STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Pacifica Kenmore LLC
Kenmore Senior Living
7221 NE 182nd St
Kenmore, WA 98028

RE: Kenmore Senior Living License # 2566

Dear Administrator:

This letter addresses Compliance Determination(s) 38064 (Completion Date 03/13/2024) and 32732 (Completion Date 01/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/13/2024 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-2665-1, WAC 388-78A-2665-2, WAC 388-78A-2665-4, WAC 388-78A-2665-5, WAC 388-78A-2665-6, WAC 388-78A-2160

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Kenmore Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2566
Compliance Determination #: 32732
Intake ID: 103198
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 11/16/2023 through 01/11/2024
Complainant Contact Date(s):

Allegation(s):

1. The Assisted Living Facility (ALF) will not offer Medicaid bed to the Named Resident (NR) after spending down personal funds and states they only have a certain amount of Medicaid beds available.
2. The NR's spouse was assisting with care, instead of the ALF caregivers.

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Identified resident Staff to resident interactions Resident to resident interactions
Interviews:	Family members Executive Director
Record Reviews:	Resident Records ALF Policy

Investigation Summary:

1. Record review and interview showed the facility had Medicaid contracts in place with a license for 100 assisted living beds, therefore the ALF could offer a Medicaid bed per contract, however the NR moved out prior to qualifying for Medicaid. The ALF failed to ensure residents had signed Medicaid Policies under current license.
2. Record review showed the ALF had a Negotiated Service Agreement in place with appropriate care and interventions. In interview, care staff stated the spouse would assist but in wasn't required. In interview, sampled residents had no issues with care staff providing care. The NR had moved out prior to investigation.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Kenmore Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2566
Compliance Determination #: 32732
Intake ID: 106524
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 11/16/2023 through 01/11/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident 1(NR1) attempted to force their way into Named Resident 2 (NR2)'s apartment.

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Dining Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members
Record Reviews:	Resident Records Investigations State reporting log

Investigation Summary:

1. Interview and Record review showed NR1 had a history and pattern of inappropriate sexual behavior towards female residents in the Memory Care Unit. Record review showed no record of NR1 forcing their way into NR2s apartment however the ALF failed to implement the Negotiated Service Agreement and monitor NR1 which resulted him touching female residents inappropriately repeatedly including being found unsupervised in a residents room removing their clothing.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Kenmore Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2566
Compliance Determination #: 32732
Intake ID: 105891
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 11/16/2023 through 01/11/2024
Complainant Contact Date(s):

Allegation(s):

1. Named Resident 1 (NR1) attempted to remove the clothing of Named Resident 2 (NR2) on the Assisted Living Facility's (ALF) Memory Care Unit (MCU).

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 2 Closed records sample size: 1
Observations:	Identified resident Residents Dining Activities
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	Resident Records Incident Investigations

Investigation Summary:

1. Interview and Record review showed NR1 had a history and pattern of inappropriate sexual behavior towards female residents in the Memory Care Unit. Record review and observation showed the ALF failed to implement the Negotiated Service Agreement and monitor NR1 which resulted him touching female residents inappropriately repeatedly including being found unsupervised in NR2's room removing their clothing.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Kenmore Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2566
Compliance Determination #: 32732
Intake ID: 112829
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 11/16/2023 through 01/11/2024
Complainant Contact Date(s):

Allegation(s):

1. The ALF did not refund care and service fees after the Named Residents (NR) moved out on the [redacted] of the month.

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Family members Identified staff
Record Reviews:	Medical records, admission agreement

Investigation Summary:

1. In interview, the ALF refused to refund the NR for the days following moving out per their admission agreement of a 30 day notice. In interview, the NRs family stated they felt the NRs safety was at risk so they moved out. The ALF failed to implement the Negotiated Service Agreement and monitor another Named Resident which resulted him touching female residents inappropriately repeatedly including being found unsupervised in a residents room removing their clothing.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2566	Compliance Determination # 32732
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 11/16/2023, 01/04/2024, 11/16/2023, 12/04/2023 and 11/16/2023 of:

Kenmore Senior Living
7221 NE 182nd St
Kenmore, WA 98028

This document references the following complaint number(s): 103198, 106524, 106194, 105891, 105529, 107288, 112829, 110502, 112163

The following sample was selected for review during the unannounced on-site visit: 2 of 74 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

01/22/2024
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) 1/30/2024 Date

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide a written policy on accepting [redacted] as a payment source for 3 of 3 residents (Resident 3, 4, and 5). This failure placed Resident 3, 4, and 5 at risk of not knowing the ALFs requirements and circumstances of [redacted] eligibility.

Findings included...

Review of the Facilities Management System Database showed this ALF was licensed under the current ownership on 02/17/2021.

Resident 3
Review of an undated Characteristic Roster (CR) showed Resident 3 moved into the building on [redacted] 2018 under previous ALF ownership. Records showed Resident 3 had a signed policy on accepting [redacted] as a payment source dated [redacted] 2019. This was a contract with the previous owner of the ALF which closed on 02/16/2021.

The ALF did not have a signed policy on accepting [redacted] as a payment source for Resident 3.

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Resident 4
Review of an undated CR showed Resident 4 moved into the building on [redacted]/2015 under previous ALF ownership. Records showed Resident 4 had a signed policy on accepting [redacted] as a payment source dated 08/03/2015. This was a contract with the previous owner of the ALF which closed on 07/31/2018.

The ALF did not have a signed policy on accepting [redacted] as a payment source for Resident 4.

Resident 5
Review of an undated CR showed Resident 5 moved into the building on [redacted]2012 under previous ALF ownership. Records showed Resident 5 had a signed policy on accepting [redacted] as a payment source 09/25/2014. This was a contract with the previous owner of the ALF which closed on 07/31/2018.

The ALF did not have a signed policy on accepting [redacted] as a payment source for Resident 5.

In an interview, on 01/04/2024 at 10:55 AM, Staff A (Executive Director) stated he was not aware paperwork signed under closed ALF licenses were no longer valid.

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, Kenmore Senior Living is or will be in compliance with this law and / or regulation on (Date) 2/19/2024.

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

Administrator (or Representative) — Date: 1/30/2024

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility failed to implement the Negotiated Service Agreement interventions of supervision and monitoring for 1 of 1 resident (Resident 1) who had a history and pattern of sexually inappropriate behavior towards female residents. This failure resulted in Resident 1 being unsupervised exhibiting inappropriate sexual behavior towards Resident 2 and Resident 6 and placed 4 of 4 female residents in the Memory Care Unit (MCU) at risk for sexual abuse.

Findings included...

Record review of the ALF's policy titled, "Elder Abuse, Neglect, and Exploitation", dated 12/09/2021, included, "Resident abuse, neglect, and exploitation are prohibited" and "The term abuse as used in this policy also includes, but is not limited to, neglect, abandonment, exploitation, and any other form of abuse. Immediate steps will be taken to taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted."

Review of an undated Characteristic Roster (CR) showed the ALF had a locked MCU that provided care for seven residents with diagnoses of cognitive impairment.

Observation, on 11/16/2023 at 11:20 AM, showed zero staff in the MCU. Four female residents and three male residents (including Resident 1 and 2) were seated in the dining room with no supervision or monitoring. At 11:24 AM, Staff C (Caregiver) and Staff D (Caregiver) entered the MCU together.

In an interview, on 11/16/2023 at 11:26 AM, Staff C (Caregiver) confirming there was no staff in the MCU, and the residents were not monitored, prior to his return at 11:24 AM.

Resident 1
Record review of an undated Face sheet (FS) showed the ALF admitted Resident 1 on [redacted] 2023 with multiple medical diagnoses including [redacted] Record review of a Needs and Service Plan (NSP-equivalent to a Negotiated Service Agreement), dated 11/14/2023, showed that Resident 1 had a "history of inappropriate sexual approach to female residents." The NSP showed Resident 1 needed to be, "supervised at all times, when sitting with female residents in the common area."

Resident 2
Record review of an undated FS showed the ALF admitted Resident 2 on [redacted] 2019 with multiple medical diagnoses including [redacted]

Record review of ALF investigation documentation, dated 11/08/2023, showed the staff found Resident 1 in Resident 2's apartment. Resident 1 was attempting to remove Resident 2's clothing. Resident 1 was found Resident 2's apartment again, later the same day and

was redirected by staff. Record review showed Resident 1 was left unsupervised when staff were busy assisting another resident for 45 minutes.

An interview, on 11/16/2023 at 1:08 PM, showed Resident 2 was not oriented, could not respond to yes or no questions and could not provide consent.

Resident 6
Record review showed the ALF admitted Resident 6 was admitted to the MCU on [redacted] 2019.
Review of a FS showed Resident 6 had a diagnosis of [redacted]

In an interview, on 11/16/2023 at 9:21 AM, Collateral Contact 1 (CC1- Former Resident 6's Family Representative) CC1 stated Resident 1 had been found unsupervised in Resident 6's apartment with his hand under Resident 6's shirt on one occasion. CC1 stated that they moved Resident 6 out of the facility for her safety due to the Resident 1 inappropriate sexual behavior. CC1 stated that Resident 6 was not oriented and could not give Resident 1 consent.

In an interview, on 01/09/2024 at 11:20 AM, Staff E (Caregiver) stated that Resident 1 was often inappropriate with female residents in the MCU. Staff E stated, on one occasion he found Resident 1 had taken Resident 6 to his apartment and had his pants down. Staff E stated that Resident 1 had to be redirected multiple times away from the female residents.

In an interview, on 11/16/2023 at 12:50 PM, Staff B (Resident Care Director) stated that the NSP had been updated and staff should be monitoring Resident 1 at all times to keep the female residents safe. When asked about the incidents of Resident 1 being found alone with Resident 2 and 6, and the observations of no staff supervision in the MCU, Staff B stated, "They [staff] are not following the care plan [NSP]."

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, Kenmore Senior Living is or will be in compliance with this law and / or regulation on (Date) 2/19/2024 .

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

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Administrator (or Representative)

1/30/2024
Date