STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Summer Hill Operations, LLC
Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

RE: Summer Hill Assisted Living License # 2676

Dear Administrator:

This letter addresses Compliance Determination(s) 43419 (Completion Date 06/28/2024) and 39542 (Completion Date 04/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/28/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-a, WAC 388-78A-2610-2-f, WAC 388-78A-2240

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

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

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 off-site follow-up on 04/09/2024 and 04/09/2024 of:

Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

This document references the following SOD dated: 04/18/2024

The following sample was selected for review during the unannounced off-site verification: 7 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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

Residential Care Services   Date

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

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

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;

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

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 11 staff members (Staff H, Staff M, and Staff N) were fit tested for N-95 respirators (a device designed to protect the wearer from inhaling hazardous atmospheres including fumes, vapors, gases and particulate matter such as dusts and airborne pathogens such as viruses). This failure resulted in Staff H, M, and N using a respirator they were not fit tested for during a coronavirus (COVID-19) (an infectious disease caused by the SARS-CoV-2 coronavirus) outbreak and placed all residents at a higher risk of contracting and spreading a communicable disease.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed on 01/03/2024, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that the facility would have a system in place and the deficiency corrected by 02/17/2024.

Review of the Washington State Department of Health (DOH) website, titled "Respiratory Protection Program for Long-Term Care Facilities", (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program), showed that facilities were required to identify which employees would be exposed to a respiratory hazard, to fit test those employees who could potentially be exposed to a respiratory hazard, and to maintain the employees' fit test records. Facilities were required to provide initial and annual fit tests and to provide fit tested respirators to their employees.

Review of the ALF's Respiratory Protection Program, dated November 2023, showed staff

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were required to use N-95 respirators for tasks such as entering isolation rooms and other activities involving close contact with potentially infected persons. The program showed employees that were required by their employer to wear a respirator, shall be approved to do so after completing fit testing.

On 04/08/2024 at 9:53 AM, Staff A, Executive Director, stated that approximately two weeks prior the ALF experienced a COVID-19 outbreak.

Review of facility staff records showed Staff H, Director of Nursing, was hired on 05/23/2023; Staff M, Caregiver, was hired on 03/26/2024; Staff N, Caregiver was hired on 05/10/2022. There was no documentation that showed Staff H, Staff M, and Staff N completed fit testing for use of an N-95 respirator.

On 04/08/2024 at 10:31 AM, Staff A stated that Staff H, Staff M, and Staff N were unable to attend the one-day N-95 fit testing clinic the ALF had previously scheduled.

On 04/08/2024 at 11:28 AM, Staff A stated that the ALF used an outside agency to fit test their staff. Staff A stated that once there were a few staff that required testing, the facility contacted the outside agency to schedule fit testing at the ALF.

On 04/12/2024 at 1:53 PM, Staff H stated that at the beginning of April, there were nine residents confirmed with COVID-19. Staff H stated that they previously completed the N-95 fit test. Staff H stated that they were unaware of why their documentation was not complete. Staff H stated that they would try to obtain the documentation. Staff H confirmed that Staff M and Staff N did complete N-95 fit testing.

On 04/12/2024 at 2:38 PM, Staff N stated that they had not completed fit testing to wear a specific N-95 mask. Staff N stated that during the outbreak, they had chosen whatever N-95 mask was available outside the COVID-19 positive resident's room.

This is an uncorrected deficiency as to subsection 2(a) previously cited on 01/03/2024.

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, Summer Hill 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.

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

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 Assisted Living Facility (ALF) failed to obtain prescribed medications for 2 of 3 residents (Resident 2 and Resident 7). This failure resulted in Resident 2 missing 7 doses and Resident 7 missing 43 doses of prescribed medications and placed both Residents at risk for medical complications.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed on 01/03/2024, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement the facility would have a system in place and the deficiency corrected by 02/17/2024.

Review of the ALF's undated policy titled, "Medication Ordering and Delivery", showed resident medications were ordered and delivered in a timely and efficient manner to promote an excellent medication system. The policy showed that re-ordered medications may be forwarded from the pharmacy at pre-determined timeframes or staff may need to fax a reminder to the pharmacy for a medication that needed to be re-filled.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including a [redacted] [redacted].

Review of a Negotiated Service Agreement (NSA), dated 10/18/2023, showed Resident 2 required daily staff assistance with medications.

Review of a Physician Phone and Fax Numbers sheet, dated 04/06/2024, showed Resident 2 used the pharmacy services provided by the ALF.

Review of a Medication Administration Record (MAR) dated April 2024 showed Resident 2 was prescribed Aspirin (a mild pain reliever that can also reduce the risk of heart attacks)

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twice a day. The MAR showed Resident 2 missed seven doses of the prescribed Aspirin in April 2024 due to medication unavailability.

Resident 7

Resident 7 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

Review of an NSA, dated 10/16/2023, showed Resident 7 required daily staff assistance with medication management, which included management of medication reordering and refills. The NSA showed that Resident 7 received their medications from the pharmacy used by the ALF.

Review of a MAR, dated March 2024, showed Resident 7 missed a total of 36 doses of the following routine medications due to medication unavailability:

Cephalexin (a medication used to treat bacterial infections) twice a day for 14 days. Resident 7 missed a total of 11 doses.

Erthromycin (a medication used to treat bacterial infections) twice a day for 7 days. Resident 7 missed a total of 21 doses.

Vitamin D2 (a supplement of Vitamin D, a nutrient responsible for building and maintaining healthy bones) every Saturday. Resident 2 missed a total of four doses.

Review of a MAR, dated April 2024, showed Resident 7 was prescribed Advair Diskus (a medication used to treat symptoms of COPD including shortness of breath) twice a day. Resident 7 missed a total of one dose.

On 04/08/2024 at 4:20 PM, Staff G, Medication Technician, stated that staff were responsible for reordering medications if the resident received medications from the pharmacy used by the ALF. Staff G stated that medications should be reordered when staff begin to use the last bubble pack (a card that packages doses of medication within small, clear, or light resistant clear plastic bubbles that each hold medications) in stock.

On 04/08/2024 at 3:02 PM, Staff A, Executive Director, stated that the majority of their residents received medications through the pharmacy used by the ALF. Staff A stated that for those residents who used this pharmacy, the Director of Nursing or the Medication Technicians were responsible for reordering medications when the medication reached a certain level.

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This is an uncorrected deficiency previously cited on 01/03/2024.

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, Summer Hill 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.

Residential Care Services
Investigation Summary Report

Provider/Facility: Summer Hill Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2676
Compliance Determination #: 32215
Investigator: Christine Banta
Investigation Date(s): 11/06/2023 through 01/03/2024
Complainant Contact Date(s):

Intake ID: 101862
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Assisted Living Facility (ALF) staff did not do a pre-admission assessment before moving the Named Resident into the ALF.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 12 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Social services staff Business office manager
Record Reviews:	Medical records Incident investigation Facility policies Personnel files

Investigation Summary:
The ALF did not have a pre-assessment available for review for the NR and a sample resident. Failed facility practice found. A citation was written for WAC 388-78A-2070, Timing of preadmission assessment.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Summer Hill Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2676
Compliance Determination #: 32215
Investigator: Christine Banta
Investigation Date(s): 11/06/2023 through 01/03/2024
Complainant Contact Date(s):

Intake ID: 105491
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
There were residents and one staff that tested positive for COVID-1 at the ALF.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 12 Closed records sample size: 0
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Food preparation
Interviews:	Identified staff Nursing staff Residents Maintenance staff
Record Reviews:	Medical records State reporting log Facility policies

Investigation Summary:
Observation and interview showed there were five residents and one ALF staff that tested positive for COVID-19. The ALF did not notify the health department immediately and failed to make a report to the Department's hotline. The ALF did not have a required Respiratory Protection Plan and none of the staff had been fit tested for an N-95 respirator. A citation was issued for WAC 388-78A-2610 Infection control.

Conclusion / Action:

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- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

01/11/2024

Licensee: Summer Hill Operations, LLC
Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

RE: Summer Hill Assisted Living License # 2676

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 01/03/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

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

You Must:

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

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

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

Kimberley Ripley, Field Manager
Residential Care Services
Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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

You May:

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

In Addition, You May:

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

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

If You Have Any Questions:

- Please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Enclosure

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

3906-172nd St NE, Suite #100, Arlington, WA 98223

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 11/06/2023 and 11/08/2023 of:

Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

This document references the following complaint numbers: 101862, 105491.

The following sample was selected for review during the unannounced on-site visit: 12 of 48 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jodi Condyles, ALF Licensor
Christine Banta, Community Complaint investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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

________________________ Residential Care Services

____________ Date

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

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

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

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

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

(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 observations and interview, the Assisted Living Facility (ALF) failed to provide a safe, sanitary, well-maintained environment for 3 of 3 floors (Floor 1, 2, and 3). This failure resulted in unsanitary and unsafe conditions for all 48 residents and placed all residents at risk for injury and a decreased quality of life.

Findings included...

The ALF consisted of three floors. The following observations were made during a tour on 11/06/2023 beginning at 10:22 AM.

On the second-floor hallway, two electrical panels were unlocked and open allowing for access by residents.

On 11/06/2023 at 10:23 AM, Staff C, Maintenance Supervisor, stated that they had "no reason" why they [electrical panels] were unlocked. Staff C stated that they had locks in their office and would lock it up right away.

A 24x24 inch ventilation cover in the hallway by room 212 was loose on the upper left corner with sharp mental edges exposed.

A missing ceiling panel by room 219, measuring 12x24 inches was missing with wiring exposed.

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On 11/06/2023 at 10:32 AM, Staff C, Maintenance Supervisor, stated that the missing panel and exposed wires were due to the rewiring for wi-fi in the entire building and would replace the panel right away.

A ceiling panel above the entrance to the kitchen had a 5x5 inch brown liquid stain with dark brown/black mold growing from the center.

On 11/06/2023 at 10:35 AM, Staff C, Maintenance Supervisor, stated that they were not aware of the stained tile but would investigate and replace the panel right away.

The eye wash station at the entrance of the kitchen had a light gray transparent film behind the hot and cold handles of the facet and rusting around the base of the hot/cold water handles.

Outside on the back patio, the fence post to the left of a storage shed was broken at the base and was lying on the ground, leaving a gap.

A 20 ft. piece of base board trim was lying against the outside back wall of the patio with nails exposed.

On 11/06/2023 at 11:12 AM, Staff C stated that they would remove the trim and did not know why it was there.

The storage closet on the first floor housing the facilities hot water tanks had a stained toilet seat sitting between the tanks. The closet door on the right side was warped and had water damage at the bottom edge. The wall next to the closet door also had water damage along the bottom edge.

On 11/06/2023 at 11:19 AM, Staff C stated that this damage was there before they had been hired.

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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, Summer Hill 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 246-215-06525 Methods Drying mops (FDA Food Code 6-501.16). After use, mops must be placed in a position that allows them to air dry without soiling walls, equipment, or supplies.

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 and interview, the Assisted Living Facility (ALF) failed to place two mops in the kitchen storage closet off the ground to allow them to air dry. This failure resulted in mops not drying properly and placed the kitchen at risk for contaminating surfaces and unsanitary conditions for all 48 residents.

Findings included…

During the environmental tour on 11/06/2023, two wet mop heads were observed in the kitchen closet. The two mop heads were faced down in the supply closet sink basin preventing them from drying.

On 11/06/2023 at 10:54 AM, Staff A, Executive Director, stated that the night staff usually took care of the mops.

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, Summer Hill 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-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff

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person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1of 6 staff (Staff C) was screened for tuberculosis (TB) within three days of hire. This failure resulted in one staff member not having TB screenings before working with residents and placed 48 residents at risk of possible exposure to a communicable disease.

Findings included...

Record review of staff files showed Staff C, Maintenance Supervisor, was hired on 06/26/2023. There was no documentation showing TB was completed within three days of hire.

On 11/07/2023 at 1:17PM, Staff F, Administrator Assistant stated that there was no TB test done at time of hire due to no facility in the area providing testing.

On 11/08/2023 at 10:44AM, Staff C stated that they had not completed TB testing when they were hired.

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, Summer Hill 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-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not

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limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to maintain employment documentation for 1 of 6 staff (Staff E). This failure resulted in Staff E's employee file not including any information showing completion of Orientation and Safety training or continuing education credits.

Findings included...

Review of staff files on 11/07/2023 at 1:20 PM, showed Staff E was rehired on 10/11/2019. There was no record that Staff E completed the 5-hour Orientation and Safety training and no record that Staff E completed 12 hours of continuing education training.

On 11/07/2023 at 1:25PM, Staff F, Administrative Assistant, stated that they had reviewed the files and there was no documentation found for Staff E's continuing education requirement.

On 11/07/2023 at 1:25PM, Staff A, Executive Director stated that the business had been recently sold and the new ownership was using a different computer/documentation system and thought items were missing or unavailable due to the change in ownership.

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, Summer Hill 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-2610 Infection control.

(2) The assisted living facility must:

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

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for

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

preventing and controlling the spread of infections;

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure they had a respiratory protection program (RPP) and ensured 10 care staff (Staff B, D, E, H, I, J, K, L, M, and N) were fit tested for N-95 respirators. This failure resulted in care staff not being prepared for a communicable disease outbreak at the ALF and placed all residents, staff, and visitors at risk of contracting a communicable disease.

Findings included…

Review of the Washington Administrative Code (WAC) 296-842-15005, Conducting fit testing, showed the ALFwas to provide, at no cost to the employee, fit test for all tight-fitting respirators on the following schedule: Before employees are assigned duties that may require the use of respirators.

Review of the Departmentof Health's Respiratory Protection Program for Long-TermCare Facilities (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program)showed there were five steps to the Respiratory Protection program: a written program, respirator medical evaluation, training, fit testing, and record keeping.

Review of the Assisted Living Facility Guidebook Partners in Protection, dated February 2018, page 26 Appendix D showed when there is a communicable disease outbreak, the ALF is required to report to the DSHS hotline and to the local health department.

Review of the ALF's policy "Infection Prevention and Control for Suspected or Confirmed COVID-19", dated 03/02/2020, showed the policy was created to minimize exposures to respiratory pathogens and promptly identify residents with clinical features and an epidemiologic risk for the COVID-19 and to adhere to Standard, Contact and Airborne Precautions, including the use of eye protection. The policy showed when there was a resident with suspected COVID-19, the ALF staff is to immediately contact the local health department. The policy also showed in the event of a facility outbreak, the ALF would make an "immediate" report and consult with public health department. The policy showed if the facility is using a Fit-tested NIOSH-Certified disposable N95 respirators, staff must be medically cleared and fit-tested and trainer prior to use.

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

On 11/06/2023 at 9:45 AM, Staff A, Executive Director, stated that there were two residents who tested positive for COVID-19 that day and were quarantined in their rooms. Staff A stated that Staff B, Director of Nursing, had also tested positive for the virus and stayed home.

On 11/07/2023 at 11:30 AM, Resident 8 was observed on a stretcher being taken to an ambulance by medics.

On 11/07/2023 at 12:45 PM, Staff A stated that 911 was called after Resident 8 was seen breathing heavily in the dining room. Staff A stated that Resident 8 was transported to the Emergency Department. Staff A stated that they would have to reach out to Staff G, Regional Administrator, regarding the ALF's RPP and was unable to explain if they had a RPP. Staff A stated that they had not contacted the local health department.

On 11/07/2023 at 1:10 PM, Staff A stated that no formal procedure was put in place after the first two positive cases. Staff A stated that the current protocol for a communicable disease response was, when something came up they would check with the Centers for Disease Control and Prevention.

On 11/07/2023 at 2:48 PM, Staff A stated that Resident 8 had tested positive for COVID-19. Staff A stated that they instructed staff to start wearing masks and encouraged residents to start distancing. Staff A stated that Staff B was getting everything ready to contact the local health department. Staff A stated that the ALF's previous owners were supposed to have had a RPP in place and conduct fit testing for the staff in 2022 but it was not done. Staff A stated that Staff G had just sent over a list of contractors to get the ALF staff fit tested.

Review of staff list showed 10 staff (Staff B, D, E, H, I, J, K, L, M, and N) were identified as care givers/med techs.

On 11/08/2023 at 10:00 AM, Staff A stated that two more residents tested positive for COVID-19 that morning.

On 11/08/2023 at 2:31 PM, Staff L, Caregiver, stated that they were not fit tested at the ALF but was fit tested 3 years ago at a different facility.

On 11/21/2023 at 1:29 PM, Collateral Contact 1 (CC1), local health department representative, stated that they received an email from the ALF notifying them of the positive COVID-19 cases on 11/07/2023.

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, Summer Hill 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 interview and record review, the Assisted Living Facility (ALF) failed to investigate an incident for 1 of 1 sample residents (Resident 1) when Resident 1 was found on the floor. This failure resulted in the ALF not having a documented incident report or investigation to rule out abuse and neglect or identify preventative measures and placed Resident 1's safety at risk for unmet care needs.

Findings...

Review of the Assisted Living Facility Guidebook; Partners in Protection, dated 02/2018, Chapter 2 showed all alleged incidents of abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation must be thoroughly investigated. This investigation is done to determine what occurred and to make necessary changes to the provision of care and services to prevent reoccurrence. In order for the facility to provide evidence of the thoroughness of the investigation, the information must be documented. Chapter 2 of this guidebook covers the investigation process. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

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

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 1's progress notes from 11/02/2023 showed Resident 1 was found on the floor of the ALF lounge. The progress note showed Resident 1 sensed a seizure approaching and attempted to get back in the building and did not make it to a chair.

On 11/08/2023 at 2:12 PM, Staff A, Executive Director, stated that they did not have an incident report when Resident 1's was found on the ground on 11/02/2023.

On 11/22/2023 at 3:44 PM, Staff B, Director of Nursing, stated that they did not do an incident report because it was known that Resident 1 had a history of seizures and puts themselves on the floor.

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, Summer Hill 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 interviews and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 7 residents' (Resident 1 and 2) medications were obtained. This failure resulted in several days of missed medications for Resident 1 and 2 and placed them at risk medical complications and not having their medication needs met.

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Findings...

Review of the facilities undated medication policy showed the ALF would provide medications to residents in a timeframe and in a manner that promotes health and welfare. The policy showed all medications that are the responsibility of the ALF would be re-ordered from the pharmacy at a pre-designated and negotiated timeframe with the pharmacy. If the ALF employs a licensed nurse, the designated staff person will contact the nurse, who 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.

Review of the facilities Disclosure of Service showed Section 4 “Help with Medications” states that the facility must assist the resident with medications if requested by the resident. The facility will deliver medications to the resident’s apartment at the physicians prescribed times.

Resident 1

Resident 1 was admitted to the ALF on /2023 with multiple diagnoses including and .

Review of the temporary service plan dated 10/12/2023 showed Resident 1 would receive medication assistance from the ALF, including refills.

Review of the Medication Administration Record (MAR) for October 2023 showed Resident 1 did not receive a total of 170 doses of the following routine medications due to “prior authorization needed” or “medication unavailable”:

Docusate Sodium (Stool softener) 100mg (milligram) tabs twice daily. Resident 1missed a total of 16 doses.

Fluoxetine 20mg (antidepressant) tab one tab daily to start on 10/12. Resident 1 missed a total of seven doses.

Gemfibrozil 600mg (treats high cholesterol) take one tab twice daily to start on 10/12. Resident 1 missed a total of 16 doses.

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Lacosamide 200mg (prevents seizures) twice daily to start on 10/11. Resident 1 missed a total of 16 doses.

Lamotrigine 200mg (prevent seizures) every morning to start on 10/11. Resident 1 missed a total of eight doses.

Lamotrigine 100mg tabs to be given in the evenings. Resident 1 missed a total of six doses.

Levetiracetam 500mg (prevent seizures) two tabs by mouth twice a day; Resident 1 missed a total of 14 doses.

Levothyroxine 100mg (thyroid supplement) once daily. Resident 1 missed a total of seven doses.

Metformin 500mg (helps blood sugar) once daily. Resident 1 missed a total of seven doses.

Mirtazapine 15mg (antidepressant) once daily. Resident 1 missed a total of seven doses.

Olanzapine 20mg (antipsychotic) once daily. Resident 1 missed a total of 14 doses.

Omeprazole 20mg (treats heartburn) once daily. Resident 1 missed a total of seven doses.

Propranolol 10mg (treats blood pressure) once daily. Resident 1 missed a total of seven doses.

Spiriva inhaler 18 micrograms (mcg) once daily. Resident 1 missed a total of seven doses.

Topiramate 100mg (anticonvulsant) three times a day. Resident 1 missed a total of 21 doses.

Venlafaxine 75mg once daily (antidepressant). Resident 1 missed a total of 10 doses.

On 11/27/2023 at 2:56 PM, Staff B, Director of Nursing, stated that they would notify the pharmacy when they did not have a medication and it was the pharmacy's job to ask for a refill. Staff B stated that the medication technicians would write "prior authorization needed" when they did not receive the medications from the pharmacy. Staff B stated that they did not notify any of Resident 1's prescribing doctor that Resident 1 had multiple missed doses of different medications and needed refills on them immediately.

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Review of Resident 1's progress notes from [redacted]/2023 to 11/02/2023 showed no communication between the ALF staff and the physician clinic regarding the resident missing medications.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Review of the Negotiated Service Agreement dated 10/16/2023 showed that the facility will provide daily medication assistance and will be responsible for all refills of medications.

Review of the Medication Administration Record (MAR) for October 2023 showed Resident 2 did not receive the following routine medications:

Doxazosin 4mg twice a day (8:00am and 8:00PM) from 10/16/2023 through 10/31/2023, a total of 30 doses. The MAR showed" prior authorization needed" was documented as the reason why the medication was not given as ordered.

Estradiol Cream, apply three times per week (Monday, Wednesday, Friday) from 10/16/2023 through 10/31/2023, a total of 8 doses. The MAR showed "prior authorization needed" was documented as the reason why the medication was not given as ordered.

On 11/08/2023 at 11:15AM, Staff D, Medication Technician, stated that the prior authorization needed on the MAR meant there was an order sent to the pharmacy for the medication, but the facility had not heard back from the pharmacy. The medication technicians continued to document prior authorization needed.

On 11/08/2023 at 11:45 AM, Resident 2 stated that the facility provided medication they needed to take. Resident 2 stated that medication technicians would deliver the medications to their room. Resident 2 stated that if they had planned on being out of the facility, they would meet the medication technician at the medication cart to take the scheduled medications.

On 11/27/2023 at 3:50 PM, Collateral Contact 5, physician's clinic nurse stated that the

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clinics medication record for Resident 2 showed Doxazosin 4mg twice a day was an active order, and the facility should have provided it to the resident. Per clinical records for Resident 2, the physician had not been contacted by the facility regarding any medication related issues including medications as ordered.

On 11/27/2023 at 3:56 PM, Collateral Contact 4, pharmacist, stated that the pharmacy had been aware of the Doxazosin 4mg twice a day and Estradiol Cream. They had sent three faxes to the physician for clarification for the specific medications. The fax was sent on 10/18/2023, 10/20/2023 and 10/23/2023 with no confirmation from the physician. Due to the physician's lack of communication, the pharmacy considered the medications cancelled as of 10/23/2023 and did not refill.

On 11/28/2023 at 1:57PM, Staff B, Director of Nursing stated that they had contacted the physician and the pharmacy to request clarity regarding several medications including the Doxazosin and Estradiol Cream. On 10/30/2023 the pharmacy responded to Staff B stating that the Doxazosin was discontinued on 10/18/2023. Staff B stated that they couldn't show documentation that they contacted the physician or pharmacy by phone as they have no tracking system for such calls.

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-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 7 residents (Resident 1) had a pre-admission assessment completed prior to moving into the facility. This failure resulted in ALF staff not having an identified care plan for Resident 1's seizures and placed Resident 1 at risk of unmet care needs.

Findings included...

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

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

On 11/08/2023 at 1:54 PM, Staff G, Regional Director, stated that they had done the pre-admission assessment for Resident 1 prior to move in and that the pre-admission assessment was in the chart.

On 11/09/2023 at 3:30 PM, Resident 1 stated that he wanted to move into the ALF because he thought he would like it better and wanted to be with a friend who lived at the ALF.

Review of Resident 1's file showed no documented pre-admission assessment. The file contained a DSHS Summary Service, dated 08/10/2023, and was signed by the social worker in September 2023. The Service summary did not include Resident 1's medical history or a list of their medications.

On 11/30/2023 at 11:50 AM, Staff A, Executive Director, stated that they review the DSHS assessment but also do their own pre-admission assessment.

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

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