accidently kicked the bins when they worked in the area and that was why they had been soiled. The ice machine remained soiled. Staff H stated they had cleaned the ice machine and had worked with the facility staff maintenance to dissemble the machine to clean it further in approximately one to two days. Staff H said they would sweep the freezer floor as soon as the ice embedded onto the ground had been chiseled off. Staff H said the system in place for sweeping floor services had been when the facility staff saw that it became soiled then they would take care of it.

Food Storage

In an Interview on 11/12/2024 at 12:22 PM, Staff H said the food shipment got delivered today and they had not had a chance to put away the food. Staff H stated there would be food on the floor in the refrigerator, freezer, and in the dry storage area.

In an interview on 11/12/2024 at 4:00 PM, Staff H said it had been time to clock off work for the day.

In an observation on 11/12/2024 at 12:40 PM, the dry storage area showed in a box on the ground were 12 cans of V8 juice, 32 containers of cranberry juice, two 30-pound buckets of mayonnaise, one box of decaffeinated coffee, 13.36 pounds of Nestle hot cocoa mix, and 20 pounds of tree top apple sauce cups in a box on the ground. At 3:54 PM the food items in the dry storage remained on the ground.

In an observation on 11/12/2024 at 12:41 PM, the freezer located outside of the building showed six 10-pound boxes of jimmy dean sausage links on the ground. At 3:55 PM the sausage links remained on the ground.

In an observation on 11/12/2024 at 12:45 PM, the refrigerator located outside of the building showed one box of bacon on the ground. One box of pork that contained six pieces of pork boneless loin on the ground. A carton of eggs was placed on the ground. At 4:03 PM the food items in the refrigerator remained on the floor.

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In an observation on 11/13/2024 at 10:19 AM, the dry storage area showed two 30-pound buckets of mayonnaise on the ground.

In an observation and interview on 11/13/2024 at 4:13 PM, in the freezer located outside of the building showed six 10-pound boxes of jimmy dean sausage links on the ground. Staff H stated the facility contractors were the ones that moved the boxes back onto the ground after they had been picked up.

Hand Hygiene Assisted Living

In an observation on 11/12/2024 at 12:31 PM, Staff I, Cook, had been into the kitchen, without performing hand hygiene they donned (put on) a pair of gloves. Staff I had been observed to touch parchment paper and place that on top of a rectangular tray.

In an observation on 11/13/2024 at 11:45 AM, Staff J, Helper, had been observed to pass out macaroni and cheese salad on a tray to the residents without gloves on. Staff J had been observed to touch a resident's shoulder. Staff J went into the kitchen and did not perform hand hygiene. Staff J exited the kitchen at 11:49 AM and distributed a plate of food to a resident. Staff J went and retrieved a shirt protector from the cabinet and helped a resident tie it around their neck. Staff J had been observed to touch the resident's hair at 11:50 AM. Staff J reentered the kitchen and did not perform hand hygiene and exited the kitchen to serve two residents their food. At 11:57 AM staff J returned to the kitchen, did not perform hand hygiene, and touched the silver countertop with bare hands, then picked up food plates to deliver to the residents. At 12:07 PM, Staff J went to the juice station did not perform hand hygiene before they donned on black gloves.

In an observation on 11/13/2024 at 11:47 AM, Staff K, Resident Care Assistant (RCA), had been observed to escort a resident in their wheelchair to the dining table. Staff K did not perform hand hygiene before they retrieved and served the resident cranberry juice and silverware. At 12:07 PM, Staff K did not perform hand hygiene before they donned on a pair of black gloves. Staff K then touched the microwave door to open it and put soup on a tray. At 12:08 PM, Staff K doffed (removed) their gloves and did not perform hand hygiene.

In an observation on 11/13/2024 at 12:04 PM, Staff Q, Server had been observed to return to the kitchen and with their black gloved hands touched the silver countertop before they picked up food plates to deliver to the residents. At 12:11 PM, Staff Q touched the rim of the trash can outside of the kitchens opened door. Staff Q then returned to the kitchen without doffing their gloves and performing hand hygiene and picked up a resident's plate of food and delivered it to them.

In an observation on 11/13/2024 at 11:53 AM, Staff R, Helper, donned a pair of clear gloves without performing hand hygiene and then proceeded into the kitchen to get plates of food for the residents and drop it off to them. At 12:00 PM, Staff R had been observed to touch Resident 6 (R6)'s shoulder and then went into the kitchen to gather more residents' plates of food to deliver. Staff R returned to the kitchen and bypassed the hand washing sink and had been observed to get a drinking glass with ice and poured water into it. Staff R got a cup of orange juice off a table and then delivered the drinks to R6. At 12:04 PM Staff R got a can of tomato soup out of the cabinet and poured it into the bowl with the same pair of gloves they were wearing since 11:53 AM. At 12:08 PM Staff R doffed their pair of gloves but did not perform hand hygiene before

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they donned another pair of gloves. At 12:09 PM, Staff R opened the refrigerator inside of the dining room and proceeded to touch a rolling cart that had a tray of ice cream which they passed out to residents.

In an observation on 11/14/2024 at 11:55 AM, Staff R, donned a pair of gloves without performing hand hygiene.

In an observation on 11/14/2024 at 11:59 AM, Staff H had been observed to not perform hand hygiene or don on a glove before they picked up a green garnish bare handed and placed it on a resident's plate to be served.

Hand Hygiene Memory Care

In an observation on 11/12/2024 at 10:40 AM, no hand sanitizer had been observed upon entrance to the South Hampton, memory care unit.

In an observation on 11/13/2024 at 11:56 AM, Staff U, RCA, delivered premade plates of foods to the residents. At 11:57 AM, Staff U exited the dining room and went into an office in the memory care unit. Staff U returned within a minute and did not perform hand hygiene before they donned on a pair of gloves.

In an observation on 11/13/2024 at 12:00 PM, Staff V, RCA, had been observed to escort a resident into the dining room as the resident sat in their wheelchair and Staff V pushed. Staff V doffed their gloves they had worn and without performing hand hygiene they started to serve residents premade plates of food from a tray.

In an interview on 11/13/2024 at 1:32 PM, Staff H said that the facility staff were to wash their hands when they entered the kitchen. Staff H said the facility staff were to perform hand hygiene before they donned on gloves. Staff H said there should be no bare hand contact with ready to eat foods. Staff H said if a ready to eat food needed to be touched the facility staff would use utensils such as tongs or gloves.

On 11/14/2024 at 11:52, Staff F, Resident Care Assistant, had been observed to serve residents trays with food. Staff F then doffed their gloves. Without performing hand hygiene, Staff F went over near the back window to position a resident in their wheelchair and adjusted the wheelchair wheel brakes. At that same time, Resident 30 (R30) waved their empty glass to request a refill of their drink. Still, without performing hand hygiene nor donning new gloves, Staff F went and took R30's empty glass and asked them if they wanted lemonade and went to retrieve more. When Staff F arrived at the juice machine, there was no lemonade in the machine, so Staff F went over to the cabinet, opened some cabinets and appeared to look for something, then returned to the juice machine and attempted to refill R30's cup with lemonade. Staff F adjusted the cup and held it by the rim and returned the full cup to R30. After Staff F delivered the refilled beverage to R30, Staff F returned to the cart with trays and donned another pair of gloves without sanitizing nor washing their hands. With the new gloves on, Staff F then adjusted their clothing and subsequently opened the food cart and pulled out resident food to continue meal delivery amongst the residents.

Plan/Attestation Statement

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sherwood Assisted Living 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-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 2 of 2 sampled areas (South Hamptons Memory Care and Assisted Living) reviewed had the means to summon on duty staff in the common areas and failed to ensure wireless communication pendants performed reliably. These failures placed 69 of 69 residents, visitors, and staff at risk of not being able to summon staff when help was needed.

Findings included...

The South Hamptons Memory Care

In an observation on 11/12/2024 at 10:41 AM - 11:15 AM, a general tour of the South Hamptons memory care unit showed there were no call lights accessible for all the memory care residents, staff, and visitors available in the common hallways for use.

In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Assistant, said the facility does not provide pendants to the Hampton memory care residents. Staff E stated the memory care unit did not have call lights in the hallways that residents, staff, or visitors could utilize.

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Record review of R3's "Resident Information" document, dated 11/12/2024, showed R3 admitted to the facility on [redacted]2024.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed a box that was checked in the column titled "Dementia/Alzheimer's/Cognitive Impairment (conditions affecting thinking, memory, and decision-making), which indicated R3 has a condition affecting their memory.

Record review of R3's Service Agreement, dated 09/12/2024, showed R3 required an emergency pendant to communicate with staff as needed.

In an observation on 11/14/2024 at 1:15 PM, R3 did not have a call light pendant that was seen on nor near them.

Assisted Living

In an interview on 11/12/2024 at 1:30 PM, 22 residents and two resident representatives were present for a group meeting conducted by the Department. Resident 15 [R15] expressed concern about long call wait times and that sometimes it took over an hour for staff to show up and respond. Resident 19 [R19] stated the concern for long call wait times and stated sometimes the facility staff did not show up at all. Resident 11 [R11] recalled a time when a caregiver pushed their wheelchair away from their bedside and forgot to move it back before exiting the room. R11 pushed their call light because they needed assistance with going to the bathroom. R11 stated that when care staff showed up half an hour later with their breakfast tray, they had brought R11 their food because they thought that was why they pushed their call light and was unaware R11 requested assistance to get up out of bed to use the bathroom. Collateral Contact 5, Resident 20's Representative expressed concern for long call light wait times. R11 stated not all facility staff members had call light pagers to utilize.

In an interview and observation on 11/14/2024 at 11:02 AM, R15 stated they had ongoing concerns about how long it took to get a response from facility staff members after they had pushed their call light. R15 stated to their understanding the timeframe should not exceed 15 minutes of waiting. R15 said sometimes the wait time exceeded one hour and a half. At 11:06 AM the Department pressed R15's call light and no facility staff had followed up. The Department exited R15's room at 11:32 AM without a staff member responding to the call light that was pushed at 11:06 AM.

In an interview on 11/14/2024 at 9:01 AM, Staff W, Medication Technician, stated that all residents were provided pendants to utilize on the assisted living side of the facility. Staff W acknowledged there were no pull cords for residents to use in the assisted living common hallways or outside of the facility.

In an interview on 11/14/2024 at 11:00 AM, Staff E said they were unsure if the facility had a policy related to expectations on timelines of when staff answered resident call lights. Staff E stated the facility staff tried to answer call lights within 10 minutes.

In an interview and observation on 11/14/2024 at 11:34 AM, Staff Y, Resident Care Assistant, said if a resident pressed their call light, then it would come up on the screen at the nurse's station. Staff Y noted that the call light showing on the screen did not currently work. At 11:38 AM, observation of the screen at the nurse's station showed no

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way of knowing when a resident call light had been turned off or responded to by a staff member.

In an interview on 11/14/2024 at 11:40 AM, Staff G, Maintenance stated when a resident pressed their call light button the information showed up on the screen at the nurse's station and the pagers that the facility staff members had. Staff G stated there had been no way to know when the residents call light had been answered. Staff G stated not all the facility staff members and caregivers on shift carried a pager.

In an interview and observation on 11/14/2024 at 11:44 AM, Staff K, Resident Care Assistant, stated they did not have a call light pager on them. Staff K was observed to check their pockets and sweatshirt pocket and was unable to show the Department a call light pager. Staff K stated it was often that they would work on their shift without a pager as there was never any pagers available to carry. Staff K stated they would have to be at the nurses' station to know when a resident called for assistance if they did not have a pager on them.

In an interview on 11/14/2024 at 11:45 AM, Staff A, Marketing Director, stated the facility staff responded to resident call lights as quick as they could, but staff should be to the resident within 10 minutes to check in on them.

In an interview on 11/14/2024 at 1:03 PM, Staff A confirmed that the system at the nurse's station did not inform facility staff how long it took to answer resident call lights.

In an interview on 11/19/2024 at 9:01 AM, Collateral Contact 1 (CC1), Power of Attorney for Resident 8, said residents at the facility had to wait an excessive amount of time before their call lights were answered. CC1 said sometimes call lights were never answered all together.

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) ____________________ 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;

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(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 1 of 10 areas within the building (Resident 8 [R8]'s room). The facility failed to keep exterior grounds in good repair for 1 of 1 facility reviewed. These failures placed 69 of 69 residents at risk for to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility provided, "Disclosure of Services Required by RCW 18.20.300", dated 01/2023, showed all assisted living facilities must maintain resident living quarters and other areas residents would use in a safe, clean, and comfortable condition.

Record review of the untitled and undated document that was a list of the facility employees showed Staff G, Maintenance, was hired on 08/16/2017.

R8

Record review of R8's, "Resident Information", dated 11/12/2024, showed R8 moved into the facility on [redacted]/2010.

In an observation on 11/13/2024 at 11:13 AM, R8's bedroom wall showed behind their television on the backside of the walls wallpaper protruded out of the wall from the top of the ceiling to the bottom of the floor in a wrinkled wavy motion.

In an interview on 11/14/2024 at 8:47 AM, Staff G stated they had been aware R8 had a water leak in their room that caused their wall to have water damage. Staff G could not recall when the water leak took place. Staff G said they did not have plans in place of when R8's room wall would be fixed.

In an interview on 11/14/2024 at 1:03 PM, Staff A, Marketing Director, said they had been unaware R8 had water damage in their room, and it must have occurred a long time ago.

In an interview on 11/19/2024 at 9:01 AM, Collateral Contact 1 (CC1), Power of Attorney for R8, said that R8's wall had water damage for over 10 years. CC1 said historically the facility had a lot of problems with their roof and drains which caused the walls to leak. CC1 expressed concern that R8's room had mold inside of the walls. CC1 stated they talked to Staff G who acknowledged R8's room had the damage for the seven years that they were employed at the facility.

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Exterior of the Facility

In an observation on 11/12/2024 at 12:47 PM, the backside of the facility by the kitchen's refrigerator and freezer showed a bike rack had 12 cardboard
boxes stacked on the fixture. There were two nonskid black mats on the ground. In the corner a grey funnel had been on top of the rocks. A green crate box had been outside of the door. On the side of the wastebin showed two buckets with detergent and one bucket with rinse additive. A wire rolling rack that had a plastic cover on the bottom of the rack had leaves and water embedded into the plastic. A white and blue stripped hamper that had a soiled white rag inside of it. A wooden pallet had been propped upwards and leaned against the siding.

In an observation on 11/13/2024 at 4:13 PM, the backside of the facility by the kitchen's refrigerator and freezer showed a bike rack had 8 cardboard boxes stacked on the fixture. There were two nonskid black mats on the ground. In the corner a grey funnel had been on top of the rocks. A green crate box had been outside of the door. On the side of the wastebin showed two buckets with detergent and one bucket with rinse additive. A wire rolling rack that had a plastic cover on the bottom of the rack had leaves and water embedded into the plastic. A white and blue stripped hamper that had a soiled white rag inside of it. A wooden pallet had been propped upwards and leaned against the siding. At 4:18 PM the backside of the building past the garage showed a black frame and white lattice fence that had five white missing fence posts, one white post had been attached but leaned forward, and four white fence posts were off the fence and leaned up against the nearby shrubs.

In an observation on 11/14/2024 at 8:30 AM, the backside of the facility by the kitchen's refrigerator and freezer showed a bike rack had 4 cardboard boxes stacked on the fixture. There were two nonskid black mats on the ground. In the corner a grey funnel had been on top of the rocks. A green crate box had been outside of the door. On the side of the wastebin showed two buckets with detergent and one bucket with rinse additive. A wire rolling rack that had a plastic cover on the bottom of the rack had leaves and water embedded into the plastic. A white and blue stripped hamper that had a soiled white rag inside of it. A wooden pallet had been propped upwards and leaned against the siding.

In an interview on 11/12/2024 at 1:30 PM, 22 residents and two resident representatives were present for a group meeting conducted by the Department. Resident 11 (R11) stated their door lock had not been secure for their room. Collateral Contact 5, Resident 20's Representative, stated their door lock was not secure. R16 said the key to their room had the ability to open another resident's room. R11 expressed concern that when they left the facility on the weekends the backside parking lot had a lot of potholes. R11 stated it was scary to have to get off the sidewalk and use their wheelchair on the uneven surface. Multiple residents expressed concern for the uneven back parking lot.

In an interview on 11/14/2024 at 11:02 AM, Resident 15 (R15) stated they had ongoing concerns about their safety when they had to be in the backside of the facility's parking lot. R15 said they used a wheelchair and when they were pushed in the parking lot, they rattled all over. R15 said they had to take extra caution to ensure they did not fall out of their wheelchair.

In an interview and observation on 11/14/2024 at 8:32 AM, Staff G, Maintenance, stated

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the white lattice fence had been brittle and when the wind blew the posts would break. Staff G had been unaware of the facility plan to fix the fence. Staff G acknowledged the backside of the facility's parking lot had uneven surfaces throughout the area. Staff G stated the garbage trucks and propane trucks caused divots when they drove through the area. Staff G confirmed that the sidewalk next to the disabled parking spot was not level. Staff G confirmed the front entrance door had been closed on Sundays so if residents left the facility they would leave from the backside entrance.

In an interview and observation on 11/14/2024 at 9:34 AM, Staff A acknowledged the backside of the facility's parking lot had uneven surfaces throughout the area. Staff A stated the sidewalk that led to the parking lot had not been level. Staff A stated they had not had any residents report concerns to them about the area but could see how the uneven surface would be a concern. Staff A confirmed the front entrance door to the facility had been closed on Sundays. Staff A confirmed the white lattice fence had missing posts. Staff A stated that they knew in the future that the fence would become enclosed but to their knowledge there had been no current plans in place to fix the broken fence posts.

In an interview on 11/14/2024 at 8:56 AM, Staff W, Medication Technician, stated that Resident 5 (R5) liked to go outside, and they could not keep them out of the bushes. Staff W said R5 liked to strip off the leaves in the rhododendron. Staff W stated R5 had multiple falls and injuries related to them going outside and pruning the plants.

In an observation on 11/14/2024 at 10:53 AM, R5 had been observed to go out of the backside of the facility and started to pick the rose bushes. R5 had been observed to go off the sidewalk and walk along the white lattice fence. R5 started to pick at the rhododendron bush.

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) Date

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

(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:

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(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff F) completed the required continuing education required to provide care to vulnerable adults. This failure placed 69 of 69 residents at risk of receiving care by an unqualified staff member.

Findings included...

Record review of the untitled and undated document that was a list of the facility employees, showed Staff F, Resident Care Assistant (RCA), was hired 12/12/2017.

Record review of Staff F's Department of Health Credential Verification showed 09/28/2023 to 09/28/2024 as the last complete year for continuing education requirement review.

Record review of Staff F's training records showed 2.0 continuing education credits from 09/28/2023 to 09/28/2024.

In an interview on 11/14/2024 at 1:31 PM, Staff A, Marketing Director and Staff E, Resident Care Assistant, acknowledged they only provided two completed hours of continued education credits for Staff F's last birthday to their current birthday. Staff E stated the facility recently got the Relias system back and going forward would use Relias to track continued education credits. Staff A said Staff E would now be responsible to ensure facility staff trainings were 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, Sherwood Assisted Living 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

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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.

(3) The assisted living facility must provide a minimum of thirty days written notice to the residents and the residents' representatives, if any:

(b) Before the effective date of any voluntary decrease in the scope of care or services provided by the assisted living facility, and any such decrease in the scope of services provided will not result in the discharge of one or more residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a completed copy of their Disclosure of Services for 1 of 4 sampled newly admitted residents (Resident 9 [R9]). The facility failed to provide an updated copy of their Disclosure of Services when they decreased the scope of care in the services provided for 3 of 5 sampled older residing residents (Resident 1 [R1], Resident 5 [R5], and Resident 8 [R8]). The facility failed to provide personal care products for 1 of 9 sampled residents (Resident 7 [R7]) that was listed on the in-house facility supply list. These failures impacted 69 of 69 residents, resident representatives, and any visitor at the facility from having knowledge of what services the facility provided.

Findings included...

Record review of the facility's policy titled, "Disclosure of Services", dated "07/2005", showed the disclosure statement clearly identified the scope of care and services provided. The facility would provide the disclosure of services to any resident prior to admission and every 24 months thereafter. The resident and/or the resident representative would be provided with written notification of any changes of available services and costs for services at least 30 days prior to any change taking effect unless otherwise agreed upon by the resident and/or resident representative and the facility.

Record review on 11/12/2024 of the facility provided, "Disclosure of Services Required by RCW 18.20.300", undated, showed the facility administrator was Staff A, Marketing Director. The document showed the facility may change the services that were available and the charges for these services, by providing thirty days advance notice to residents. However, an assisted living facility must give the resident ninety days advance notice of any voluntary decrease in services that would affect your decision as to whether you would want to move to a different location or require you to move out. Under the section titled, "Intermittent Nursing Services", showed the facility typically had a licensed practical nurse and a registered nurse in the building without anything being documented for the number of days and total number of hours. Under the section titled, "personal hygiene", showed personal products provided were outlined on the "in-house supply list".

Record review of the facility's "2024 resident in-house provided supply list", undated, showed the facility was to supply paper towels and soap for the residents.

In an observation on 11/12/2024 at 10:24 AM, in the jacuzzi room, the soap dispenser on the wall was compressed without any soap being dispensed.

R7

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Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R7 moved into the facility on [redacted]/2024. In an observation and interview on 11/13/2024 at 11:29 AM, inside the bathroom of R7's room, there was no facility provided soap or paper towels available for use. R7 stated the bottle of lavender and chamomile purple liquid hand soap by the bathroom sink was brought from the previous place he lived at.

R9

Record review of R9's document titled, "resident information", dated 11/12/2024, showed R9 moved into the facility on [redacted]/2024.

The Department requested a copy of R9's signed disclosure of services on 11/12/2024 at 12:23 PM. As of 5:30 PM, the Department had not received R9's signed disclosure of services for review.

The Department requested a copy of R9's signed disclosure of services on 11/13/2024 at 12:27 PM.

Record review of an email sent to the Department on 11/13/2024 at 2:03 PM, showed Staff A, Marketing, said the facility could not locate R9's signed disclosure of services to provide for review.

R1

Record review of R1's document titled, "resident information", dated 11/12/2024, showed R1 moved into the facility on [redacted]/2020.

Record review of R1's "Disclosure of Services Required by RCW 18.20.300", dated 08/15/2021, under the section titled, "intermittent nursing services", showed the facility had a registered nurse in the building for seven days per week and total of 168 hours per week and a licensed practical nurse in the building for seven days per week totaling 120 hours per week.

R5

Record review of R5's document titled, "resident information", dated 11/12/2024, showed R5 moved into the facility on [redacted]/2022.

Record review of R5's, "Disclosure of Services Required by RCW 18.20.300", dated [redacted]/2022, under the section titled, "intermittent nursing services", showed the facility had a registered nurse in the building for seven days per week and total of 168 hours per week and a licensed practical nurse in the building for seven days per week totaling 120 hours per week.

R8

Record review of R8's document titled, "resident information", dated 11/12/2024, showed R8 moved into the facility on [redacted]/2010.

Record review of R8's, "Disclosure of Services Required by RCW 18.20.300", dated

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08/24/2021, under the section titled, "intermittent nursing services", showed the facility had a registered nurse in the building for seven days per week and total of 168 hours per week and a licensed practical nurse in the building for seven days per week totaling 120 hours per week.

In an interview on 11/13/2024 at 5:30 PM, Staff A, Marketing Director, stated anytime the facility changed the disclosure of services and decreased the amount of services provided to the residents, a new disclosure of services would be printed and provided to the resident or the resident representative for review and returned to the facility signed. Staff A stated the business office manager was responsible to send the letters out to all of the residents and the resident representatives if the facility's disclosure of services were changed. Staff A acknowledged the facility's current disclosure of services did have a decrease in licensed nurse services and should have been updated to all the residents and resident representatives for review and signature. Staff A stated all new residents would receive a copy of the facility's disclosure of services and sign that they received a copy prior to moving into the facility.

In an interview on 11/19/2024 at 9:01 AM, Collateral Contact 1, Power of Attorney for R8, said there were no nurses at the facility 24 hours a day 7 days a week as advertised.

In an interview on 11/12/2024 at 1:30 PM, Collateral Contact 5, Resident Representative for Resident 20, expressed concern that the facility did not have a nurse present at all times.

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Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

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This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to investigate, document investigative actions, and findings after becoming aware a resident developed a new skin impairment for 1 of 4 sampled residents (Resident 7 [R7]). This failure placed R7 at risk for further skin breakdown, infection, and medical complications.

Findings included...

Record review of the facility provided document titled, "incident report policy and procedure", dated 10/29/2024, showed the incident reports would be filled out by the charge nurse upon any incident including but not limited to skin problems. Documentation would be done at least 48 hours and/or continued until incident or issue resolved. The staff would use the facility "incident report" form for documentation of the incident. All information required on the form was to be done completely.

R7

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 11/12/2024, showed R7 moved into the facility on [redacted]2024.

Record review of R7's document titled, "discharge summary and plan", dated 10/01/2024, showed it was discharge orders from the skilled nursing facility R7 discharged from. The document showed R7 was discharged from the skilled nursing facility on [redacted]/2024 with order to have home health services for therapy and nursing services. R7 had multiple medical diagnoses that included [redacted] Under the section titled, "treatments", showed R7 skin was to be assessed for cellulitis (a bacterial infection that affects the skin and tissue below the skin's surface), had a sore on their left great toe that required to be cleaned with normal saline, antibiotic ointment applied three times daily and kept open to air, and barrier cream to be applied to his buttocks area. Under the section titled, "recapitulation of stay", showed R7 admitted to the skilled nursing facility for cellulitis of the left leg. R7 had an open area on their buttocks that had resolved and only required barrier cream. R7 had an open skin area to their left big toe that required treatment. R7 was to discharge to the facility by the facility's van.

Record review of R7's document titled, "observations", dated 09/01/2024 through 11/12/2024, showed there were no progress notes for dates [redacted]/2024 through 10/04/2024 that showed R7 had admitted to the facility.

Record review of R7's document titled, "observations", dated 10/10/2024 at 10:00 AM, showed R7's left buttocks cheek was slightly red.

Record review of R7's document titled, "observations", dated 10/10/2024 at 6:45 PM, showed R7's physician told the facility to apply zinc oxide barrier cream per the facility's protocol.

Record review of R7's document titled, "observations", dated 11/01/2024 at 9:30 PM, showed the medication technician was called into R7's room for a skin check on R7 buttocks. R7 had a bad open sore on their butt cheek. There were no further

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documentation for dates 11/02/2024 through 11/10/2024 about the open sore on R7 buttocks area for review.

Record review of R7's home health multi-disciplinary progress notes, dated 10/13/2024 through 11/12/2024, the progress notes dated 10/13/2024 through
11/05/2024, showed there was no documentation about wound care being provided to R7's open wound to their left buttocks.

Record review of R7's home health multi-disciplinary progress notes, dated 11/06/2024 at 10:45 AM, showed R7 had a new pressure sore to the left gluteal fold (buttocks). The open area was two centimeters by 0.1 centimeters with a pink and moist wound bed. The Registered Nurse (RN) applied zinc barrier cream and a mepilex (a specific type of bandage to put on the open area) four by four dressing to the area.

Record review of the facility provided incident and accident investigation's binder showed there was no incident report or incident investigation for review for R7's left buttocks open skin wound documented on 11/01/2024.

In an interview on 11/14/2024 at 11:00 AM, Staff E, Resident Care Assistant, stated there was no incident report completed or investigation for R7's open skin wound to their left buttocks. Staff E stated R7 admitted to the facility with the left buttocks open skin wound.

This WAC deficiency previously received a consultation on 09/09/2024.

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Administrator (or Representative) Date

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;

(ii) Indicate the date, day of week, month and year;

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

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This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure menus were posted in resident accessible areas for 1 of 1 facility reviewed. This failure placed 69 of 69 residents at risk of a diminished quality of life.

Findings included...

In an observation on 11/12/2024 at 11:50 AM, outside of the door in the hallway by Staff E's, Resident Care Assistant, office showed an "A" frame sign that had the weekly menu posted. The menu posted for the residents to view had the dates 10/20/2024 through 10/26/2024. There had not been a current weekly menu posted for review.

In an interview on 11/12/2024 at 1:30 PM, 22 residents and two resident representatives were present for a group meeting conducted by the Department. Resident 21 [R21] expressed concern that the menu was not provided ahead of time. R21 stated the residents had brought this to the facility's attention two months ago. Resident 11 [R11] agreed that they do not receive food menus ahead of time. Resident 22 [R22] stated that the facility staff did not always update the residents if they ran out of a menu item and served an alternative.

In an interview on 11/13/2024 at 1:30 PM, Staff H, Dietary Manager, stated they were the person responsible to update the facility menus posted on the bulletin board. Staff H acknowledged at times they forgot to update the menus for the residents to review.

In an observation on 11/13/2024 at 2:00 PM, the Department attended the facility's food forum meeting with Staff H and the facility residents. Residents expressed concern that the weekly menu had not been updated on the bulletin boards to review, and Staff H acknowledge that they had not been updating the menus for all the residents to review.

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