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

Sunrise Senior Living Management Inc
Sunrise of Redmond
15241 NE 20TH ST
BELLEVUE, WA 98007

RE: Sunrise of Redmond License # 2464

Dear Administrator:

This letter addresses Compliance Determination(s) 28816 (Completion Date 09/01/2023) and 24508 (Completion Date 06/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/01/2023 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-2140-1-a-ii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-2, WAC 388-78A-2140-3, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3, WAC 388-78A-2464-2, WAC 388-78A-2464-1, WAC 388-78A-2464, WAC 388-78A-2210-1-b, WAC 388-78A-2466-1-a, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-2090-6-e

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

Sincerely,

Laurie Anderson, Field Manager
Region 2, Unit D

Residential Care Services

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

| Statement of Deficiencies | License #: 2464 | Compliance Determination # 24508 |
|---|---|---|
| Plan of Correction | Sunrise of Redmond | Completion Date |
| Page 1 of 19 | Licensee: Sunrise Senior Living Management Inc | 06/20/2023 |

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 05/22/2023, 05/22/2023, 05/25/2023, 05/26/2023 and 05/25/2023 of:
Sunrise of Redmond
15241 NE 20TH ST
BELLEVUE, WA 98007

The following sample was selected for review during the unannounced on-site visit: 7 of 58 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

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

Laurie Anderson
Residential Care Services

06/21/2023
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.

DSHS/ALTSA
Residential Care Services
JUN 28 2023
Received

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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



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

The department completed data collection for the unannounced on-site full inspection on 05/22/2023, 05/22/2023, 05/25/2023, 05/26/2023 and 05/25/2023 of:

Sunrise of Redmond
15241 NE 20TH ST
BELLEVUE, WA 98007

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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)

6/27/23
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;

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

(a) Exclusively for the individual resident; or

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

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

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to document in the resident records the potential medication side effects and caregiver instructions related to routine blood thinner therapy for 4 of 4 sampled residents (Resident 1, Resident 4, Resident 6, and Resident 7). The facility also failed to document in the resident records the various responsibilities of medication assistance and catheter care for 1 of 1 (Resident 5). These failures placed the residents at risk for unmet care needs and worsening of medical conditions.

DSHS/ALTSA
Residential Care Services
JUN 28 2023
Received

Findings included...

MONITORING MEDICATION SIDE EFFECTS
Review of the MedlinePlus website titled "Blood Thinners", (https://medlineplus.gov/bloodthinners.html), dated 05/31/2023, showed blood thinners (medicines that

Administrator (or Representative) Date

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Based on observation, interview, and record review, the facility failed to document in the resident records the potential medication side effects and caregiver instructions related to routine blood thinner therapy for 4 of 4 sampled residents (Resident 1, Resident 4, Resident 6, and Resident 7). The facility also failed to document in the resident records the various responsibilities of medication assistance and catheter care for 1 of 1 (Resident 5). These failures placed the residents at risk for unmet care needs and worsening of medical conditions.

Findings included…

MONITORING MEDICATION SIDE EFFECTS
Review of the MedlinePlus website titled "Blood Thinners", (https://medlineplus.gov/bloodthinners.html), dated 05/31/2023, showed blood thinners (medicines that

prevent blood clots from forming) included aspirin. The website showed the common side effects of blood thinners included bleeding, red or brown urine, red or black bowel movements, bleeding from the gums and nose that does not stop quickly, brown or bright red vomit, coughing up something red, severe headache or stomachache, unusual bruising, a cut that does not stop bleeding, and a serious fall or bump on the head.

RESIDENT 1
Review of Resident 1's "Individual Service Plan" (ISP), dated 03/25/2023, showed the facility admitted Resident 1 in [redacted] 2023. The ISP showed a diagnosis of [redacted] Further review of the ISP showed no documentation of instructions to the staff about the potential side effects from taking aspirin once a day.

Review of Resident 1's March 2023 and April 2023 electronic Medication Administration Records (eMAR) showed Resident 1 received 81 milligrams (mg) enteric coated (a coating on the outside of a pill that it does not dissolve in stomach acid) aspirin, one tablet by mouth, once a day, for cardiovascular health. The eMARs showed no instructions about the potential side effects staff should be aware for Resident 1, who received routine aspirin therapy.

RESIDENT 4
Review of Resident 4's ISP, dated 02/28/2023, showed the facility admitted Resident 4 in [redacted] 2023. The ISP showed a diagnosis of [redacted]. Further review of the ISP showed no documentation of [redacted] ential side effects from taking aspirin once a day.

Review of Resident 4's April 2023 and May 2023 eMAR showed Resident 4 received 81 mg enteric coated aspirin, one tablet by mouth, once a day, related to atherosclerosis of the aorta. The eMARs showed no instructions about the potential side effects staff should be aware of for Resident 4, who received routine aspirin therapy.

RESIDENT 6
Review of Resident 6's ISP, dated 02/14/2023, showed the facility admitted Resident 6 in [redacted] 2023. The ISP showed a diagnosis of [redacted]. The ISP showed no documentation of instructions to the staff about the potential side effects from taking aspirin once a day.

Review of Resident 6's March 2023, April 2023, and May 2023 eMARs showed Resident 6 received 81 mg delayed release aspirin, one tablet by mouth, one time a day, related to hyperlipidemia (a condition in which there are high levels of fat in the blood). The eMARs showed that between 03/01/2023 and 05/22/2023, the facility administered aspirin to Resident 6. The eMARs showed no instructions about the potential side effects staff should be aware of for Resident 6, who received routine aspirin therapy.

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Review of Resident 1's "Individual Service Plan" (ISP), dated 03/25/2023, showed the facility admitted Resident 1 in [redacted] 2023. The ISP showed a diagnosis of [redacted]. Further review of the ISP showed no documentation of instructions to the staff about the potential side effects from taking aspirin once a day.

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RESIDENT 4
Review of Resident 4's ISP, dated 02/28/2023, showed the facility admitted Resident 4 in [redacted] 2023. The ISP showed a diagnosis of [redacted]. Further review of the ISP showed no documentation of instructions to the staff about the potential side effects from taking aspirin once a day.

Review of Resident 4's April 2023 and May 2023 eMAR showed Resident 4 received 81 mg enteric coated aspirin, one tablet by mouth, once a day, related to atherosclerosis of the aorta. The eMARs showed no instructions about the potential side effects staff should be aware of for Resident 4, who received routine aspirin therapy.

RESIDENT 6
Review of Resident 6's ISP, dated 02/14/2023, showed the facility admitted Resident 6 in [redacted] 2023. The ISP showed a diagnosis of [redacted]. The ISP showed no documentation of instructions to the staff about the potential side effects from taking aspirin once a day.

Review of Resident 6's March 2023, April 2023, and May 2023 eMARs showed Resident 6 received 81 mg delayed release aspirin, one tablet by mouth, one time a day, related to hyperlipidemia (a condition in which there are high levels of fat in the blood). The eMARs showed that between 03/01/2023 and 05/22/2023, the facility administered aspirin to Resident 6. The eMARs showed no instructions about the potential side effects staff should be aware of for Resident 6, who received routine aspirin therapy.

RESIDENT 7
Review of Resident 7's ISP, dated 12/17/2022, showed the facility admitted Resident 7 in [redacted] 2022. The ISP showed a diagnosis of [redacted]. The ISP showed no documentation of instructions to staff about the potential side effects from taking aspirin once a day.

Review of Resident 7's eMARs dated March 2023, April 2023, and May 2023, showed they received aspirin, 81 milligrams (mg), one tablet by mouth one time a day for prevent heart attack. The eMARs showed that between 03/01/2023 and 05/22/2023, Resident 7 self-administered aspirin every day. The eMARs showed no instructions about the side potential side effects staff should be aware of for Resident 7, who received routine aspirin therapy.

CATHETER CARE AND FAMILY MEDICATION PLAN
RESIDENT 5
Review of the facility's document titled "WA 3.0 Service Evaluation and Health Assessment (SEHA) – V4" for Resident 5, dated 01/09/2023, showed that the facility admitted Resident 5 in [redacted] 2022, with a diagnosis of [redacted]. The document showed that Resident 5 was unable to self-administer medications. The document showed that the facility staff provided medication assistance. The document also showed that Resident 5 required catheter care assistance.

Review of Resident 5's ISP, dated 01/27/2023, showed that the facility staff or private home care aide provided Resident 5 with catheter care assistance. The ISP provided no schedule of when the facility staff provided catheter care assistance and when the private HCAs provided this service. The ISP further showed Resident 5's family assisted with Resident 5's medication management. The ISP showed no documentation of a family medication plan and emergency medication plan. The ISP showed no defined care tasks for the facility staff's assistance in catheter care and medication administration. The ISP also showed no documentation of an alternate plan in case the private HCA was unavailable and absent from duty.

Review of the facility's document titled "WA Medication Service Level Evaluation – V2", dated 03/04/2023, showed that Resident 5's family and private home care aides (HCA) provided medication assistance. The document showed no documentation of a family medication plan, no documentation of the facility's role and responsibility in the care coordination, and no documentation of an alternate medication plan if family were unavailable.

During an interview on 05/24/2023 at 2:35 PM, Staff A, Executive Director, stated that Resident 5's private HCAs provided care assistance for two hours in the morning and two hours in the evening, every day. Staff A stated that the facility's staff provided Resident 5 with care and services for the hours the HCAs were not present or absent from duty.

During an interview on 05/24/2023 at 2:50 PM, Staff B, Resident Care Director, stated that Resident 5 required assistance with medications and catheter care. Staff B stated that Resident 5's daughter prepared the medi-set (a medication organizer device) every month.

RESIDENT 7
Review of Resident 7's ISP, dated 12/17/2022, showed the facility admitted Resident 7 in [redacted] 2022. The ISP showed a diagnosis of [redacted]. The ISP showed no documentation of instructions to staff about the potential side effects from taking aspirin once a day.

Review of Resident 7's eMARs dated March 2023, April 2023, and May 2023, showed they received aspirin, 81 milligrams (mg), one tablet by mouth one time a day for prevent heart attack. The eMARs showed that between 03/01/2023 and 05/22/2023, Resident 7 self-administered aspirin every day. The eMARs showed no instructions about the side potential side effects staff should be aware of for Resident 7, who received routine aspirin therapy.

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During an interview on 05/24/2023 at 2:35 PM, Staff A, Executive Director, stated that Resident 5's private HCAs provided care assistance for two hours in the morning and two hours in the evening, every day. Staff A stated that the facility's staff provided Resident 5 with care and services for the hours the HCAs were not present or absent from duty.

During an interview on 05/24/2023 at 2:50 PM, Staff B, Resident Care Director, stated that Resident 5 required assistance with medications and catheter care. Staff B stated that Resident 5's daughter prepared the medi-set (a medication organizer device) every month.

Staff B stated that they were unaware Resident 5's ISP showed no family medication plan and no alternate plan available for times when family was unavailable. Staff B stated that Resident 5 received assistance from private HCA several hours a day in coordination with the facility staff. Staff B stated that they were unaware the ISP showed no documentation of the care tasks and the facility's staff responsibilities. Staff B further stated that they were unaware Resident 5's ISP was not updated.

Observation on 05/25/2023 at 8:30 AM showed that Collateral Contact 1 (CC1), Private Home Care Aide, assisted Resident 5 with personal care tasks, which included catheter care. Observation showed CC1 cleaned the urinary catheter tubing, connected the urine bag, and secured the urine bag to Resident 5's left thigh.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/5/23.

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

Administrator (or Representative) — Date 6/27/23

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

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

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

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

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to assess and implement nurse delegation services for 3 of 3 residents (Resident 2, Resident 4, and Resident 6). These failures placed the residents at risk for medication errors and potential decline in their health when unqualified staff provided care.

DSHS/ALTSA
Residential Care Services

JUN 28 2023

Received

Findings included...

Review of the facility's undated document titled "Disclosure of Services Required by RCW 18.20.300", showed the facility provided intermittent nursing services /administration by trained unlicensed staff through nurse delegation.

Staff B stated that they were unaware Resident 5's ISP showed no family medication plan and no alternate plan available for times when family was unavailable. Staff B stated that Resident 5 received assistance from private HCA several hours a day in coordination with the facility staff. Staff B stated that they were unaware the ISP showed no documentation of the care tasks and the facility's staff responsibilities. Staff B further stated that they were unaware Resident 5's ISP was not updated.

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

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Administrator (or Representative) Date

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**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to assess and implement nurse delegation services for 3 of 3 residents (Resident 2, Resident 4, and Resident 8). These failures placed the residents at risk for medication errors and potential decline in their health when unqualified staff provided care.

Findings included...

Review of the facility's undated document titled "Disclosure of Services Required by RCW 18.20.300", showed the facility provided intermittent nursing services /administration by trained unlicensed staff through nurse delegation.

Review of the facility's policy titled "Nurse Delegation", dated April 2012, showed that the nurse delegator would "assess the resident's nursing care needs and determine that their condition is stable and predictable". The policy also showed that the nurse delegator would determine whether the resident could be taught to perform the task of medication administration independently or with assistance.

During the entrance conference on 05/22/2023 at 8:10 AM, Staff B, Registered Nurse, Resident Care Director, identified themselves as the facility's Registered Nurse Delegator (RND). Staff B stated there were currently no residents in the facility who received or required nurse delegation services.

Review of the facility's undated document titled "Assisted Living Facility Resident Characteristic Roster" showed the facility admitted Resident 2 and Resident 4 in [redacted] 2023, and Resident 8 in January 2023. The roster showed that all three residents resided in the secured Memory Care unit. The roster showed Resident 2 and Resident 4 required maximum assistance with their care needs and activities of daily living. The roster showed that Resident 8 required moderate assistance with care and activities of daily living. Further review of the roster showed Resident 2 received Hospice Services (end of life care).

RESIDENT 2
Review of Resident 2's Individual Service Plan (ISP), dated 03/20/2023, showed a diagnosis of [redacted] nable to self-administer" their medications and required the Medication Technicians to "assist" and "administer" the medications.

Observation on 05/22/2023 at 12:28 PM, showed Resident 2 sat in a reclining wheelchair at the dining room table. Observation showed Resident 2 made no attempt to feed themselves and was unable to engage in a conversation. Further observation showed Staff L, Care Manger, fed Resident 2. Observation on 05/23/2023 at 12:05 PM, showed Staff L cut Resident 2's food into smaller bites. Then Staff L fed Resident 2 their lunch. Observation on 05/24/2023 at 7:37 AM, showed Staff K, Medication Care Manager (unlicensed staff who dispense and administer medications), crushed Resident 2's medications and mixed the crushed medications in applesauce. Staff K then spoon fed the applesauce with the medications to Resident 2. Further observation showed Staff K placed chewable medications in Resident 2's mouth with a spoon. Resident 2 showed no awareness that they received their medications.

During an interview on 05/22/2023 at 12:28 PM, and on 05/23/2023 at 12:05 PM, Staff L stated that Resident 2 was mostly non-verbal. Staff L stated that Resident 2 did not know the difference between various food items. Staff L stated that they moved the silverware, napkins, and other objects away from Resident 2 to prevent them from putting the items in their mouth. Staff L stated that Resident 2 was not able to express or show whether they

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Review of the facility's undated document titled "Assisted Living Facility Resident Characteristic Roster" showed the facility admitted Resident 2 and Resident 4 in [redacted] 2023, and Resident 8 in January 2023. The roster showed that all three residents resided in the secured Memory Care unit. The roster showed Resident 2 and Resident 4 required maximum assistance with their care needs and activities of daily living. The roster showed that Resident 8 required moderate assistance with care and activities of daily living. Further review of the roster showed Resident 2 received Hospice Services (end of life care).

RESIDENT 2
Review of Resident 2's Individual Service Plan (ISP), dated 03/20/2023, showed a diagnosis of [redacted] Further review showed Resident 2 was "unable to self-administer" their medications and required the Medication Technicians to "assist" and "administer" the medications.

Observation on 05/22/2023 at 12:28 PM, showed Resident 2 sat in a reclining wheelchair at the dining room table. Observation showed Resident 2 made no attempt to feed themselves and was unable to engage in a conversation. Further observation showed Staff L, Care Manger, fed Resident 2. Observation on 05/23/2023 at 12:05 PM, showed Staff L cut Resident 2's food into smaller bites. Then Staff L fed Resident 2 their lunch. Observation on 05/24/2023 at 7:37 AM, showed Staff K, Medication Care Manager (unlicensed staff who dispense and administer medications), crushed Resident 2's medications and mixed the crushed medications in applesauce. Staff K then spoon fed the applesauce with the medications to Resident 2. Further observation showed Staff K placed chewable medications in Resident 2's mouth with a spoon. Resident 2 showed no awareness that they received their medications.

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wanted wedged potatoes or bites of the hamburger. Staff L stated that the care managers decided for Resident 2 what the next bite of food would be.

During an interview on 05/24/2023 at 2:53 PM, Staff B stated that Resident 2's medical diagnoses included [redacted]. Staff B acknowledged that based on the observations, Resident 2 should be on nurse delegation services.

RESIDENT 4
Review of Resident 4's ISP dated 02/28/2023 showed a diagnosis of [redacted] and [redacted]. Further review of the ISP showed Resident 4 had limited ability to "express" themselves and "communicate" their needs. The ISP showed Resident 4 was "unable to self-administer" medications and required the facility staff to "assist" and "administer" their medications.

Observation on 05/22/2023 at 12:55 PM, showed Resident 4 sat in a recliner with only a bath towel wrapped around their waist. Resident 4 was unable to appropriately respond to questions or engage in conversation. Resident 4 verbalized several nonsensical (having no meaning, making no sense) sounds.

Observation on 05/24/2023 at 8:00 AM, showed Staff L fed Resident 4 lunch. Resident 4 responded to cues to open their mouth while their eyes remained closed. Resident 4 did not attempt to feed themselves.

During an interview on 05/24/2023 at 8:59 AM, Staff K stated that when they administered Resident 4's medications, they crushed them in applesauce and spoon fed the applesauce with the medications to Resident 4. Staff K stated that Resident 4 was unable to self-direct the staff to put the medications in their mouth. Staff K stated that Resident 4 would open their mouth when staff told them the medications were ready to be taken. Staff K stated that the day before, Resident 4 attempted to put the medications in their mouth and was unable to do so. Staff K stated that Resident 4 required the Medication Technicians to administer the medications for them.

RESIDENT 8
Review of Resident 8's ISP dated 04/24/2023 showed a diagnosis of [redacted] and [redacted]. The ISP showed that Resident 8 was unable to self-administer their own medications. The ISP showed that staff assisted or administered Resident 8's medications.

Observation on 05/24/2023 at 8:12 AM, showed Staff K placed Resident 8's pills in a medicine cup filled with applesauce. Staff K used a spoon to put the pills in Resident 8's mouth. Resident 8 did not ask, or direct Staff K to administer the medication. During an interview at this same time, Staff K stated that even though Resident 8 was physically

wanted wedged potatoes or bites of the hamburger. Staff L stated that the care managers decided for Resident 2 what the next bite of food would be.

During an interview on 05/24/2023 at 2:53 PM, Staff B stated that Resident 2's medical diagnoses included [redacted]. Staff B acknowledged that based on the observations, Resident 2 should be on nurse delegation services.

RESIDENT 4
Review of Resident 4's ISP, dated 02/28/2023, showed a diagnosis of [redacted] and [redacted]. Further review of the ISP showed Resident 4 had limited ability to "express" themselves and "communicate" their needs. The ISP showed Resident 4 was "unable to self-administer" medications and required the facility staff to "assist" and "administer" their medications.

Observation on 05/22/2023 at 12:55 PM, showed Resident 4 sat in a recliner with only a bath towel wrapped around their waist. Resident 4 was unable to appropriately respond to questions or engage in conversation. Resident 4 verbalized several nonsensical (having no meaning, making no sense) sounds.

Observation on 05/24/2023 at 8:00 AM, showed Staff L fed Resident 4 lunch. Resident 4 responded to cues to open their mouth while their eyes remained closed. Resident 4 did not attempt to feed themselves.

During an interview on 05/24/2023 at 8:59 AM, Staff K stated that when they administered Resident 4's medications, they crushed them in applesauce and spoon fed the applesauce with the medications to Resident 4. Staff K stated that Resident 4 was unable to self-direct the staff to put the medications in their mouth. Staff K stated that Resident 4 would open their mouth when staff told them the medications were ready to be taken. Staff K stated that the day before, Resident 4 attempted to put the medications in their mouth and was unable to do so. Staff K stated that Resident 4 required the Medication Technicians to administer the medications for them.

RESIDENT 8
Review of Resident 8's ISP dated 04/24/2023 showed a diagnosis of [redacted] and [redacted]. The ISP showed that Resident 8 was unable to self-administer their own medications. The ISP showed that staff assisted or administered Resident 8's medications.

Observation on 05/24/2023 at 8:12 AM, showed Staff K placed Resident 8's pills in a medicine cup filled with applesauce. Staff K used a spoon to put the pills in Resident 8's mouth. Resident 8 did not ask, or direct Staff K to administer the medication. During an interview at this same time, Staff K stated that even though Resident 8 was physically

capable of placing the pills in their own mouth, the staff did it for them. Staff K stated that when Resident 8 administered their own medications, they would take more than one pill at a time, which would cause them to choke. Staff K stated that to prevent Resident 8 from choking, it was necessary for staff to administer Resident 8's medications for them.

During an interview on 05/24/2023 at 12:56 PM, Staff M, Reminiscence Coordinator, stated that they were not responsible for the nurse delegation. Staff M stated that the licensed nurses were the ones who determined which residents required nurse delegation. Staff M stated that Staff B was the person responsible to complete the nurse delegation assessments and services

During an interview on 05/24/2023 at 2:53 PM, Staff B stated that nurse delegation occurred when a resident was no longer able to put the medications in their mouth and were unable to direct the Med Techs to do it for them. Staff B acknowledged Resident 2 showed no awareness they received medications and was not cognitively capable to direct staff to place the medications in their mouth. Staff B stated that Resident 4 had advanced dementia. Staff B agreed that Resident 4 showed no awareness they received medications and were not able to self-direct staff to administer the medications. Staff B stated that Resident 4 also required nurse delegation. Staff B stated that Resident 8 needed an evaluation to determine if nurse delegation services were appropriate. Staff B stated that the Resident Care Coordinators were responsible to communicate to the nurses when a resident was no longer able to self-administer their own medications. Staff B stated that they were unaware Resident 2, Resident 4 and Resident 8 had not been evaluated for nurse delegation.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/5/23 .

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

Administrator (or Representative) — Date: 6/27/23

**WAC 388-78A-2130 Service agreement planning. The assisted living facility must:**

(3) Review and update each resident's negotiated service agreement consistent with WAC 388 78A 2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

capable of placing the pills in their own mouth, the staff did it for them. Staff K stated that when Resident 8 administered their own medications, they would take more than one pill at a time, which would cause them to choke. Staff K stated that to prevent Resident 8 from choking, it was necessary for staff to administer Resident 8's medications for them.

During an interview on 05/24/2023 at 12:56 PM, Staff M, Reminiscence Coordinator, stated that they were not responsible for the nurse delegation. Staff M stated that the licensed nurses were the ones who determined which residents required nurse delegation. Staff M stated that Staff B was the person responsible to complete the nurse delegation assessments and services.

During an interview on 05/24/2023 at 2:53 PM, Staff B stated that nurse delegation occurred when a resident was no longer able to put the medications in their mouth and were unable to direct the Med Techs to do it for them. Staff B acknowledged Resident 2 showed no awareness they received medications and was not cognitively capable to direct staff to place the medications in their mouth. Staff B stated that Resident 4 had advanced dementia. Staff B agreed that Resident 4 showed no awareness they received medications and were not able to self-direct staff to administer the medications. Staff B stated that Resident 4 also required nurse delegation. Staff B stated that Resident 8 needed an evaluation to determine if nurse delegation services were appropriate. Staff B stated that the Resident Care Coordinators were responsible to communicate to the nurses when a resident was no longer able to self-administer their own medications. Staff B stated that they were unaware Resident 2, Resident 4 and Resident 8 had not been evaluated for nurse delegation.

**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-2130 Service agreement planning. The assisted living facility must:**

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review the facility failed to update the "Individual Service Plans" (ISP) for 3 of 3 residents (Resident 2, Resident 3, and Resident 4). This failure placed the three residents at risk for not having their care needs met.

Review of the facility's undated document titled "Resident Characteristics Roster" showed that the facility admitted Resident 2 in [redacted] of 2023, Resident 3 in [redacted] 2023, and Resident 4 in [redacted] 2023. The Characteristics Roster showed that Resident 2, Resident 3, and Resident 4 resided in the secured Memory Care unit.

RESIDENT 2
The Characteristics Roster showed Resident 2 received Hospice Services (end of life care).

Observation on 05/22/2023 at 1:03 PM, showed Staff J, Care Manager, and Staff F, Lead Care Manager, used a Mechanical Lift to transfer Resident 2 from a reclining wheelchair to a hospital bed. Observation showed Resident 2's hospital bed had an alternating pressure relief overlay mattress on top of a regular mattress. Observation showed a non-operational air pump located at the foot of the bed. The air mattress was deflated. Further observation showed Staff J lowered Resident 2's hospital bed to the lowest position, close to the floor. Staff J placed a regular twin size mattress next to Resident 2's bed. Staff J then placed a mat on top of the floor mattress. Staff J then placed a second mat next to the mattress on the floor. During an interview at this same time, Staff J stated that when Resident 2 occupied the bed, the hospital bed was needed to be in the lowest position. Staff J stated the floor mattress and mats were to prevent Resident 2 from potential injury if they rolled out of the bed. Staff J stated that the second mat protected Resident 2 if they rolled off the floor mattress.

Review of Resident 2' ISP dated 03/20/2023 showed Resident 2 was diagnosed with [redacted]. The ISP did not show any documentation that Resident 2 used an alternating pressure relief air mattress. The ISP provided no staff instructions to check that the pump was operational, turned on and the mattress was inflated. The ISP did not show any documentation that Resident 2 required floor mats and a mattress next to the bed. There were no instructions that informed staff on the correct sequence for positioning the mattress and pads next to the bed. The ISP did not show Resident 2 used a hospital bed. There were no instructions that informed staff to place the hospital bed in the lowest position when Resident 2 occupied the bed.

During an interview on 05/24/2023 at 12:56 PM, Staff M, Memory Care Reminiscence Coordinator, stated that the hospital bed, air mattress and floor mats and mattress needed to be documented in Resident 2's ISP. Staff M stated that the floor mat should be placed next to the hospital bed. Staff M stated that they were unaware a twin-size mattress was used. Staff M stated that they were unaware of the correct sequence and position staff used for the placement of the mattress or mats. Staff M confirmed the air pump was broken.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review the facility failed to update the "Individual Service Plans" (ISP) for 3 of 3 residents (Resident 2, Resident 3, and Resident 4). This failure placed the three residents at risk for not having their care needs met.

Review of the facility's undated document titled "Resident Characteristics Roster" showed that the facility admitted Resident 2 in [redacted] of 2023, Resident 3 in [redacted] 2023, and Resident 4 in [redacted] 2023. The Characteristics Roster showed that Resident 2, Resident 3, and Resident 4 resided in the secured Memory Care unit.

RESIDENT 2
The Characteristics Roster showed Resident 2 received Hospice Services (end of life care).

Observation on 05/22/2023 at 1:03 PM, showed Staff J, Care Manager, and Staff F, Lead Care Manager, used a Mechanical Lift to transfer Resident 2 from a reclining wheelchair to a hospital bed. Observation showed Resident 2's hospital bed had an alternating pressure relief overlay mattress on top of a regular mattress. Observation showed a non-operational air pump located at the foot of the bed. The air mattress was deflated. Further observation showed Staff J lowered Resident 2's hospital bed to the lowest position, close to the floor. Staff J placed a regular twin size mattress next to Resident 2's bed Staff J then placed a mat on top of the floor mattress. Staff J then placed a second mat next to the mattress on the floor. During an interview at this same time, Staff J stated that when Resident 2 occupied the bed, the hospital bed was needed to be in the lowest position. Staff J stated the floor mattress and mats were to prevent Resident 2 from potential injury if they rolled out of the bed. Staff J stated that the second mat protected Resident 2 if they rolled off the floor mattress.

Review of Resident 2' ISP dated 03/20/2023 showed Resident 2 was diagnosed with [redacted]. The ISP did not show any documentation that Resident 2 used an alternating pressure relief air mattress. The ISP provided no staff instructions to check that the pump was operational, turned on and the mattress was inflated. The ISP did not show any documentation that Resident 2 required floor mats and a mattress next to the bed. There were no instructions that informed staff on the correct sequence for positioning the mattress and pads next to the bed. The ISP did not show Resident 2 used a hospital bed. There were no instructions that informed staff to place the hospital bed in the lowest position when Resident 2 occupied the bed.

During an interview on 05/24/2023 at 12:56 PM, Staff M, Memory Care Reminiscence Coordinator, stated that the hospital bed, air mattress and floor mats and mattress needed to be documented in Resident 2's ISP. Staff M stated that the floor mat should be placed next to the hospital bed. Staff M stated that they were unaware a twin-size mattress was used. Staff M stated that they were unaware of the correct sequence and position staff used for the placement of the mattress or mats. Staff M confirmed the air pump was broken.

RESIDENT 3
Observation on 05/22/2023 at 9:41 AM, showed a Continuous Positive Airway Pressure [CPAP- a device used to keep a person's airway open when sleeping, used for people with sleep apnea (a condition where a person's breathing stops and restarts multiple times during sleep which causes oxygen deprivation)] on the nightstand in Resident 3's room. Observation showed a bottle of distilled water used to fill the CPAP reservoir sat on the floor, next to the nightstand.

Review of Resident 3's ISP dated 04/21/2023 showed a diagnosis of [redacted] and [redacted]. The ISP did not show Resident 3 used a CPAP. The ISP did not provide staff instructions on how to manage or care for the CPAP or when the CPAP was to be used.

During an interview on 05/24/2023 at 7:40 AM, Resident 3 stated that they used the CPAP at night. Resident 3 stated that they put the CPAP mask on themselves. Resident 3 stated that the Care Managers filled the CPAP reservoir with the distilled water. Resident 3 stated that the Care Managers cleaned the mask and the air hose.

Observation on 05/24/2023 at 7:58 PM, showed Staff L, Care Manger, used their care tablet to review Resident 3's care tasks and ISP. During an interview at this time, Staff L stated that they were unable to find any information that showed Resident 3 used a CPAP. Staff L stated that the Care Managers used a sanitation cloth to clean the CPAP mask and the licensed nurses cleaned the CPAP hose.

During an interview on 05/24/2023 at 2:53 PM, Staff B, Registered Nurse, Resident Care Director, stated that when they completed Resident 3's initial assessment, Resident 3 did not use a CPAP machine. Staff B stated that the Reminiscence Care Coordinator was responsible for communicating to the nurses when residents obtain new medical devices. Staff B stated they were unsure of when Resident 3 started with the CPAP. Staff B stated that information about the CPAP machine, instructions for when it was used and how it was cleaned needed to be in the ISP.

RESIDENT 4
Observation on 05/22/2023 at 2:54 PM and 05/24/2023 at 8:59 AM showed Resident 4 asleep in their room. On 05/23/2023 at 8:00 AM, 05/23/2023 at 12:05 PM, and 05/24/2023 at 8:00 AM, observations showed Resident 4 asleep during mealtimes. Observations showed Staff L continuously woke, cued, and fed Resident 4 breakfast and lunch. Further observation showed Resident 4 open their mouth to accept food while their eyes remained closed.

Review of Resident 4's ISP dated 02/28/2023 showed a diagnosis of [redacted] and [redacted]. The ISP showed that Resident 4 had altered respiratory status and had difficulty breathing due to obstructive sleep apnea. The ISP showed Resident 4 used a CPAP machine and the supplies were kept at the bedside. The ISP did not provide the Care Managers with instructions on how to operate the CPAP.

RESIDENT 3
Observation on 05/22/2023 at 9:41 AM, showed a Continuous Positive Airway Pressure [CPAP- a device used to keep a person's airway open when sleeping, used for people with sleep apnea (a condition where a person's breathing stops and restarts multiple times during sleep which causes oxygen deprivation)] on the nightstand in Resident 3's room. Observation showed a bottle of distilled water used to fill the CPAP reservoir sat on the floor, next to the nightstand.

Review of Resident 3's ISP dated 04/21/2023 showed a diagnosis of [redacted] and [redacted]. The ISP did not show Resident 3 used a CPAP. The ISP did not provide staff instructions on how to manage or care for the CPAP or when the CPAP was to be used.

During an interview on 05/24/2023 at 7:40 AM, Resident 3 stated that they used the CPAP at night. Resident 3 stated that they put the CPAP mask on themselves. Resident 3 stated that the Care Managers filled the CPAP reservoir with the distilled water. Resident 3 stated that the Care Managers cleaned the mask and the air hose.

Observation on 05/24/2023 at 7:58 PM, showed Staff L, Care Manger, used their care tablet to review Resident 3's care tasks and ISP. During an interview at this time, Staff L stated that they were unable to find any information that showed Resident 3 used a CPAP. Staff L stated that the Care Managers used a sanitation cloth to clean the CPAP mask and the licensed nurses cleaned the CPAP hose.

During an interview on 05/24/2023 at 2:53 PM, Staff B, Registered Nurse, Resident Care Director, stated that when they completed Resident 3's initial assessment, Resident 3 did not use a CPAP machine. Staff B stated that the Reminiscence Care Coordinator was responsible for communicating to the nurses when residents obtain new medical devices. Staff B stated they were unsure of when Resident 3 started with the CPAP. Staff B stated that information about the CPAP machine, instructions for when it was used and how it was cleaned needed to be in the ISP.

RESIDENT 4
Observation on 05/22/2023 at 2:54 PM and 05/24/2023 at 8:59 AM showed Resident 4 asleep in their room. On 05/23/2023 at 8:00 AM, 05/23/2023 at 12:05 PM, and 05/24/2023 at 8:00 AM, observations showed Resident 4 asleep during mealtimes. Observations showed Staff L continuously woke, cued, and fed Resident 4 breakfast and lunch. Further observation showed Resident 4 open their mouth to accept food while their eyes remained closed.

Review of Resident 4's ISP dated 02/28/2023 showed a diagnosis of [redacted] and [redacted]. The ISP showed that Resident 4 had altered respiratory status and had difficulty breathing due to obstructive sleep apnea. The ISP showed Resident 4 used a CPAP machine and the supplies were kept at the bedside. The ISP did not provide the Care Managers with instructions on how to operate the CPAP,

who was responsible to clean the CPAP, who filled the reservoir or if assistance was required to place the CPAP mask on Resident 4.

During an interview on 05/24/2023 at 12:56 PM, Staff M stated that Resident 4's ISP provided no clear instructions about the CPAP to show who was responsible to clean the attachments, fill the reservoir and place the mask on the resident in Resident 4. Staff M confirmed the CPAP information needed to be in Resident 4's ISP.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/5/23 .

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

Administrator (or Representative) Date 6/27/23

**WAC 388-78A-2464 Background checks Process Background authorization form. Before the assisted living facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must:**

(1) Require the person to complete a DSHS background authorization form; and

(2) Submit to the department's background check central unit, including any additional documentation and information requested by the department.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to complete a Department of Social and Health Services (DSHS) background check (BGI) for 2 of 3 sampled contracted private home care aides (HCA; Collateral Contact 1 [CC1] and Collateral Contact 2 [CC2]). This failure placed Resident 5 at risk for potential abuse and neglect from caregivers with unknown background check results.

DSHS/ALTSA
Residential Care Services

JUN 28 2023

Received

Findings included...

Review of the facility's "Assisted Living Facility Resident Characteristic Roster", dated 05/22/2023, showed that the facility admitted Resident 5 in [redacted] 2022.

Review of the facility's document titled "Companion Care, Inc. - 7 Day Client Schedule", dated 05/24/2023, showed Resident 5 hired three private Home Care Aides that included Collateral Contact 1 (CC1) and Collateral Contact 2 (CC2). The document showed the

who was responsible to clean the CPAP, who filled the reservoir or if assistance was required to place the CPAP mask on Resident 4.

During an interview on 05/24/2023 at 12:56 PM, Staff M stated that Resident 4's ISP provided no clear instructions about the CPAP to show who was responsible to clean the attachments, fill the reservoir and place the mask on the resident in Resident 4. Staff M confirmed the CPAP information needed to be in Resident 4's ISP.

**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, Sunrise of Redmond 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-2464 Background checks Process Background authorization form. Before the assisted living facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must:**

(1) Require the person to complete a DSHS background authorization form; and

(2) Submit to the department's background check central unit, including any additional documentation and information requested by the department.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to complete a Department of Social and Health Services (DSHS) background check (BGI) for 2 of 3 sampled contracted private home care aides (HCA; Collateral Contact 1 [CC1] and Collateral Contact 2 [CC2]). This failure placed Resident 5 at risk for potential abuse and neglect from caregivers with unknown background check results.

Findings included…

Review of the facility's "Assisted Living Facility Resident Characteristic Roster", dated 05/22/2023, showed that the facility admitted Resident 5 in [redacted] 2022.

Review of the facility's document titled "Companion Care, Inc. - 7 Day Client Schedule", dated 05/24/2023, showed Resident 5 hired three private Home Care Aides that included Collateral Contact 1 (CC1) and Collateral Contact 2 (CC2). The document showed the

private HCAs worked a split daily schedule: 8:00 AM – 11:00 AM and 7:00 PM – 10:00 PM. The document showed that CC1 worked on 05/22/2023 and 05/23/2023 and CC2 worked on 05/24/2023 and 05/25/2023.

Review of CC1's background check obtained from the home care agency showed the agency completed a Washington State Patrol (WSP) "Washington Access to Criminal History (WATCH)" report, dated 05/26/2022. The report showed no record found. Review of a facility email titled "DSHS Background Check" (BGI), dated 06/01/2023, showed the home care agency confirmed CC1's first day of work for Resident 5 in the facility was 04/16/2023. There was no documentation that showed the facility completed a DSHS BGI when CC1 started work with Resident 5 in April 2023.

Review of CC2's background check obtained from the home care agency showed the agency completed a Washington State Patrol (WSP) "Washington Access to Criminal History (WATCH)" report, dated 05/24/2023. The report showed no record found. Review of a facility email titled "DSHS Background Check", dated 06/01/2023, showed the home care agency confirmed CC2's first day of work for Resident 5 in the facility was 02/24/2023. There was no documentation that showed the facility completed a DSHS BGI when CC2 started work for Resident 5 in February 2023.

During an interview on 05/24/2022 at 2:35 PM, Staff A, Executive Director, identified one Assisted Living Resident, Resident 5, who employed private HCAs from a contracted home care agency. Staff A stated that Resident 5 employed private HCAs in coordination with the facility for care and services. Staff A stated that the home care agency conducted the background check on the private HCAs and provided the facility with the background check results. Staff A stated that they were unaware the facility was responsible to complete a BGI through DSHS background check central unit for the private HCAs. Staff A further stated that they were unaware CC1 and CC2 did not have a DSHS BGI result when they started work at the facility with Resident 5.

Observation on 05/25/2023 between 8:30 AM and 9:30 AM showed that CC1 assisted Resident 5 with showering, dressing, and catheter care. During an interview at this time, CC1 stated that they were a private home care aide. CC1 stated that they worked two hours in the morning and two hours in the evening, every day. CC1 stated that they provided Resident 5 morning care and medication assistance. CC1 further stated that another home care aide worked in the evening and assisted with the evening care and medications.



**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/2/23.

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

private HCAs worked a split daily schedule: 8:00 AM – 11:00 AM and 7:00 PM – 10:00 PM. The document showed that CC1 worked on 05/22/2023 and 05/23/2023 and CC2 worked on 05/24/2023 and 05/25/2023.

Review of CC1's background check obtained from the home care agency showed the agency completed a Washington State Patrol (WSP) "Washington Access to Criminal History (WATCH)" report, dated 05/26/2022. The report showed no record found. Review of a facility email titled "DSHS Background Check" (BGI), dated 06/01/2023, showed the home care agency confirmed CC1's first day of work for Resident 5 in the facility was 04/16/2023. There was no documentation that showed the facility completed a DSHS BGI when CC1 started work with Resident 5 in April 2023.

Review of CC2's background check obtained from the home care agency showed the agency completed a Washington State Patrol (WSP) "Washington Access to Criminal History (WATCH)" report, dated 05/24/2023. The report showed no record found. Review of a facility email titled "DSHS Background Check", dated 06/01/2023, showed the home care agency confirmed CC2's first day of work for Resident 5 in the facility was 02/24/2023. There was no documentation that showed the facility completed a DSHS BGI when CC2 started work for Resident 5 in February 2023.

During an interview on 05/24/2022 at 2:35 PM, Staff A, Executive Director, identified one Assisted Living Resident, Resident 5, who employed private HCAs from a contracted home care agency. Staff A stated that Resident 5 employed private HCAs in coordination with the facility for care and services. Staff A stated that the home care agency conducted the background check on the private HCAs and provided the facility with the background check results. Staff A stated that they were unaware the facility was responsible to complete a BGI through DSHS background check central unit for the private HCAs. Staff A further stated that they were unaware CC1 and CC2 did not have a DSHS BGI result when they started work at the facility with Resident 5.

Observation on 05/25/2023 between 8:30 AM and 9:30 AM showed that CC1 assisted Resident 5 with showering, dressing, and catheter care. During an interview at this time, CC1 stated that they were a private home care aide. CC1 stated that they worked two hours in the morning and two hours in the evening, every day. CC1 stated that they provided Resident 5 morning care and medication assistance. CC1 further stated that another home care aide worked in the evening and assisted with the evening care and medications.

**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, Sunrise of Redmond 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.

| Statement of Deficiencies | License #: 2464 | Compliance Determination # 24508 |
|---|---|---|
| Plan of Correction | Sunrise of Redmond | Completion Date |
| Page of 19 | Licensee: Sunrise Senior Living Management Inc | 06/20/2023 |

Administrator (or Representative) 6/27/23 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.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled Staff (Staff U, Licensed Practical Nurse, Wellness Nurse, and Staff V, Registered Nurse, Wellness Nurse) documented the blood sugar checks and insulin administration on the electronic Medication Administration Record for 1 of 1 sampled resident (Resident 6). This failure placed Resident 6 at risk of potential medication errors and adverse medical outcomes.

Findings included...

Review of the facility's document titled "Medication Oversight Program V3.0", dated April 2023, showed that the facility followed all applicable state/province laws and regulations and accepted standards of practice related to medications and medication administration. The document showed that the facility weekly and monthly reviewed electronic Medication Administration Record (eMAR)/Orders Dashboard and Orders Portals to ensure medications were available, administered and documented and to identify issues that needed to be corrected immediately.

Review of Resident 6's "Individual Service Plan (ISP)" dated 02/14/2023, showed that the facility admitted Resident 6 in [redacted] 2023, with a medical diagnosis of [redacted]. The ISP showed that the facility provided insulin administration.

Review of Resident 6's March 2023 and April 2023 electronic Medication Administration Records (eMAR) showed that Resident 6's received insulin (a medication used to control high blood sugar), injected subcutaneously (inject under the skin) before meals, per sliding scale order (physician's order of the prescribed dose of insulin given, based on blood glucose levels). The eMARs showed no documentation of blood sugar check results and insulin doses given on 03/06/2023 at 4:30 PM, on 04/13/2023 at 11:30 AM, on 04/21/2023 at 4:30 PM, and on 04/22/2023 at 4:30 PM. The eMAR showed no explanation about why the blood sugar checks and insulin administrations were undocumented or if Resident 6 refused.

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.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled Staff (Staff U, Licensed Practical Nurse, Wellness Nurse, and Staff V, Registered Nurse, Wellness Nurse) documented the blood sugar checks and insulin administration on the electronic Medication Administration Record for 1 of 1 sampled resident (Resident 6). This failure placed Resident 6 at risk of potential medication errors and adverse medical outcomes.

Findings included…

Review of the facility's document titled "Medication Oversight Program V3.0", dated April 2023, showed that the facility followed all applicable state/province laws and regulations and accepted standards of practice related to medications and medication administration. The document showed that the facility weekly and monthly reviewed electronic Medication Administration Record (eMAR)/Orders Dashboard and Orders Portals to ensure medications were available, administered and documented and to identify issues that needed to be corrected immediately.

Review of Resident 6's "Individual Service Plan (ISP)" dated 02/14/2023, showed that the facility admitted Resident 6 in [redacted] 2023, with a medical diagnosis of [redacted]. The ISP showed that the facility provided insulin administration.

Review of Resident 6's March 2023 and April 2023 electronic Medication Administration Records (eMAR) showed that Resident 6's received Insulin (a medication used to control high blood sugar), injected subcutaneously (inject under the skin) before meals, per sliding scale order (physician's order of the prescribed dose of insulin given, based on blood glucose levels). The eMARs showed no documentation of blood sugar check results and insulin doses given on 03/08/2023 at 4:30 PM, on 04/13/2023 at 11:30 AM, on 04/21/2023 at 4:30 PM, and on 04/22/2023 at 4:30 PM. The eMAR showed no explanation about why the blood sugar checks and insulin administrations were undocumented or if Resident 6 refused.

Observation on 05/24/2023 at 11:10 AM showed Staff T, Registered Nurse, Wellness Nurse, performed a blood sugar check and administered an insulin injection for Resident 6. During an interview at this time, Staff T stated that Resident 6 was unable to self-administer blood sugar checks and insulin injections. Staff T stated that they administered Resident 6's blood sugar checks and administered insulin injections. Staff T stated that after completion of the blood sugar checks and insulin administration, Staff T documented the information in the eMAR.

During an interview on 05/24/2023 at 2:50 PM, Staff B, Registered Nurse, Resident Care Director, stated that the facility's Wellness Nurses completed Resident 6's the blood sugar checks and administered the insulin injections. Staff B stated that they were unaware of the four missing sign-offs of the blood sugar check and insulin administration in Resident 6's March 2023 and April 2023 eMARs.

During a follow-up interview on 05/25/2023 at 10:00 AM, Staff B stated that they conducted the medication review every month. Staff B stated that they did not complete a medication review for the month of April 2023. Staff B stated that they were unaware of the missing documentation for Resident 6's the blood sugar check results and insulin injections.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/5/23.

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

Administrator (or Representative) — Date: 6/27/23

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

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

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

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**This requirement was not met as evidenced by:**

Based on interview and record review the facility failed to ensure 1 of 6 sampled staff (Staff

Observation on 05/24/2023 at 11:10 AM showed Staff T, Registered Nurse, Wellness Nurse, performed a blood sugar check and administered an insulin injection for Resident 6. During an interview at this time, Staff T stated that Resident 6 was unable to self-administer blood sugar checks and insulin injections. Staff T stated that they administered Resident 6's blood sugar checks and administered insulin injections. Staff T stated that after completion of the blood sugar checks and insulin administration, Staff T documented the information in the eMAR.

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**Plan/Attestation Statement**

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_____ _____

Administrator (or Representative) Date

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

**This requirement was not met as evidenced by:**

Based on interview and record review the facility failed to ensure 1 of 6 sampled staff (Staff

| Statement of Deficiencies | License #: 2464 | Compliance Determination # 24508 |
|---|---|---|
| Plan of Correction | Sunrise of Redmond | Completion Date |
| Page of 19 | Licensee: Sunrise Senior Living Management Inc | 06/20/2023 |

A, Executive Director) completed the Washington State name and date of birth background check every two years. This failure placed the 59 residents at risk for potential abuse, neglect, or exploitation by a staff with an unknown national background checks.

Findings included...

Review of Staff A's facility's personnel records showed the facility hired Staff A on 09/17/2021. Staff A completed the initial Washington State Name and Date of Background inquiry (BGI) on 05/19/2021. The initial background check expired on 05/19/2023. Further review of Staff A's personnel records showed Staff A completed a new BGI on 05/25/2023, 6 days after the expiration of the initial BGI.

During an interview on 05/25/2023 at 1:00 PM, Staff Q, Business Office Coordinator stated that they maintained the facility's personnel records. Staff Q confirmed that Staff A's two-year BGI was submitted late.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/3/23.

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

Administrator (or Representative) — Date 6/27/23

**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;

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure an environment free of hazards. This placed 59 residents at risk of injury or harm related to potential trip and fall, and exposure to harmful chemical products.

Findings included...

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A, Executive Director) completed the Washington State name and date of birth background check every two years. This failure placed the 59 residents at risk for potential abuse, neglect, or exploitation by a staff with an unknown national background checks.

Findings included…

Review of Staff A's facility's personnel records showed the facility hired Staff A on 09/17/2021. Staff A completed the initial Washington State Name and Date of Background inquiry (BGI) on 05/19/2021. The initial background check expired on 05/19/2023. Further review of Staff A's personnel records showed Staff A completed a new BGI on 05/25/2023, 6 days after the expiration of the initial BGI.

During an interview on 05/25/2023 at 1:00 PM, Staff Q, Business Office Coordinator stated that they maintained the facility's personnel records. Staff Q confirmed that Staff A's two-year BGI was submitted late.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

**WAC 388-78A-3090 Maintenance and housekeeping.**

(1) The assisted living facility must:

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

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

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure an environment free of hazards. This placed 59 residents at risk of injury or harm related to potential trip and fall, and exposure to harmful chemical products.

Findings included…

Review of facility's document titled, "Housekeeping PM (preventive maintenance) Policy," dated 10/30/2015, showed that the facility staff performed reoccurring tasks and periodic project cleaning tasks assigned by the facility's automated preventive maintenance system. The document showed that the preventive maintenance standards included the facility's physical asset, which were the resident's suites, common areas, and back-of-house areas.

Observation on 05/22/2023 during the environmental tour at 11:45 AM, showed a pallet stacked with hazardous chemicals and paints, a metal picnic table, and old metal lockers, in an area that was assigned for parking. Observation showed multiple 5-gallon containers of hazardous chemicals, which included oxidizer and corrosive liquids. The containers had no protective cover and no warning signs posted to alert of potential physical and health hazards. Additionally, there were six old metal lockers on the ground with exposed, sharp metal feet. There were also two freestanding metal lockers near the sidewalk. The standing lockers had the potential to be tipped over or fall on residents who walked by. There was no caution sign to warn residents of this potential safety hazard. Further observation showed a metal picnic table obstructed a designated fire lane. This obstruction had the potential to prevent emergency responders' easy access to the building.

During an interview on 05/22/2023 at 11:50 AM, Staff R, Maintenance Coordinator stated that the hazardous chemicals were previously removed from the facility's storage area. Staff R stated that the chemicals were scheduled for disposal by the environmental waste services in three days.

Observation on 05/24/2023 at 3:26 PM, showed two residents using a walker and a companion of two other residents walked around the building. During an interview at this same time, Staff S, Assisted Living Activities and Volunteer Coordinator confirmed that there were residents that independently walked around the premise.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/9/23 .

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

Administrator (or Representative) — Date: 6/27/23

**WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:**

DSHS/ALTSA Residential Care Services

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received

Review of facility's document titled, "Housekeeping PM (preventive maintenance) Policy," dated 10/30/2015, showed that the facility staff performed reoccurring tasks and periodic project cleaning tasks assigned by the facility's automated preventive maintenance system. The document showed that the preventive maintenance standards included the facility's physical asset, which were the resident's suites, common areas, and back-of-house areas.

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During an interview on 05/22/2023 at 11:50 AM, Staff R, Maintenance Coordinator stated that the hazardous chemicals were previously removed from the facility's storage area. Staff R stated that the chemicals were scheduled for disposal by the environmental waste services in three days.

Observation on 05/24/2023 at 3:26 PM, showed two residents using a walker and a companion of two other residents walked around the building. During an interview at this same time, Staff S, Assisted Living Activities and Volunteer Coordinator confirmed that there were residents that independently walked around the premise.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

**WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:**

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (Resident 3), who used a medical device, was assessed to safely and properly use the device. The facility also failed to ensure the device was securely installed for safe use and to prevent possible entrapment. These failures placed Resident 3 at risk for potential entrapment and injury.

Findings included...

BED SIDE RAIL
Review of the Department of Health and Social Services (DSHS) document titled "Dear Assisted Living Facility Administrator", dated 05/16/2013, showed Assisted Living Facility Providers were issued this letter related to the safety risks associated with the use of all medical devices. The letter listed some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted.

Review of the facility's undated policy titled "North America Assistive Devices" showed that the facility's corporation did not approve the utilization of side/bed rails in their communities. The policy showed that devices were defined as any device designed or adapted to assist resident with physical or emotional limitation to perform actions, tasks, and activities. The policy showed action steps to be taken prior to installation of an assistive devices included step 1. The licensed Nurse "will assess the resident. This assessment is to include a review of the resident's: a. bed mobility; b. ability to transfer between positions, to and from bed or chair to stand and toilet; c. cognition and the ability to use an assistive device independently". The policy showed the assessment was kept in the electronic health record of the resident. Further review showed the licensed Nurse would outline the reason for the use of the assistive device, monitoring and resident specific care instructions in the progress notes and the Individual Service Plan (ISP)

Record review of the facility's undated document titled "Resident Characteristics Roster" showed that the facility admitted Resident 3 in [redacted] of 2022. The Characteristics Roster showed no documentation that Resident 3 used a medical device (bed side rail). The Characteristics Roster showed that Resident 3 resided in the secured Memory Care unit.

Review of Resident 3's undated "Progress Notes" showed no record that Resident 3 admitted with a bed side rail attached to the hospital bed.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

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Findings included...

BED SIDE RAIL
Review of the Department of Health and Social Services (DSHS) document titled "Dear Assisted Living Facility Administrator", dated 05/15/2013, showed Assisted Living Facility Providers were issued this letter related to the safety risks associated with the use of all medical devices. The letter listed some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted.

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Review of Resident 3's undated "Progress Notes" showed no record that Resident 3 admitted with a bed side rail attached to the hospital bed.

Review of the Resident 3's facility document titled "Individual Service plan" (ISP), dated 04/21/2023, showed no documentation that Resident 3 used a bed side rail.

Review of Resident 3's undated medical records found no documentation of a bed side rail assessment. Review of Resident 3's initial "general assessment", dated 05/10/2023, showed Resident 3 was diagnosed with [redacted] and [redacted]. The assessment also documented Resident 3 had a history of falls. The assessment showed Resident 3 was alert, oriented to place, forgetful, confused about the environment, unable to remember recent events and unable to remember specific events. The general assessment did not identify Resident 3 used a bed side rail.

During the facility tour on 05/22/2023 at 9:41 AM, observation of Resident 3's room showed a Resident 3's used a hospital bed. Observation showed a bed side rail attached to the hospital bed.

Observation on 05/23/2023 at 12:32 PM showed a half bedrail, 37 inches in length by 19 inches high, on the open side of Resident 3's hospital bed. The other side of the bed was pushed up against the wall.

During an interview on 05/24/2023 at 7:49 AM, Resident 3 stated that the bed side rail fastened to their hospital bed was used to "lock me in bed" so they could not get out. Resident 3 stated that the staff locked them in bed at night and let them out in the morning. During a second interview on 05/25/2023 at 7.50 AM, Resident 3 stated that they wanted the bed side rail for bed mobility.

During an interview on 05/24/2023 at 7:58 AM, Staff L, stated that Resident 3 used the bed side rail to keep them from falling out of bed. Staff L stated that Resident 3 had upper body paralysis. Staff L stated that Resident 3 also used the bed side rail to exercise in bed, turning themselves from side to side. During this same time, observation of Staff L's electronic tablet showed specific care tasks assigned for Resident 3. The tablet also showed Resident 3's ISP. Review of the assigned tasks and the ISP showed no documentation that Resident 3 used a bed side rail.

During an interview on 05/24/2023 at 2:40 PM, Staff N, Care Manager, stated that Resident 3 used the bed side rail to move around in the bed. Staff N stated that there were times Resident 3 placed their leg on the side of the bed and the bed side rail prevented Resident 3 from a fall. out. Staff N stated that when Resident 3 required any transfer assistance, Resident 3 used the bed side rail to support themselves to stand-up.

During an interview on 05/24/2023 at 12:56 PM. Staff M, Reminiscence Coordinator, stated that they were unaware Resident 3 had a bed side rail attached to the bed. Staff M stated that the Care Managers were responsible to communicate with Staff M when a resident in the secured Memory Care unit used a medical device, such as a bed side rail.

Review of the Resident 3's facility document titled "Individual Service plan" (ISP), dated 04/21/2023, showed no documentation that Resident 3 used a bed side rail.

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| Statement of Deficiencies | License #: 2464 | Compliance Determination # 24508 |
|---|---|---|
| Plan of Correction | Sunrise of Redmond | Completion Date |
| Page of 19 | Licensee: Sunrise Senior Living Management Inc | 06/20/2023 |

Staff M stated that they were unaware if a licensed nurse completed an assessment for the bed side rail or if it was noted in Resident 3's individualized service plan.

During an interview on 05/24/2023 at 2:53 PM, Staff B, Registered Nurse, Resident Care Director, stated that they were unaware if an assessment for Resident 3's bed side rail was completed when Resident 3 admitted to the facility. Staff B stated that they were unaware if Resident 3's ISP identified the bed side rail.

**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, Sunrise of Redmond is or will be in compliance with this law and / or regulation on (Date) 8/5/23 .

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

Administrator ~~(or Representative)~~ 6/27/23 Date

Staff M stated that they were unaware if a licensed nurse completed an assessment for the bed side rail or if it was noted in Resident 3's individualized service plan.

During an interview on 05/24/2023 at 2:53 PM, Staff B, Registered Nurse, Resident Care Director, stated that they were unaware if an assessment for Resident 3's bed side rail was completed when Resident 3 admitted to the facility. Staff B stated that they were unaware if Resident 3's ISP identified the bed side rail.

**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

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

06/21/2023

Sunrise Senior Living Management Inc
Sunrise of Redmond
15241 NE 20TH ST
BELLEVUE, WA 98007

RE: Sunrise of Redmond # 2464

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 06/20/2023 and found that your facility does not meet the Assisted Living Facility requirements.

**The Department:**

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

**You Must:**

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

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

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

DSHS/ALTSA
Residential Care Services
JUN 28 2023
Received

Kent, WA 98032

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

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

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

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

The facility license posted in the building expired December 2022. During the inspection, the facility Maintenance Coordinator removed the expired license and posted the current license, as required.

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

**You May:**
• Contact me for clarification of the deficiency or deficiencies found.

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

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 (253)234-6020.

Sincerely,

*Laurie Anderson*

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

Enclosure