STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Bremerton SCC LLC
The Arbor at Bremerton
3510 9th Street
Bremerton, WA 98312

RE: The Arbor at Bremerton License # 2619

Dear Administrator:

This letter addresses Compliance Determination(s) 40575 (Completion Date 05/02/2024) and 34986 (Completion Date 02/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/02/2024 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-2480, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2160, WAC 388-78A-2474-2-d, WAC 388-78A-2150, WAC 388-78A-2150-1, WAC 246-215-03351-1-b, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3100-4, RCW 70.129.070.1, WAC 388-78A-3040-2-a, WAC 388-78A-3040-2-b, WAC 388-78A-3040-2-c, WAC 388-78A-2040-1, WAC 388-78A-2630-2, WAC 388-78A-2400-2, WAC 388-78A-2260-2-a, WAC 388-78A-2610-1, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-d, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-d, WAC 388-78A-3090-1, WAC 388-78A-3090-2-c-ii, WAC 388-78A-3060-1, WAC 388-78A-3060-3, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-b, WAC 388-78A-2240, WAC 388-78A-2320-2-b

The Department staff who did the on-site verification:
Shirley Grew, LTC Surveyor
Cory Myers, ALF Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 98250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2619	Compliance Determination #34956
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 1 of 43	Licensee: Bremerton SCC LLC	02/28/2024

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

The department completed data collection for the unannounced on-site full inspection on 01/24/2024 and 01/28/2024 of:
The Arbor at Bremerton
3610 9th Street
Bremerton, WA 98312

The following sample was selected for review during the unannounced on-site visit: 7 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Shirley Orew, LTC Surveyor
Anissa Bearden, Licensor
Lisa Mason, NCI ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 98250
Lakewood, WA 98496

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.

[signature]	03/11/2024
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.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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

The department completed data collection for the unannounced on-site full inspection on 01/24/2024 and 01/29/2024 of:
The Arbor at Bremerton
3510 9th Street
Bremerton, WA 98312

The following sample was selected for review during the unannounced on-site visit: 7 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Shirley Grew, LTC Surveyor
Anissa Bearden, Licensor
Lisa Mason, NCI ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

Residential Care Services

03/11/2024
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.

Statement of Deficiencies	License #: 2593	Compliance Determination #34996
Plan of Correction	The Arbor at Bremerton	Complaint Date
Page 2 of 43	Licensee: Bremerton SCC LLC	01/29/2024

Administrator (or Representative) 3/24/24 Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

(2) For purposes of WAC 388-78A-2481 through 388-78A-2488, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on record reviews and interview, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 4 of 4 sampled new staff members (Staff A, B, C and D) were screened for tuberculosis (TB, a communicable disease) within three days of employment as required. This failure placed all 48 ALF residents at risk of TB infection.

Findings included...

Record review of the facility's employee roster, dated 01/24/2024, showed Staff A, Assistant Executive Director, was hired on 12/04/2023. Review of Staff A's personnel records failed to show results from a TB test done within three days of employment.

Record review of the facility's employee roster, dated 01/24/2024, showed Staff B, Caregiver, was hired on 04/22/2023. Review of Staff B's personnel records failed to show results from a TB skin test done within three days of employment.

Record review of the facility's employee roster, dated 01/24/2024, showed Staff C, Med Tech, was hired on 03/24/2023. Review of Staff C's personnel records failed to show results from a TB skin test done within three days of employment.

Record review of the facility's employee roster, dated 01/24/2024, showed Staff D, Med Tech, was hired on 12/01/2023. Review of Staff D's personnel records failed to show results from a TB skin test done within three days of employment.

During an interview on 01/29/2024 at 10:15 AM, Staff J, Regional Business Office Manager, said that they had provided everything they had on file for TB testing for the sampled staff.

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

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

This requirement was not met as evidenced by:

Based on record reviews and interview, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 4 of 4 sampled new staff members (Staff A, B, C and D) were screened for tuberculosis (TB, a communicable disease) within three days of employment as required. This failure placed all 45 ALF residents at risk of TB infection.

Findings included...

Record review of the facility's employee roster, dated 01/24/2024, showed Staff A, Assistant Executive Director, was hired on 12/04/2023. Review of Staff A's personnel records failed to show results from a TB test done within three days of employment.

Record review of the facility's employee roster, dated 01/24/2024, showed Staff B, Caregiver, was hired on 04/22/2023. Review of Staff B's personnel records failed to show results from a TB skin test done within three days of employment.

Record review of the facility's employee roster, dated 01/24/2024, showed Staff C, Med Tech, was hired on 03/24/2023. Review of Staff C's personnel records failed to show results from a TB skin test done within three days of employment.

Record review of the facility's employee roster, dated 01/24/2024, showed Staff D, Med Tech, was hired on 12/01/2023. Review of Staff D's personnel records failed to show results from a TB skin test done within three days of employment.

During an interview on 01/29/2024 at 10:15 AM, Staff J, Regional Business Office Manager, said that they had provided everything they had on file for TB testing for the sampled staff.

Statement of Deficiencies	License # 2619	Compliance Determination # 54306
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 3 of 43	Licensee: Bremerton SCC LLC	02/26/2024

Plan/Action 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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/24/24 4/18/24 JC.

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

Administrator (or Representative) — Date: 3/12/24

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 interviews and record review, the Assisted Living Facility (ALF) failed to follow the Negotiated Service Agreement (NSA) when the facility failed to provide showers for hygiene care, weekly housekeeping, and resident monitoring/supervision for safety for 7 of 10 Residents (Residents 1, 2, 3 ,4, 5, 6, and 7). This failure placed all 7 residents at risk for skin related infections, quality of life and safety concerns.

Findings included...

Resident 1 (R1) per record review on 03/25/2024 was admitted on [redacted]2023 with diagnoses to include [redacted]

Record review of R1's Negotiated Service Agreement (NSA) revised date 01/24/2024 said the facility was to provide resident monitoring/supervision for safety 7-3 times a shift. No documentation of completion on evening shifts from January 7-10, 2024.

Record review of R1's NSA revised date 01/24/2024 said housekeeping to be provided once a week. No documentation of completion from January 8-22, 2024.

Resident 2 (R2) per record review on 03/25/2024 was admitted on [redacted]2016 with diagnoses to include [redacted]

Record review of R2's NSA revised date of 06/24/2023 said the facility was to provide

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, The Arbor at Bremerton 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-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 interviews and record review, the Assisted Living Facility (ALF) failed to follow the Negotiated Service Agreement (NSA) when the facility failed to provide showers for hygiene care, weekly housekeeping, and resident monitoring/supervision for safety for 7 of 10 Residents (Residents 1, 2, 3 ,4, 5, 6, and 7). This failure placed all 7 residents at risk for skin related infections, quality of life and safety concerns.

Findings included...

Resident 1 (R1) per record review on 01/25/2024 was admitted on [redacted]/2023 with diagnoses to include [redacted].

Record review of R1's Negotiated Service Agreement (NSA) revised date 01/24/2024 said the facility was to provide resident monitoring/supervision for safety 7-8 times a shift. No documentation of completion on evening shifts from January 7-10, 2024.

Record review of R1's NSA revised date 01/24/2024 said housekeeping to be provided once a week. No documentation of completion from January 9-23, 2024.

Resident 2 (R2) per record review on 01/25/2024 was admitted on [redacted]/2018 with diagnoses to include [redacted].

Record review of R2's NSA revised date of 05/24/2023 said the facility was to provide

bathing assistance twice weekly. No documentation of completion from January 9-17 or 19-23, 2024.

Record review of R2's NSA revised date of 05/24/2023 said the facility was to provide laundry two times a week. No documentation of completion from January 9-18 and 19-23, 2024.

Record review of R2's NSA revised date of 05/24/2023 said the facility was to provide monitoring/supervision of ADLs for safety 7-8 times a shift. No documentation of completion from January dayshifts 7, 9, 11, 15-17, 22, 2024; evening shifts January 7-10, 21-22, 2024.

Resident 3 (R3) per record review on 01/25/2024 was admitted on [redacted]/2023 with diagnoses to include [redacted].

Record review of R3's NSA revised date 11/13/2023 and 12/11/2023 said to provide bathing assistance twice weekly. ADL log showed no documentation of completion from November 1-9, 2024, December 2-11, 2024 and January 6-11, 2024.

Record review of R3's NSA revised date 11/13/2023 said to provide housekeeping once a week. No documentation for completion from November 2023 dayshift 1-13.

Record review of R3's NSA revised date 11/13/2023 and 12/11/2023 said to provide monitoring/supervision of ADLs for safety 1-2 times a shift. No documentation of dayshifts November 1-13, 2023 and January dayshifts 6-7, 9, 12-16, 22, 2024. No documentation of evenings and nightshifts for November, December 2023 or January 2024.

Resident 4 (R4) per record review on 01/25/2024 was admitted on [redacted]/2023 with diagnoses to include [redacted].

Record review of R4's NSA revised date 10/13/2023 said to provide monitoring/supervision of ADLS for safety 3-4 times a shift. No documentation of completion for dayshift, evenings, or nightshift for January 3-24, 2024.

Record review of R4's NSA revised date 10/13/2023 said to provide housekeeping/room cleaning weekly. No documentation of completion for January 3-24, 2024.

Resident 5 (R5) per record review on 01/25/2024 was admitted on [redacted]/2022 with diagnoses to include [redacted] and [redacted].

Record review of R5's NSA revised date 09/07/2023 said to provide monitoring/supervision of ADLs for safety 7-8 times a shift. No documentation for January day shifts 9, 14-16,22, 2024, evening shifts January 9-10, 16, 21-22, 2024 and January nightshifts 14, 19, 2024.

Resident 6 (R6) per record review on 01/25/2024 was admitted on [redacted]/2023 with diagnoses to include [redacted].

Record review of R6's NSA revised date 04/17/2023 said monitoring/supervision of ADLs for safety. No documentation January dayshifts 9, 11, 15-17, 22-23, 2024 and January evening shifts 8-10, 15-16, 2024.

Resident 7 (R7) record review on 01/25/2024 showed that R7 was admitted on [redacted]/2018 with diagnoses to include [redacted].

Record review of R7's NSA revised date 09/07/2023 said to provide weekly housekeeping. No documentation of completion for January 5-17, 19-24, 2024.

Record review of R7's NSA revised date 09/07/2023 said to provide monitoring/supervision of ADLs for safety 1-2 times a shift. No documentation of completion for January dayshifts 5-6, 9, 11, 14-16, 21-22, 2024 and evening shifts 4,7-10, 12, 21-23, 2024.

An interview on 01/24/2024 at noon, CC1 (R2's Daughter) said she had been unhappy with care at the facility. The bathroom had been very dirty for a few weeks. They do not use the fall safety mat and she felt compelled to call in the middle of the night to check on him. He seldom had his own clothes available in the room closet and she often had to go to the laundry and find clothes that fit him. She said care staff are required to do the laundry and clean the rooms.

An observation on 01/24/2024 at noon, of R2's closet showed only three white T-shirts and no pants available.

An interview on 01/29/2024 at 12:30 PM, Staff E, Caregiver, said deep cleaning is supposed to be done once a week by housekeeping but they were short staffed, so caregivers try to do housekeeping and are required to do resident laundry.

Statement of Deficiencies	License # 2019	Compliance Determination # 34088
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 6 of 43	Licensee: Bremerton SCC LLC	03/26/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/26/24 4/12/24 JV

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

Administrator (or Representative) — Date: 3/12/24

WAC 388-76A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on record reviews and interview, the facility failed to ensure 1 of 4 sampled new staff (Staff D) had a valid First Aid/CPR (cardiopulmonary resuscitation) card on file. This failure placed 46 of 46 residents at risk of improper care and inadequate emergency response from untrained staff.

Findings included...

WAC 388-112A-0720
"What are the CPR and first aid training requirements?
(2) Assisted living facilities.
(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire."

Record review of the facility-provided staff list, dated 3/12/2024, showed Staff D, Medication Technician, was hired on 12/04/2023.

Record review of Staff D's personnel file showed Staff D's First Aid/CPR card expired on 09/22/2021.

In an interview on 01/26/2024 at 2:30 PM, Staff J, Regional Business Office Manager, stated they were in process of scheduling a trainer to update Staff D's First Aid/CPR certification.

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton 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-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on record reviews and interview, the facility failed to ensure 1 of 4 sampled new staff (Staff D) had a valid First Aid/CPR (cardiopulmonary resuscitation) card on file. This failure placed 45 of 45 residents at risk of improper care and inadequate emergency response from untrained staff.

Findings included...

WAC 388-112A-0720
"What are the CPR and first-aid training requirements?
(2) Assisted living facilities.
(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire."

Record review of the facility-provided staff list, dated 01/24/2024, showed Staff D, Medication Technician, was hired on 12/01/2023.

Record review of Staff D's personnel file showed Staff D's First Aid/CPR card expired on 08/22/2021.

In an interview on 01/25/2024 at 2:30 PM, Staff J, Regional Business Office Manager, stated they were in process of scheduling a trainer to update Staff D's First Aid/CPR certification.

Statement of Deficiencies	License #: 2519	Compliance Determination #:24336
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 7 of 43	Licensee: Bremerton SCC LLC	02/29/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date): 4/29/24 4/12/24

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

Administrator (or Representative) — Date: 3/12/24

WAC 388-78A-2160 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to ensure that the negotiated service agreement (NSA) was signed annually by the resident or their representative, for 5 of 7 sampled residents (Residents 1, 2, 3, 4, and 7). This failure placed the 5 residents at potential harm when the resident or resident's representative had not been involved in their care decisions and the services being provided.

Findings include...

Resident 1 (R1)
Record review showed that R1 was admitted to the ALF on [redacted] 2023. Review of R1's NSA, dated 12/14/2023, showed no signature from R1 or R1's representative.

Resident 2 (R2)
Record review showed that R2 was admitted to the ALF on [redacted] 2018. Review of R2's NSA, dated 05/24/2023, showed no signature from R2 or R2's representative.

Resident 3 (R3)
Record review showed that R3 was admitted to the ALF on [redacted] 2023. Review of R3's NSA, dated 12/18/2023, showed no signature from R3 or R3's representative.

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, The Arbor at Bremerton 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-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to ensure that the negotiated service agreement (NSA) was signed annually by the resident or their representative, for 5 of 7 sampled residents (Residents 1, 2, 3, 4, and 7). This failure placed the 5 residents at potential harm when the resident or resident's representative had not been involved in their care decisions and the services being provided.

Findings included...

Resident 1 (R1)
Record review showed that R1 was admitted to the ALF on [redacted]/2023. Review of R1's NSA, dated 12/14/2023, showed no signature from R1 or R1's representative.

Resident 2 (R2)
Record review showed that R2 was admitted to the ALF on [redacted]/2018. Review of R2's NSA, dated 05/24/2023, showed no signature from R2 or R2's representative.

Resident 3 (R3)
Record review showed that R3 was admitted to the ALF on [redacted]/2023. Review of R3's NSA, dated 12/11/2023, showed no signature from R3 or R3's representative.

Statement of Deficiencies	License # 2049	Compliance Determination # 34936
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 8 of 43	Licensee: Bremerton SCC LLC	02/26/2024

Resident 4 (R4)
Record review showed that R4 was admitted to the ALF on [redacted]2023. Review of R4's NSA, undated, showed no signature from R4 or R4's representative.

Resident 7 (R7)
Record review showed that R7 was admitted to the ALF on [redacted]2018. Review of R7's NSA, dated 01/21/2024, showed no signature from R7 or R7's representative.

In an interview on 01/25/2024 at 11:27 AM, Staff A, Assistant Executive Director, and Staff I, Regional Executive Director, said that all NSAs that were signed would be in the hard chart.

In an interview on 01/25/2024 at 4:00 PM, Staff I said that the ALF had provided all the signed NSAs they had for the sampled residents.

Plan/Action 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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/26/24 4/24/24 JC

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

Administrator (or Representative) — Date 2/26/24

WAC 246-216-03361 Preventing contamination from the premises Food storage (FDA Food Code 3-306.11).

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

(a) Where it is not exposed to splash, dust, or other contamination; and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to close three large bags of flour in it's dry pantry. This failure caused potential harm to all 45 residents when contaminates could enter the flour and the flour is then used to cook with.

Findings included...

Resident 4 (R4)
Record review showed that R4 was admitted to the ALF on [redacted]/2023. Review of R4's NSA, undated, showed no signature from R4 or R4's representative.

Resident 7 (R7)
Record review showed that R7 was admitted to the ALF on [redacted]/2018. Review of R7's NSA, dated 01/21/2024, showed no signature from R7 or R7's representative.

In an interview on 01/25/2024 at 11:27 AM, Staff A, Assistant Executive Director, and Staff I, Regional Executive Director, said that all NSAs that were signed would be in the hard chart.

In an interview on 01/25/2024 at 4:00 PM, Staff I said that the ALF had provided all the signed NSAs they had for the sampled residents.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 246-215-03351 Preventing contamination from the premises Food storage (FDA Food Code 3-305.11).

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

(b) Where it is not exposed to splash, dust, or other contamination; and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to close three large bags of flour in the dry pantry. This failure caused potential harm to all 45 residents when contaminates could enter the flour and the flour is then used to cook with.

Findings included...

Statement of Deficiencies	License #: 2813	Compliance Determination #: 34595
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 9 of 43	Licensee: Bremerton SOC LLC	03/29/2024

An observation on 01/24/2024 at 11:52 AM, and an observation on 1/25/2024 at 11:28 AM, showed three bulk-size flour bags open to air on a low shelf in the dry pantry.

On 01/25/2024 at 2:30 PM, Staff H, Regional Executive Chef, said she was unaware that the bags were open.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/1/2024.

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

Administrator (or Representative) — Date: 3/29/24

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

(1) The residents' characteristics and needs;

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

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

This requirement was not met as evidenced by:

Based on record review, observation, and interview the facility failed to secure potentially hazardous supplies accessible to memory care assisted living residents for 1 of 1 location within the facility (beauty salon). This failure placed 45 of 45 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed "the community will ensure that all supplies and equipment, dirty and clean, are handled and stored in a safe manner, protecting residents from

An observation on 01/24/2024 at 11:52 AM, and an observation on 1/25/2024 at 11:20 AM, showed three bulk-size flour bags open to air on a low shelf in the dry pantry.

On 01/25/2024 at 2:30 PM, Staff H, Regional Executive Chef, said she was unaware that the bags were open.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

(1) The residents' characteristics and needs;

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

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

This requirement was not met as evidenced by:

Based on record review, observation, and interview the facility failed to secure potentially hazardous supplies accessible to memory care assisted living residents for 1 of 1 location within the facility (beauty salon). This failure placed 45 of 45 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed "the community will ensure that all supplies and equipment, dirty and clean, are handled and stored in a safe manner, protecting residents from

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exposures and risk."

Record review of the facility's policy, "Cleaning resident rooms and furnishings," undated, under the section "procedure," showed all equipment and supplies would be stored in the commercial laundry room. The door would be locked when housekeeper was not on duty. Supplies would always be locked in a separate cabinet and room with commercial laundry room.

In an observation on 01/24/2024 at 11:45 AM, inside the unlocked beauty salon and inside the unlocked cabinets was a 15-ounce (oz) bottle with a label that showed "hydrogen peroxide," five tubes of 50 milliliters of perfect intensity semi-permanent color cream, and 12 boxes of 2 fluid oz bottles of permanent Loreal hair color. In the unlocked cabinet next to the window was a black tray with 50 multiple colors of fingernail polish bottles. Under the sink in the unlocked cabinets was a clear bottle with a gray spray handle that was ¾ full of green liquid. The bottle had a printed labeled that showed "Lysol" marked on the bottle. There was a clear spray bottle with a white and blue spray handle that was ¾ full of yellow liquid. The label on the bottle showed "room sense disinfectant cleaner." There was a third clear spray bottle with a yellow and white spray handle that was ¾ full of clear liquid. There was no label on the bottle but was black handwritten word "vinegar."

In an interview on 01/24/2024 at 12:01 PM, Staff K, Main Assistant, stated the beauty salon was to be locked at all times.

Plan/Restitution 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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 3/28/24 4/8/24 JC

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

Kim Coulson 3/28/24
Administrator (or Representative) Date

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

exposures and risk."

Record review of the facility's policy, "Cleaning resident rooms and furnishings," undated, under the section "procedure," showed all equipment and supplies would be stored in the commercial laundry room. The door would be locked when housekeeper was not on duty. Supplies would always be locked in a separate cabinet and room with commercial laundry room.

In an observation on 01/24/2024 at 11:45 AM, inside the unlocked beauty salon and inside the unlocked cabinets was a 16-ounce (oz) bottle with a label that showed "hydrogen peroxide," five tubes of 90 milliliters of perfect intensity semi-permanent color cream, and 12 boxes of 2 fluid oz bottles of permanent Loreal hair color. In the unlocked cabinet next to the window was a black tray with 50 multiple colors of fingernail polish bottles. Under the sink in the unlocked cabinets was a clear bottle with a gray spray handle that was ¼ full of green liquid. The bottle had a printed labeled that showed "Lysol" marked on the bottle. There was a clear spray bottle with a white and blue spray handle that was ¾ full of yellow liquid. The label on the bottle showed "room sense disinfectant cleaner." There was a third clear spray bottle with a yellow and white spray handle that was ¾ full of clear liquid. There was no label on the bottle but was black handwritten word "vinegar."

In an interview on 01/24/2024 at 12:01 PM, Staff K, Main Assistant, stated the beauty salon was to be locked at all times.

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, The Arbor at Bremerton 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

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure resulted in all residents and visitors being without access to and being informed of the facility's inspections results.

Findings included...

In an observation on 01/24/2024 at 9:53 AM, the survey binder (inspection results) was unable to be located by the receptionist desk or lobby area for review. There were no notes or signs posted in the area that indicated where the survey binder was located.

In an interview on 01/24/2024 at 9:58 AM, Staff P, Main Assistant, was unable to tell the Department where the survey binder was stored. Staff L, Resident Care Coordinator, stated they would get the survey binder and entered the executive director's office and shut the door. At 10 AM, Staff L came out of the executive director's office and stated Staff A, Assistant Executive Director, had the binder and would bring it to the Department for review.

In an interview on 01/24/2024 at 10:17 AM, Staff I, Regional Executive Director, stated they would get the survey binder from Staff A's office. At 10:24 AM, Staff I brought the survey binder for the Department to review.

Record review of the survey binder showed there was only inspections dated 11/05/2019 and 09/04/2018. The binder did not have any complaint inspections that resulted in citations available to review.

Record review of the Department records showed the facility had received numerous citations and inspection reports since the last annual full inspection on 11/05/2019.

In an interview on 01/24/2023 at 4:00 PM, Staff I stated the executive director was to ensure that the survey binder was updated with all the inspection for the residents, visitors, and all public to review.

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4/10/24 KC

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

Ana Cawlock 3/12/24
Administrator (or Representative) Date

WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 1 laundry rooms (memory care laundry rooms) implemented infection control practices to keep clean and soiled laundry separated. This failure resulted in 45 of 45 residents and 24 staff members not having infection control practices in place for proper handling and prevention of cross contamination for all laundry services.

Findings included...

Record review of the facility's policy titled, "Laundry Services-Personal Laundry," dated 10/01/2023, showed "policy to provide assistance with and/or access to laundry service for resident personal laundry in order to promote good hygiene, provide access to clean clothing, and enhance or maintain self-esteem."

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed "the community will ensure that all supplies and equipment, dirty and clean, are handled and stored in a safe manner, protecting residents from exposure and risk." Under the section "procedures," showed areas for cleaning and storing soiled equipment, supplies and laundry may be combined when there is no risk of spread of infection to those who are sensitive, had a work counter or table, and there must be no significant risk of contamination to clean equipment, clean laundry, preparation, or service.

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton 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-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 1 laundry rooms (memory care laundry rooms) implemented infection control practices to keep clean and soiled laundry separated. This failure resulted in 45 of 45 residents and 24 staff members not having infection control practices in place for proper handling and prevention of cross contamination for all laundry services.

Findings included...

Record review of the facility's policy titled, "Laundry Services-Personal Laundry," dated 10/01/2020, showed "policy to provide assistance with and/or access to laundry service for resident personal laundry in order to promote good hygiene, provide access to clean clothing, and enhance or maintain self-esteem."

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed "the community will ensure that all supplies and equipment, dirty and clean, are handled and stored in a safe manner, protecting residents from exposure and risk." Under the section "procedures," showed areas for cleaning and storing soiled equipment, supplies and laundry may be combined when there is no risk of spread of infection to those who are sensitive, had a work counter or table, and there must be no significant risk of contamination to clean equipment, clean laundry, preparation, or service.

In an observation on 01/25/2024 at 10:05 AM, on the wall behind a desk near the medication room was a sign that was posted on the wall. The sign was undated and showed, "all staff we no longer have a laundry aide. It is now your responsibility to pull all your laundry, wash, dry and fold and take back."

In an observation and interview on 01/25/2024 at 10:33 AM, entered the laundry room for the facility. Upon walking in from the soiled linen room to the right were two commercial washing machines. In front of the second washing machine on the ground was a large pile of white substance. There were multiple bags full of soiled resident clothing and linens that were on the ground. There was a pile of unbagged soiled linens and clothing that sat on the ground near one of the commercial drying machines. Across from the washing machines was a counter that was covered with multiple stacks of unbagged folded resident clothing and linens. The was no area of the countertop that was available to fold clean clothing or linen. In front of the counter was a rolling laundry cart with bagged clothing inside the basket. All the unbagged laundry on the countertop was touching a washing machine that had white clumped powdered substance inside. Inside the second washing machine was large amounts of thick pink substance that was on top of the lid and frame of the machine. When the washing machine lid was opened, a smell that resembled musk and mold existed. Inside the washing machine was more of the thick pink substance, a beige sweater, and a pillow. The drying machine beside the second washing machine was unable to be accessed as there was large amounts of unbagged folded resident clothing and linens stacked on top of the machine. There was a large laundry basket that sat on the ground in front of the machine. The laundry basket had a large stack of unbagged folded linens and clothes that was stacked higher than the top of the drying machine. The unbagged clothing and linens were stored next to the one washing machine with the thick pink substance on top. Staff D, Med Tech, was unable to say what side was clean and what side of the laundry room was dirty or the process. Staff D stated the caregivers were responsible to ensure all the laundry was completed. Staff D stated the caregivers had to come in on their days off to get the laundry caught up for the residents as they did not have time during their scheduled shifts.

In an observation and interview on 01/25/2024 at 5:18 PM, inside the laundry room, Staff N, Maintenance Specialist, stated the caregivers were to bring the soiled linen and resident's clothes in from the soiled linen room. Caregivers were to use the two commercial washing machines to wash the clothes. The clothes then got dried and then folded. Staff N stated the clean clothes and linens were to be bagged and then delivered to the resident's room. Staff N stated "the buried table" to the left of the laundry room was considered the clean side of the room. Staff N was unable to explained what the white clumped powdered substance was that was inside the washing machine beside the "clean" counter. On the same side of the "clean" counter. Staff I stated the washing machine needed to be cleaned. Staff N opened the second washing machine and stated the items inside the machine were an assisted living resident's items. Staff I, Regional Executive Director, stated some assisted living resident's clothes were washed in the washing machines. Staff I stated the laundry room needed to be cleaned up.

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

[signature] 3/12/24
Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure that the designated smoking area was 25 feet away from the building per Washington State law. The facility failed to ensure that the fire extinguishers were checked timely. These failures placed 45 of 45 residents at risk for exposure to smoke and the risk of the residents', staff, and visitors' life and safety at risk in the event of a fire.

Findings included...

"Code 906.2 General Requirements. 906.2 General requirements.
Portable fire extinguishers shall be selected, installed and maintained in accordance with this section and NFPA 10.
Exceptions:
1.The distance of travel to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2.Thirty-day inspections shall not be required, and maintenance shall be allowed to be once every 3 years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met.
2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by

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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-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure that the designated smoking area was 25 feet away from the building per Washington State law. The facility failed to ensure that the fire extinguishers were checked timely. These failures placed 45 of 45 residents at risk for exposure to smoke and the risk of the residents', staff, and visitors' life and safety at risk in the event of a fire.

Findings included...

"Code 906.2 General Requirements. 906.2 General requirements.
Portable fire extinguishers shall be selected, installed and maintained in accordance with this section and NFPA 10.
Exceptions:
1.The distance of travel to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2.Thirty-day inspections shall not be required, and maintenance shall be allowed to be once every 3 years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by

NFPA 10.
3. In Group I-3, portable fire extinguishers shall be permitted to be located at staff locations."

RCW 70.160.075 titled "Smoking prohibited within twenty-five feet of public places or places of employment - Application to modify presumptively reasonable minimum distance. "Smoking is prohibited within a presumptively reasonable minimum distance of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited so as to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means."

Fire Extinguishers

In an observation on 01/24/2024 at 9:29 AM, on the wall across from the room 146, the fire extinguisher was last checked "Dec." There was no day or year documented.

In an observation on 01/24/2024 at 9:30 AM, on the wall near room 136, the fire extinguishers service tag showed last time it was checked was "Dec." There was no day or year documented.

In an observation on 01/24/2024 at 9:32 AM, on the wall near room 130, the fire extinguishers service tag showed last time it was checked was "Dec." There was no day or year documented.

In an observation on 01/24/2024 at 9:35 AM, on the wall near room 106, the fire extinguishers service tag showed last time it was checked was "Dec." There was no day or year documented.

In an observation on 01/24/2024 at 11:13 AM, on the wall near the television and independent activity supply room, the fire extinguishers service tag showed it was last checked "Dec." There was no day or year documented.

In an observation on 01/24/2024 at 3:02 PM, on the wall next to the dining room, the fire extinguishers service tag showed last time it was checked was "Dec." There was no year or date documented and just initials.

In an interview on 01/25/2024 at 11:07 AM, Staff N, Maintenance Specialist, stated they were to check the fire extinguishers every month. Staff N stated they were to document the day, month, and the year of the day they checked the fire extinguisher on the service tag.

In an observation and interview on 01/25/2024 at 11:11 AM, inside the maintenance office across from the laundry room next to the desk to the left, was a fire extinguisher that was

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standing on the ground. The fire extinguisher was unsecured and standing next to a multiple level shelf with various tools, boxes, and items stored and power tools. Staff H stated, "it needs a new home," when Staff N was asked if the fire extinguisher was stored properly. Staff N stated the fire extinguisher needed to be mounted on the wall and would be when Staff N initiated it. In an observation on 01/29/2024 at 10:06 AM, inside the maintenance office, the fire extinguisher remained standing upright on the ground next to the shelves and the power tools unsecured or mounted.

Smoking area

In an observation on 01/25/2024 at 11:26 AM, outside the back door of the laundry room on the other side of the sidewalk across from resident room windows was a smoking discard post. Near the smoking post was a black bin with standing water that had multiple floating yellow and white cigarette burnt pieces. On the outside ledge of the buildings trim by the laundry door was a lighter that was stored.

In an observation and interview on 01/25/2024 at 5:20 PM, outside the back door of the laundry room, the smoking discard post remained beside the sidewalk across from resident rooms. The smoking post was measured at 18 feet 4 inches away from the building. Staff I and Staff N, both stated that was not 25 feet away. Staff I observed to lift the lid of the smoking post up and noted there was ash inside. The black bin with standing water near the smoking post still have floating numerous yellow and white cigarette burnt pieces. Staff I stated they would have the smoking post removed on 01/26/2024.

In an observation on 01/29/2024 at 9:59 A.M, out the back of the laundry door outside, the smoking post was moved further down the sidewalk area, but remained less than 25 feet from the facility and across from resident room windows.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 2/9/24.

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

[redacted] 2/9/24
(Administrator (or Representative)) Date

WAC 388-78A-2530 Reporting abuse and neglect.

(1) The assisted living facility must prominently post on all readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident

standing on the ground. The fire extinguisher was unsecured and standing next to a multiple level shelf with various tools, boxes, and items stored and power tools. Staff N stated, "it needs a new home," when Staff N was asked if the fire extinguisher was stored properly. Staff N stated the fire extinguisher needed to be mounted on the wall and would be when Staff N installed it. In an observation on 01/26/2024 at 10:05 AM, inside the maintenance office, the fire extinguisher remained standing upright on the ground next to the shelves and the power tools unsecured or mounted.

Smoking area

In an observation on 01/25/2024 at 11:25 AM, outside the back door of the laundry room on the other side of the sidewalk across from resident room windows was a smoking discard post. Near the smoking post was a black bin with standing water that had multiple floating yellow and white cigarette burnt pieces. On the outside ledge of the buildings trim by the laundry door was a lighter that was stored.

In an observation and interview on 01/25/2024 at 5:20 PM, outside the back door of the laundry room, the smoking discard post remained beside the sidewalk across from resident rooms. The smoking post was measured at 10 feet 4 inches away from the building. Staff I and Staff N, both stated that was not 25 feet away. Staff I observed to lift the lid of the smoking post up and noted there was ash inside. The black bin with standing water near the smoking post still have floating numerous yellow and white cigarette burnt pieces. Staff I stated they would have the smoking post removed on 01/26/2024.

In an observation on 01/26/2024 at 9:58 AM, out the back of the laundry door outside, the smoking post was moved further down the sidewalk area, but remained less than 25 feet from the facility and across from resident room windows.

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, The Arbor at Bremerton 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-2630 Reporting abuse and neglect.

(2) The assisted living facility must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident

abuse and neglect.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to have the required state agency and state ombudsman's contact information posted within the facility for 45 of 45 residents, staff members, and visitors for review. This placed all 45 residents, visitors, and staff members at risk of not having the contact information to report to the Department of any abuse, neglect, or violation of the resident's rights.

Findings included...

"RCW 70.129.030 Notice of rights and services—Admission of individuals. (b) A posting of names, addresses, and telephone numbers of the state survey and certification agency, the state licensure office, the state ombuds program, and the protection and advocacy systems; and (c) A statement that the resident may file a complaint with the appropriate state licensing agency concerning alleged resident abuse, neglect, and misappropriation of resident property in the facility."

In an observation on 01/24/2024 at 9:29 AM, upon entering the memory care residents living area, front dining room area, and near the life enrichment's office showed there was no poster posted with the Departments Complaint Resolution Unit's (CRU) phone number or the state ombudsman's contact information for review on the walls.

In an observation on 01/24/2024 at 11:13 AM, on the walls near and around the area of the television and independent activity room area showed there was no poster posted with the Departments CRU phone number or the state ombudsman's contact information for review.

In an observation on 01/24/2024 at 11:23 AM, on the walls behind the desk near room 131 and the surrounding hallways showed there was no poster posted with the Departments CRU phone number or the state ombudsman's contact information for review on the walls.

In an observation on 01/24/2024 at 12 PM, on the wall in the hallways near the beauty salon showed there was no poster posted with the Department's CRU phone number or the state ombudsman's contact information for review on the walls.

In an observation on 01/24/2024 at 12:10 PM, on the walls behind the desk near the front medication room and the surrounding hallways showed there was no poster posted with the Department's CRU phone number or the state ombudsman's contact information for review on the walls.

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In an interview on 01/24/2024 at 12:14 PM, Staff D, Med Tech, stated the Department's CRU phone number and poster was posted in the employee break room. Staff D stated they had not seen the Department's CRU poster or the state ombudsman's contact information posted up throughout the facility or the lobby.

In an interview and observation on 01/25/2024 at 10:24 AM, Staff D stated there was no Department CRU poster posted up in the facility. Staff D was observed to look at all the hallways near the television and independent activity room. Staff D stated they had never seen the Department CRU poster or the state ombudsman's contact information that was posted on the wall above a fire extinguisher prior to today.

In an interview on 01/26/2024 at 11:52 AM, Staff I, Regional Executive Director, stated a few posters of the Department's CRU notice and the state ombudsmen's contact information was to be posted throughout the residents' living area and the front lobby on the cork board. Staff I was observed to check the corkboard in the lobby and stated, the poster was not posted there.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 3/15/24 4/12/24 jc

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

Administrator (or Representative) — Date 3/19/24

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records, maintain records for easy access, and provide the department with access to resident records for 2 of 2 medication carts observed. These failures placed 45 of 46 residents at risk for exposure of confidential records and resulted in delays of information to authorized representatives of the Department.

Findings included...

In an interview on 01/24/2024 at 12:14 PM, Staff D, Med Tech, stated the Department's CRU phone number and poster was posted in the employee break room. Staff D stated they had not seen the Department's CRU poster or the state ombudsman's contact information posted up throughout the facility or the lobby.

In an interview and observation on 01/25/2024 at 10:24 AM, Staff D stated there was no Department CRU poster posted up in the facility. Staff D was observed to look at all the hallways near the television and independent activity room. Staff D stated they had never seen the Department CRU poster or the state ombudsman's contact information that was posted on the wall above a fire extinguisher prior to today.

In an interview on 01/26/2024 at 11:52 AM, Staff I, Regional Executive Director, stated a few posters of the Department's CRU hotline and the state ombudsman's contact information was to be posted throughout the residents living area and the front lobby on the cork board. Staff I was observed to check the corkboard in the lobby and stated, the poster was not posted there.

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, The Arbor at Bremerton 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-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records, maintain records for easy access, and provide the department with access to resident records for 2 of 2 medication carts observed. These failures placed 45 of 45 residents at risk for exposure of confidential records and resulted in delays of information to authorized representatives of the Department.

Findings included...

Statement of Deficiencies	License # 2619	Compliance Determination # 34985
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"RCW 70.129.050 Privacy and confidentiality of personal and medical records. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records."

Record review of the facility's policy titled, "Confidentiality of Resident Records," showed it was the policy of the facility to hold all resident information in the strictest confidence and make sure information accessible only to authorized staff, the resident, authorized authorities, and individuals with the resident's approval in accordance with applicable state and federal law. All resident medical records are kept in secure location and accessible to authorized staff members.

In an observation and interview on 01/24/2024 at 9:37 AM, during a general tour of the facility, on top of one of the medication carts was an empty medication card that had a prescription label with Resident 9's name displayed. Staff D, Med Tech, stated they were not to leave any documents of medical records with resident's name or information left out for any unauthorized person to review.

In an observation and interview on 01/25/2024 at 5:13 PM, upon entering the residents living area next to the resident dining room area were multiple residents sitting at the dining room tables and walking around. On top of one of the medication carts that was parked by the dining room was a computer that was open and the screen on that displayed numerous residents' pictures and names. Review of the computer screen showed Resident 9's picture and name displayed along with multiple other residents' names and pictures. Staff I, Regional Executive Director, stated the computer screen was not locked and residents' names and information was not secured properly.

Plan/Alteration 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, The Arbor at Bremerton is or will be in compliance with the law and / or regulation on (Date): 4/2/24 fc

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

Lisa Cavlock — Administrator (or Representative)

3/20/24 — Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

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

Record review of the facility's policy titled, "Confidentiality of Resident Records," showed it was the policy of the facility to hold all resident information in the strictest confidence and make sure information accessible only to authorized staff, the resident, authorized authorities, and individuals with the resident's approval in accordance with applicable state and federal law. All resident medical records are kept in secure location and accessible to authorized staff members.

In an observation and interview on 01/24/2024 at 9:37 AM, during a general tour of the facility, on top of one of the medication carts was an empty medication card that had a prescription label with Resident 8's name displayed. Staff D, Med Tech, stated they were not to leave any documents or medical records with resident's name or information left out for any unauthorized person to review.

In an observation and interview on 01/25/2024 at 5:13 PM, upon entering the resident living area next to the resident dining room area were multiple residents sitting at the dining room tables and walking around. On top of one of the medication carts that was parked by the dining room was a computer that was open and the screen on that displayed numerous residents' pictures and names. Review of the computer screen showed Resident 5's picture and name displayed along with multiple other residents' names and pictures. Staff I, Regional Executive Director, stated the computer screen was not locked and residents' names and information was not secured properly.

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, The Arbor at Bremerton 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-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

Statement of Deficiencies	License # 2019	Compliance Determination #24996
Plan of Correction	The Arbor at Bremerton	Completion Date
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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a medication cart was locked to ensure that resident medications were secured and only accessible to designated staff persons for 1 of 2 medication carts reviewed. This failure placed 46 of 46 memory care residents at risk for access and ingestion of potentially harmful medications and the medication cart was at risk to be accessed by unauthorized personnel.

Findings included...

Record review of the facility's policy titled, "Security and Storage of Medications," undated, showed it was the policy for the facility to ensure that all medications were stored in such a way as to provide safety, security, and proper environment. Under the section titled, "procedure," showed all medications shall be stored in locked cabinets, rooms, or carts and shall be accessible only to authorized residents and personnel.

In an observation and interview on 01/25/2024 at 5:13 PM, upon entering the resident living area next to the resident dining room area were multiple residents sitting at the dining room tables and walking around. One of the medication carts that was parked next to the dining room was noted to have the lock extended out and a red circle exposed. The top drawer was able to be opened and inside was observed Resident 5's Humalog (short acting insulin to help lower blood sugar levels quicker) and Lantus (long acting insulin to help lower and maintain blood sugar levels in a normal range) insulin pen, insulin pen screw top needles, and a tube of bacitracin ointment (a prescribed medicated ointment to treat scrapes, burns, and cuts) with a prescription label for Resident 2 and multiple other tubes and bottles. Staff I, Regional Executive Director, stated the medication cart was not locked properly. Staff I had Staff L, Resident Care Coordinator, stand with the medication cart until the medication technician on shift returned to the medication cart.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/1/24
4/12/24

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

[signature] 3/21/24
Administrator (or Representative) Date

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a medication cart was locked to ensure that resident medications were secured and only accessible to designated staff persons for 1 of 2 medication carts reviewed. This failure placed 45 of 45 memory care residents at risk for access and ingestion of potentially harmful medications and the medication cart was at risk to be accessed by unauthorized personnel.

Findings included...

Record review of the facility's policy titled, "Security and Storage of Medications," undated, showed it was the policy for the facility to ensure that all medications were stored in such a way as to provide safety, security, and proper environment. Under the section titled, "procedure," showed all medications shall be stored in locked cabinets, rooms, or carts and shall be accessible only to authorized residents and personnel.

In an observation and interview on 01/25/2024 at 5:13 PM, upon entering the resident living area next to the resident dining room area were multiple residents sitting at the dining room tables and walking around. One of the medication carts that was parked next to the dining room was noted to have the lock extended out and a red circle exposed. The top drawer was able to be opened and inside was observed Resident 5's Humalog (short acting insulin to help lower blood sugar levels quicker) and Lantus (long acting insulin to help lower and maintain blood sugar levels in a normal range) insulin pen, insulin pen screw top needles, and a tube of bacitracin ointment (a prescribed medicated ointment to treat scrapes, burns, and cuts) with a prescription label for Resident 2 and multiple other tubes and bottles. Staff I, Regional Executive Director, stated the medication cart was not locked properly. Staff I had Staff L, Resident Care Coordinator, stand with the medication cart until the medication technician on shift returned to the medication cart.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

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

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 3 of 3 rooms (shower room, medication charting room, and Resident 5's [R5] room) for staff and residents to use. The facility failed to implement proper infection control hand washing measures when care and services were provided by 2 of 2 sampled staff (Staff E and Staff M). The facility failed to ensure staff were fit tested for an N95 respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) for 4 of 4 sampled staff members (Staff D, Staff E, Staff K and Staff L) when a memory care resident was on isolation precautions for an infectious virus. These failures placed all 45 residents, 24 staff, and visitors at risk of being infected and spreading communicable diseases.

Findings included...

Record review of the Dear Provider Letter (DPL) ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal Protective Equipment (PPE)," dated 04/30/2021, directed Long Term Care Facilities (LTCF) under WAC 296-842-12005 to develop and maintain a respirator program which included initial fit testing and providing staff with their fit tested respirator.

Record review of the document titled, "L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE," dated 03/30/2021, showed "The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 (Corona Virus Disease 2019-an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death and other airborne hazards). A 'fit test' is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes. The 'fit test' is to be completed every 12 months."

Record review of Washington State (WA) Department of Health (DOH) website document titled, "Respiratory Protection Program for Long-Term Care Facilities," undated, under the section titled, "fit testing," showed respirator fit testing was to be done before use of N95 respirator and then every year (within 12 months of the date of the last fit test).

Record review of the Department of Health document, titled, "Respiratory Protection Program for Long-Term Care Facilities," undated, showed "providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department of Labor and Industries (L&I). Employers have an obligation to protect their employees from hazards in the workplace (General Duty WAC 296-126-094). In healthcare facilities, the tight-fitting disposable 'N95' respirator is a commonly used for respiratory protection. Respirator fit testing ensures that tight-fitting respirators seal properly and helps protect employees from exposure to airborne particles such as viruses and bacteria. Keep your employees safe and working by getting them fit tested and ready to properly use a respirator."

WAC 296-842-12010 Keep respirator program records. "(1) A written copy of the current respirator program must be kept by the employer. (2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include: (a) Employee name; (b) Test date; (c) Type of fit test performed; (d) Description (type, manufacturer, model, style, and size) of the respirator tested; (e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a printout, or other recording of the test."

Record review of the facility's policy titled, "Respirator Protection Program," dated 05/01/2023, showed the facility's respiratory protection program (RPP) was designed to maximize protection afforded by respirators when they must be used. The policy establishes procedures necessary to meet the regulator requirements described in Occupational Safety and Health Administration's (OSHA) respiratory protection standard 29 CFR 1910.134. The facility's administrator or designee was responsible for administering the respiratory protection program, keep appropriate records in regard to respirator fit testing, and ensure that each employee was fit tested annually or if other circumstances such as significant weight loss or weight gain that required the staff member to be refitted. Employees that required to wear a respirator must complete a medical evaluation check sheet and meet the criteria prior to being approved to wear a respirator.

Record review of OSHA's Respiratory Protection standard 29 CFR 1910.134, undated, showed under section "1910.134(m) Recordkeeping. This section requires the employer to establish and retain written information regarding medical evaluations, fit testing, and the respirator program. This information will facilitate employee involvement in the respirator program, assist the employer in auditing the adequacy of the program, and provide a record for compliance determinations by OSHA."

Record review of CDC's fact sheet titled, "Hand Hygiene at Work," undated, showed good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It also meant using alcohol-based hand sanitizer with at least 60

percent alcohol if soap and water was not readily available. Under the section titled, "Tips for Protecting Employee Health," showed increased access to sinks that were accessible to all employees and in places such as bathrooms, food preparation areas, or in eating areas. Provide soap, water, and a way to dry hands so employees can wash and dry hands properly. Place hand sanitizer dispensers with at least 60% alcohol near frequently touched surfaces, in areas where soap and water were not easily accessible, such as near shared equipment, building entrances and exits and more.

Record review of the facility's policy titled, "infection control policies and procedures," 02/01/2015, under section titled, "handwashing," showed handwashing was performed between resident contact, removing of gloves, before and after returning from breaks or use of the toilet. Hand washing facilities were to have hot water, soap, and single use towels available wherever residents contact occurs including but not limited to, kitchen, public restrooms, medication room and resident apartments. Under the section titled, "waterless cleaner," showed the facility policy is to not replace the use of soap and water with waterless cleaners, however it was recognized that there were times when soap and water may not be available, and the cleansing of hands was appropriate. The use of waterless, alcohol-based sanitizer could be used to cleanse hand when the hands were not visible soiled.

Record review of the facility's, "infection control," dated 03/02/2020, under the section titled, "recommendations for residents and caregivers," showed hands should be washed before and after touching the resident. Hands were to be washed after removing gloves.

Handwashing supplies

In an observation on 01/24/2024 at 11:55 AM, inside the shower room near the beauty salon, the trash can did not have a trash bag inside.

In an observation on 01/25/2024 at 10:03 AM, inside the medication and charting room near the front dining room, the sink did not have paper towels available for use.

In an observation on 01/25/2024 at 10:48 AM, inside R5's bathroom there was no soap dispenser, soap, or paper towels available for use. There was no hand sanitizer in the bathroom or the room available for use.

In an observation on 01/25/2024 at 12:11 PM, Staff D, Med Tech, entered R5's room to administer their insulin and check R5's blood sugar reading. Staff D walked into R5's bathroom and looked at the sink. R5 stated "there is no soap or paper towels." Staff D was unable to wash their hands or had paper towel available to use as a barrier for their insulin and blood sugar reading supplies.

In an observation on 01/26/2024 at 10:11 AM, inside R5's bathroom there was no soap or paper towels available to wash your hands with.

Hand washing

In an observation on 01/25/2024 at 9:40 AM, inside Resident 7's (R7) room Staff E, Caregiver, bare handed touched R7's wheelchair, and assisted R7's bottom area to sit into their wheelchair. Staff E pushed R7 down to the dining room in their wheelchair. Staff E moved some dining room chairs out of the way to make a place for R7 to sit at the dining table with their wheelchair. Staff E was not observed to wash their hands or use hand sanitizer since Staff E entered R7's room. At 9:45 AM Staff E entered the little serving kitchen attached to the front dining room, Staff E grabbed a plate of plated food from the hot box (a container that keeps foods hot until served) and delivered it to an unnamed male resident at a dining room table. Staff E was not observed to wash their hands or use hand sanitizer prior to grabbing the plate of ready to eat food to serve to the resident. Staff E entered back into the little serving kitchen. Staff E put on cream-colored disposable gloves and grabbed a bowl out of the hot box. Staff E then served the bowl to R7. Staff E with their gloved hands pulled a dining room chair out for another unnamed resident. Staff E entered back into the little serving kitchen and grabbed another plate of ready to eat food and served it to the resident. At 9:50 AM Staff E removed their disposable gloves from their hands. Staff E grabbed two cups and filled the cups with the juice dispenser and served them to the residents. Staff E was not observed to wash their hands or use hand sanitizer after they removed their gloves. At 9:59 AM, Staff E picked up dirty dishes from the residents and placed them in the little serving kitchen. Staff E brought out another cup full of juice and served it to a resident. at 10 am Staff E had not been observed to wash their hands or use hand sanitizer since first observed at 9:40 AM.

In an observation and interview on 01/25/2024 at 4:45 PM Staff M, Caregiver, was assisting an unknown-named male resident out of the shower room and locked the shower rooms door. At 4:48 PM, Staff M came into R7's room. Staff M explained to R7 they would assist them with getting changed and taken down for dinner. At 4:49 PM Staff M pulled some disposable blue gloves from their pockets and put them on. Staff M was not observed to wash their hands or use hand sanitizer prior to putting the gloves on. Staff M assisted R7 to remove their pant and urine-soiled brief and discarded it into the trash can. Staff M provided peri care for R7. Staff M assisted R7 with putting the new brief on and R7's pants with the same disposable gloves without changing them. Staff M grabbed R7's wheelchair with their gloved hands and positioned it by the bed. While R7 transferred to the wheelchair, Staff M touched their own hair and shirt with their gloved hands. Once R7 was in their wheelchair, Staff M grabbed the blanket with their same gloved hands and placed the blanket over R7's lap. Staff M removed their disposable gloves and discarded them into the trash can. Staff M removed the bag out from the trash can and tied it closed. Staff M reached into their shirt pocket and removed a roll of trash bags. Staff M put a new trash bag into the trash can and replaced the roll of trash bags back into their shirt pocket. Staff M unlocked R7's wheelchair brakes and pushed R7 toward the dining room. At 4:56 PM Staff M used their keys to open the soiled linen room and threw the trash bag away. Staff M touched their face and noted to cough into their hand. Staff M was not observed to use hand sanitizer or wash their hands. Staff M grabbed R7's wheelchair and proceeded to push R7 to the dining room. As Staff M continued to push R7 to the dining room, Staff M coughed into their fisted bare hand. Staff M grabbed R7's wheelchair with their bare hand and continued to the dining room. Staff M was not observed to wash their hands or use hand sanitizer. Staff M continued to cough in their barefisted hand and positioned R7 in

the dining room. The medication technician on shift told Staff M to wash their hands. At 5 PM Staff M entered the server room and washed their hand with soap and water for the first time. Staff M stated they did not have any hand sanitizer on them. Staff M stated they wash their hands after doing any tasks that included changing clothes, after gloves were removed, if they touched their face, after use of the bathroom, and before and after touching food.

Fit Testing

Record review of the facility's untitled document, dated 01/24/2024, showed Staff D was hired at the facility on 12/01/2023.

Record review of Staff D's document titled, "Fit Test Record Form," dated 09/05/2022, showed it had expired on 09/05/2023. There were no other fit test records in Staff D's employee file for review.

Record review of the facility's untitled document, dated 01/24/2024, showed Staff E was hired at the facility on 11/07/2023.

Record review of the facility's untitled document, dated 01/24/2024, showed Staff L, Resident Care Coordinator, was hired at the facility on 12/23/2022.

Record review of the facility's untitled document, dated 01/24/2024, showed Staff K, Main Assistant, was hired at the facility on 06/08/2023.

In an interview on 01/24/2024 at 12:03 PM, Staff K stated they were not fit tested for an N95 respirator. Staff K stated they had never been through a N95 respirator fit testing procedure before.

In an interview on 01/25/2024 at 9:25 AM, Staff D stated they were not fit tested for an N95 respirator. Staff D stated when Resident 1 was positive with COVID-19 and on isolation precautions, Staff D administered R1 their medications in R1's room. Staff D stated that Staff D got COVID-19 in the beginning of January 2024.

In an observation on 01/26/2024 at 10 AM, Staff L stated they had not been re-evaluated and fit tested for N95 respirator in two years. Staff L stated the facility does not allow any staff member to enter a resident's room that was on COVID-19 isolation precautions if they were not fit tested for an N95 respirator.

In an interview on 01/26/2024 at 10:13 AM, Staff E stated they had not been fit tested for an N95 respirator.

Statement of Deficiencies	License #: 2519	Compliance Determination #: 34156
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 2 of 49	Licensee: Bremerton SCC LLC	02/29/2024

In an interview on 01/26/2024 at 10:27 AM, Staff I, Regional Executive Director, stated the facility did not have any N95 fit testing or medical clearance records for the staff members for review. Staff I stated the previous nurse was responsible to update the staff's N95 respirator testing records and medical clearances, but since the nurse left employment at the facility, the fit testing records were unable to be located. Staff I was unable to provide the Department any N95 respirator fit testing or medical clearance records for all employees for review.

Plan/Execution 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, The Arbor at Bremerton is or will be in compliance with this law and/or regulation on (Date) 4/12/24

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

Lisa Cosiock — 3/8/24
Administrator (or Representative) — Date

WAC 388-78A-3060 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

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

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

(2) The assisted living facility must provide housekeeping supply room(s):

(a) Equipped with:

(i) Storage for wet mops;

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 areas (interior and exterior grounds of the facility). The facility failed to keep equipment and furnishings clean. These failures placed 45 of 45 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

In an interview on 01/26/2024 at 10:27 AM, Staff I, Regional Executive Director, stated the facility did not have any N95 fit testing or medical clearance records for the staff members for review. Staff I stated the previous nurse was responsible to update the staff's N95 respirator testing records and medical clearances, but since the nurse left employment at the facility, the fit testing records were unable to be located. Staff I was unable to provide the Department any N95 respirator fit testing or medical clearance records for all employees for review.

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, The Arbor at Bremerton 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;

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

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

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(ii) Storage for wet mops;

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 areas (interior and exterior grounds of the facility). The facility failed to keep equipment and furnishings clean. These failures placed 45 of 45 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's Disclosure of Services, undated, showed all assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition.

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed the facility would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

Record review of the facility's policy titled, "Cleaning Resident Rooms and Furnishings," undated, showed "It will be the responsibility of the housekeeping department to maintain each resident room and furnishings in a clean manner daily. In buildings without dedicated housekeeping staff, the responsibility will fall on the care staff." A thorough cleaning would be done one time per week, or more often as necessary. Deep cleaning would consist of disinfecting toilets, bathing fixtures, floors, and doorknobs. Residents that required more frequent housekeeping services would receive said services as negotiated. Those duties would be included in the negotiated service agreement.

Record review of the facility's policy titled, "Boarding Home Safety," dated 02/01/2015, showed it was the facility's policy to provide a safe and comfortable environment to the residents, staff, and guests. To promote a safe environment. The administrator or designated staff member would regularly inspect and walk through the facility looking for any hazards or potential hazards. Staff would be expected to report any hazards or potential hazards to their supervisor or appropriate staff members. Potential hazards included cigarette/cigar butts or water containing tobacco residue, rough, splintery furniture, flooring and/or equipment, and appropriate hardware on doors of storage rooms, closets, and other rooms to prevent residents from being locked in.

In an interview on 01/24/2024 at 09:40 AM, Staff A, Assistant Executive Director, stated the residents had access to all areas of the facility.

In an observation on 01/24/2024 at 11:13 AM, in the front television (TV) and independent activity room near the activity cabinets and windows, a strong pungent odor that resembled urine was present.

In an observation on 01/24/2024 at 11:19 AM, in the front dining room, the floor made a tacky noise when it was walked on. When the licensor walked to the courtyard door near the cabinets in the front dining room, the licensor's shoe stuck to the floor and made a tacky noise when it was lifted up from the floor.

In an observation on 01/24/2024 at 11:19 AM, in the back of the facility behind a desk on

the right side on the floor were multiple areas of dark brown substance and smears of brown substance.

In an observation on 01/24/2024 at 11:23 AM, inside an unlocked shower room, the garbage cans were overflowing with trash. On the ground was a tied up clear bag of soiled linens. The linens were visualized through the bag that had brown substance on them.

In an observation on 01/24/2024 at 11:28 AM, the sprinkler riser room's door was unlocked. Upon opening the doors there was a strong pungent smell that resembled urine present. Inside the room there was a large hammer and a crowbar that was lying on the floor. Outside of the sprinkler riser room under the window, by the desk with the wooden sewing machine that was in multiple pieces, was a pungent smell of urine.

In an observation on 01/24/2024 at 11:32 AM, the shower room near Resident 8's(R8) room was unlocked. Upon entering the shower room behind the door, a brown door was leaning up against the wall under the fire alarm light near the top of the wall. The brown door was not secured to the wall or a frame. The door had no handle and the area for the handle was noted to have been cut with sharp jagged edges. There was black tape to the side of the door frame. Behind the door frame on the ground was a large pile of light brown shavings that resembled wood cutting shavings. Next to the shower and underneath the towel bar on the wall, on the ground was an additional pile of light brown shavings that resembled wood shavings and pair of unbagged blue resident pants. There was resident clothing draped on the grab bar by the toilet that had yellow water in the toilet bowl. There was a bath towel that laid flat on the ground in front of the shower. The garbage can was overflowing with trash. On the counter by the sink was a large black plastic multiple drawer storage bin. Inside the top drawer was thick pink substance that covered three quarters of the drawer's bottom. There were red unused red bags, disposable gloves, large plastic pieces that resembled large LEGO pieces, there was a bottle of mouthwash, and long metal pieces with tiny wheels on it all stored inside and all had the pink substance on them. The vent on the ceiling was noted to have brown fuzz on the vent's opening slats.

In an observation on 01/24/2024 at 11:55 AM, inside the unlocked shower room that was near the beauty salon on the counter next to the sink was a large clear bag that was tied up with used blue disposed gloves, paper towels, a soiled brief with brown substance on it and used tissues inside. Inside the toilet bowl there was brown substance. The shower chair that was stored between the toilet and the sink had a blue cushioned seat. Near the back of the blue seat on the left and right sides was thick brown matter that resembled feces. The white shower curtain that was hung at the bottom was noted to have orange and pink substance.

In an interview on 01/24/2024 at 12:01 PM, Staff K, Main Assistant, stated the shower rooms were to be always locked when they were not in use.

In an interview and observation on 01/24/2024 at 12:07 PM, inside the shower room near R8's room, the door with the jagged edges remained leaned up against the wall. Staff K stated they had to break and cut out the doorknob on the door because it had gotten

stuck, and the caregiver was unable to exit the shower room. Staff K stated they were not the one to ask if the piles of brown wooden shavings on the floor and the broken, unsecured, door's position were safe. Staff K did lock the door upon exiting the shower room.

In an interview on 01/25/2024 at 9:28 AM, Staff D, Med Tech, stated Staff K was responsible for the housekeeping of the facility and residents' rooms.

In an observation on 01/25/2024 at 9:32 AM, inside the housekeeping closet, there was a mop that was white and black and wet that was sitting on the ground in the drain area. The garbage can in the room did not have a trash bag and was overflowing with trash that included used blue and cream colored disposable gloves and various trash. There was a clear bag that was tied up full of trash that sat on the ground near the corner. The vent on the ceiling had thick brown, fuzzy, stringing cobwebs and debris on it.

In an observation on 01/25/2024 at 9:36 AM, inside Resident 7's (R7) room, there was a strong pungent odor that resembled urine throughout the room. There were multiple brown areas of substance on the floor beside R7's bed and on the floor of R7's bathroom.

In an interview on 01/25/2024 at 9:42 AM, inside R7's room, Staff E, Caregiver, stated the smell in R7's room was present in R7's prior room before they were moved. Staff E stated they were unsure what the smell was.

In an interview on 01/25/2024 at 9:54 AM, Staff E stated the night shift caregivers were responsible to mop the dining room floor. Staff E stated that the dining room floor was sticky from juice that had been spilled.

In an observation on 01/25/2024 at 10:03 AM, in the medication and charting room near the front dining room, inside the sink there were urine collections that were stored.

In an observation on 01/25/2024 at 10:26 AM, inside the medication room in the back of the facility, inside the sink there were multiple areas of a dried substance.

In an observation and interview on 01/25/2024 at 11:25 AM, outside in the front inner courtyard there was no call light or communication system for use. Staff D, Med Tech, stated they were unsure how residents, staff or visitors, would call for assistance if they were outside. Staff D was observed to push a white button that was near the door. There was no alarm that had rung or page to the pager. There were no caregivers responding after Staff D had pushed the white button.

In an observation on 01/25/2024 at 11:30 AM, walking out the back door of the laundry room outside, there was a white washing machine, a black bin filled with water that had yellow and white burnt cigarette pieces, there was a metal grill top with grill grates on the

ground beside the side walk, there was a smoking discard post that was positioned beside the side walk across from a residents window and the facility building, there was 3 large garbage cans full of trash and a black chair stored outside. Further down the sidewalk closer to the wooden fence there were 5 twin sized mattresses stored uncovered and in the rain. Staff D grabbed the lock on the wood fence's gate and the entire fence and gait wobbled backwards and forwards. The fence was missing two panels at the end of the fence to the right of the gate. At 11:35 AM, outside of the wooden fence the dumpster was stored. Behind the dumpster on the ground was a large yellow foam pad, multiple unbagged used blue disposable gloves, multiple shredded unbagged pieces of paper and other various garbage.

In an observation and interview on 01/25/2024 at 12:00 PM, in the front dining room, Staff O, Activities, was walking in the dining room and their shoes were making a sticky noise. At 12:09 PM, Staff O stated, "The floor is so sticky."

In an observation and interview on 01/25/2024 at 4:45 PM, Staff M, Caregiver, was assisting an unnamed male resident out of the shower room near R7's room. Staff O stated to the unnamed male resident that they should not be in there and the door should have been locked.

In an observation and interview on 01/25/2024 at 5:16 PM inside R7's room, when Staff I, Regional Executive Director, walked inside, Staff I's shoes made a sticky noise. Staff K came into the room and stated there was juice spilled on R7's floor. Staff I stated the smell in R7's room was from R7's colostomy (an opening into the colon through the lower stomach area that allows feces to leave the body). Staff I stated Staff K would clean and mop the floor in R7's room.

In an interview and observation on 01/25/2024 at 5:20 PM, outside by the dumpster area, the shredded paper and disposable gloves remained on the ground. Staff I stated, "There is disposable gloves, so it is from the facility." Staff I stated the facility would get it cleaned up. Staff I observed the multiple various garbage items outside the back of the laundry room door. Staff I stated they would get the metal picked up and would get the rest of the trash picked up by 01/26/2024.

In an observation on 01/25/2024 at 5:25 PM, Staff I stated there was no call light or communication system in the inside courtyard. Staff I observed to push the white button by the door and stated it should go to a pager. No staff members came after Staff I pushed the white button. Staff I stated they would look into the functioning of the white buttons in the courtyard.

In an observation on 01/26/2024 at 9:48 AM, down the hallway near Resident 8's room there was a pungent smell that resembled urine.

In an observation on 01/26/2024 at 9:50 AM, in the back dining room was a large area that was red and sticky on the floor.

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In an observation on 01/25/2024 at 9:51 AM, inside R7's room under the window on the floor next to the side table was spilled dried dark substance. There was a strong pungent smell that resembled urine next to R7's bed. There were areas of brown substance on the floor near R7's bed.

Plan of Correction 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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/12/24 jc

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

Administrator (or Representative) — Date 3/22/24

WAC 388-76A-3060 Storage space. The assisted living facility must:

(1) Provide adequate storage space for supplies, equipment and linens;

(3) Maintain storage space to prevent fire or safety hazards.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have adequate storage space that was free of safety hazards for 5 of 5 rooms (medication room, back outside resident courtyard, back dining room, maintenance office, and resident laundry room). This failure resulted in residents and staff to not have a safe and proper storage system.

Findings included...

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed "the community will ensure that all supplies and equipment, dirty and clean, are handled and stored in a safe manner, protecting residents from exposure and risk." Under the section "procedures" showed when considering safe storage of supplies and equipment, the administrator and or designee would consider at a minimum the assessed needs of the residents and the functional and cognitive abilities to determine what supplies and equipment may be accessible to residents, the degree of hazardousness posed by the supplies or equipment, whether or not the supplies and equipment were commonly found in a private home, and how residents with special needs be protected individually without unnecessary restrictions on the general population.

In an observation on 01/26/2024 at 9:51 AM, inside R7's room under the window on the floor next to the side table was spilled dried dark substance. There was a strong pungent smell that resembled urine next to R7's bed. There were areas of brown substance on the floor near R7's bed.

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, The Arbor at Bremerton 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-3060 Storage space. The assisted living facility must:

(1) Provide adequate storage space for supplies, equipment and linens;

(3) Maintain storage space to prevent fire or safety hazards.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have adequate storage space that was free of safety hazards for 5 of 5 rooms (medication room, back outside resident courtyard, back dining room, maintenance office, and resident laundry room). This failure resulted in residents and staff to not have a safe and proper storage system.

Findings included...

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed "the community will ensure that all supplies and equipment, dirty and clean, are handled and stored in a safe manner, protecting residents from exposure and risk." Under the section "procedures" showed when considering safe storage of supplies and equipment, the administrator and or designee would consider at a minimum the assessed needs of the residents and the functional and cognitive abilities to determine what supplies and equipment may be accessible to residents, the degree of hazardousness posed by the supplies or equipment, whether or not the supplies and equipment were commonly found in a private home, and how residents with special needs be protected individually without unnecessary restrictions on the general population.

Record review of the facility's policy titled, "Boarding Home Safety," dated 02/01/2015, showed it was the facility's policy to provide a safe and comfortable environment to the residents, staff, and guests. To promote a safe environment, the administrator or designated staff member would regularly inspect and walk through the facility looking for any hazards or potential hazards. Staff would be expected to report any hazards or potential hazards to their supervisor or appropriate staff members.

In an observation on 01/24/2024 at 9:33 AM, during a general tour of the facility, in the back dining room under the far left windows, was a metal electric bed frame stored in the dining room area. There was no mattress on the frame and the frame was accessible.

In an observation on 01/25/2024 at 10:33 AM, in the hallway in between the maintenance office and the laundry room, there was multiple boxes, equipment, and furniture stored. The walking path in the hallway area was narrow.

In an observation on 01/25/2024 at 10:57 AM, inside the room labeled, "resident laundry," there were multiple boxes, televisions, three-drawer plastic bins, three large boxes labeled, "framed three door medicine cabinets," and toilet seats. The washing machine, drying machine, and the windows in the room were unable to be accessed because of the multiple items in the room.

In an observation on 01/25/2024 at 11:00 AM, outside in the back courtyard to the right on the covered walking way up against the building, there was a wooden pallet, wooden block pieces, the door with the broken handle area with jagged edges, a floor shampooing machine, a large pile that was covered with a blue and brown tarp, a cream colored cloth lying on the ground, and a chair with red cushions that had white window blinds that sat on the arm rests.

In an observation and interview on 01/25/2024 at 11:11 AM, inside the maintenance office there were large amounts of boxes, and tools that were stored on the ground up against the wall and near shelves. The walking path in the office area was narrow. Staff N, Maintenance Specialist, stated they needed a bigger office when they were asked if the items were stored properly.

In an observation and interview on 01/25/2024 at 5:30 PM, in the outside courtyard behind the back dining room area, to the right beside the building on the ground was a cream-colored cloth drape, there was a wooden palate with wood boards and blocks, there was a brown door that was broken with the handle cut out, a chair with white blinds lying across the top, and a large pile that was covered with a blue tarp. Staff N stated the large pile that was covered by the tarp was ice melt that was delivered recently in preparation for the recent ice storm. Staff I, Regional Executive Director, stated the facility would get the items cleaned up.

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Plan of Correction 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, The Arbor at Bremerton is or will be in compliance with this law and/or regulation on (Date) 4/29/24

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

Administrator (or Representative) — Date 3/29/24

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs - Prescription drugs, and other applicable statutes and administrative rules; and

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

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2260:

(a) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interviews, and record reviews, the facility failed to develop and implement systems that support and promote safe medication services for 1 of 1 sampled resident (Resident 10 [R10]) and 1 of 2 facility's first aid kits observed to have expired medications. The facility failed to ensure medications were dated and had a prescription label for 2 of 2 sampled residents (Resident 5 [R5] and Resident 8 [R8]). The facility failed to ensure residents' medications were administered as the prescribed physician ordered, for 1 of 2 sampled residents (R4). These failures placed all 65 residents at risk for harm from adverse reactions due to improper medication systems.

Findings included...

RCW 69.41.350 Labeling requirements—Penalty. (1) To every box, bottle, jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of patient, and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he or she determines that his or her patient should not

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, The Arbor at Bremerton 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-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interviews, and record reviews, the facility failed to develop and implement systems that support and promote safe medication services for 1 of 1 sampled resident (Resident 10 [R10]) and 1 of 2 facility's first aid kits observed to have expired medications. The facility failed to ensure medications were dated and had a prescription label for 2 of 2 sampled residents (Resident 5 [R5] and Resident 9 [R9]). The facility failed to ensure residents' medications were administered as the prescribed physician ordered, for 1 of 2 sampled residents (R5). These failures placed all 45 residents at risk for harm from adverse reactions due to improper medication systems.

Findings included...

RCW 69.41.050 Labeling requirements—Penalty. (1) To every box, bottle, jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of patient and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he or she determines that his or her patient should not

have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with federal law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient.

Record review of the facility's policy titled, "Medication Destruction/Disposal," dated 04/01/2021, showed it was the policy to properly dispose of medications for residents that received assistance or administration of medication within the state law, facility, and pharmacy regulations. Medications would be disposed of when the medications were discontinued, expired or outdated, resident refused, resident died, moved out of the facility without taking their medications, or when the medication was otherwise contaminated or compromised.

Record review of Diabetes Disaster Response Coalition document titled, "Safe Storage of Insulin," undated, showed "For the people with diabetes who use it, insulin is a vital need. It's important to store insulin as directed so that it remains usable by those who need it." According to the product labels from all three United States insulin manufacturers, it was recommended that insulin be stored in a refrigerator. Unopened insulin that was refrigerated maintains potency until the expiration date on the package. Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened), may be left unrefrigerated at a temperature between 59 degrees Fahrenheit (F) and 86 degrees F for up to 28 days and continue to work.

Record review of National Library of Medicine Medline Plus document titled, "Insulin and syringes-storage and safety," dated 08/12/2022, showed "Insulin is sensitive to temperature and light. Sunlight and temperatures that are too hot or too cold can affect how well insulin works. This could explain changes in blood glucose control. Proper storage will keep insulin stable." Opened insulin stored at room temperature could be stored for a maximum of 28 days. The insulin must be discarded after 28 days from the date of opening. It was best practice to check the expiration date before using insulin.

Record review of the facility's document "Med-Tech Guide with Task Instructions," undated, under the section titled, "The Five Rights of Medication Administration," showed medication technicians were to ensure and read the label of the residents' medication three times as they prepared the residents medication. The medication technician was to ensure that the residents' medication they were to receive matches what was ordered. Under the section titled, "Insulin Expiration Dates," showed "Insulins must be refrigerated when received from the pharmacy; and can be kept in the med-cart once opened. When opening a new insulin pen or vial, date and initial the date you opened it, so that we can keep track of the expiration date once opened. Common expiration dates: 21 or 28 days- refer to manufacturer's packaging for dates."

Record review of the facility's policy titled, "Medication Labeling," dated 05/26/2021, showed it was the facility's policy to ensure that medications used for residents were properly labeled. Regardless if the residents were assisted or administered, all resident medications that were utilized in the facility required a prescription label that included the resident's first and last name, pharmacy name, physician's name, complete and corrected directions for use, name and strength of the medication, amount of the medication

dispensed, initials of the dispensing pharmacist, date prescribed, and expiration date. The label on the container of the medication shall not be altered or replaced except by the pharmacist. Medication containers that were soiled, damaged, incomplete, or had makeshift labels shall be returned to the pharmacy for re-labeling or disposal. Medications in containers that had no labels or illegible labels shall be destroyed.

Expired medications

In an observation and interview on 01/24/2024 at 3:09 PM, inside the first aid kit behind the desk near the medication/charting room near the front dining room, was a container of burn cream that had a June 2019 expiration date, and a bottle of ophthalmic (eye) solution eyewash that had an August 2020 expiration date. Staff A, Assistance Executive Director, looked at the burn cream and eyewash solution and stated they were expired.

In an observation on 01/25/2024 at 10:06 AM, the expired burn cream and eyewash solution were still found stored inside the first aid kit behind the desk near the medication/charting room near the front dining room.

In an observation and interview on 01/25/2024 at 10:20 AM, inside one of the medication cart's narcotic box, Resident 10 (R10) had a bubble pack card with prescription label for oxycodone (a prescribed highly controlled strong pain medication) 5 milligrams (mg) with 59 tablets that had an expiration date of 10/06/2023. R10 had a second bubble pack card with prescription label for oxycodone 5 mg with 24 tablets that had an expiration date of 10/24/2023. Staff D, Med Tech, stated the facility nurse was responsible to destroy the expired medications.

In an observation on 01/26/2024 at 10:07 AM, the expired burn cream and eyewash solution were still stored inside the first aid kit behind the desk near the medication/charting room near the front dining room.

Insulin Pens

In an observation and interview on 01/25/2024 at 10:08 AM, inside one of the medication carts there were three insulin pens. The first insulin pen was for Lantus (long-acting insulin to help lower and maintain blood sugar levels in a more normal range) with the prescription label for R5. The Lantus insulin pen was noted to have 20 units of insulin remaining in the pen. There was no date on the insulin pen documenting when it was opened or when it would expire. The second insulin pen was for Humalog (short-acting insulin that helps quickly reduce blood sugars level) that had a prescription label for R5. The Humalog insulin pen had 80 units of insulin remaining in the pen. There was no date on the insulin pen documented when it was opened or when it would expire. Staff D, Med Tech, stated they were taught to date the insulin pens with the date they were opened. Staff D stated they were unsure how long the insulin pens were good for once they were opened and started to be used. The third insulin pen was for glargine (long-acting insulin to help reduce high blood sugar level and maintain in a more normal range) and it did not

have a documented date of when it had been opened or when it expired, no resident's name, and no prescription label observed on the insulin pen. Staff D stated the insulin pen for glargine was for Resident 9.

In an interview on 01/25/2024 at 10:26 AM, inside the back medication room, Staff D reviewed a post for insulin pens. Staff D stated that insulin pens were good for 28 days after they were opened.

Medication Parameters

Record review of R5's "Move In Record" showed R5 moved into the facility on [redacted]/2022, with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R5's Service Plan dated 12/11/2023, under the section titled, "Medical History: Diabetic," showed staff was to assist R5 with all medication and treatments as per physician order and resident's preference. Staff were to assist with all R5's oral medications and insulin.

Record review of R5's Medication Administration Record (MAR) dated 11/01/2023 through 11/20/2023, showed R5 had an order to notify primary care physician if R5's blood sugar was less than 80 or greater than 350 four time per day for blood sugar testing. Humalog insulin inject 30 units three times daily. Hold the Humalog if R5's blood sugar was less than 110. Lantus insulin inject 50 units every 12 hours. Hold the Lantus if R5's blood sugar was less than 110. Review of R5's blood sugar readings showed R5's blood sugar reading was out of the parameters 18 times. There were no medication notes that showed the primary care physician was notified that R5's blood sugar readings were out of parameters. Review of R5's Humalog administrations showed R5 was administered their Humalog three times when R5's blood sugar reading was below 110. Review of R5's Lantus administrations showed R5 was administered their Lantus five times when R5's blood sugar reading was below 110.

Record review of R5's MAR dated 12/01/2023 through 12/31/2023, showed R5 was administered their Humalog insulin one time when their blood sugar reading level was below the parameters of 110. Review of R5's administration record for their Lantus insulin showed R5 was administer their Lantus insulin one time when R5's blood sugar reading was below 110. Review of R5's blood sugar readings showed R5's blood sugar reading levels were out of the parameters four times. There were no medication notes that showed the primary care physician was notified that R5's blood sugar readings were out of parameters.

Record review of R5's MAR dated 01/01/2024 through 01/24/2024 showed R5's blood sugar readings were out of the parameters four times. There were no medication notes that

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showed the primary care physician was notified that R5's blood sugar readings were out of parameters.

Record review of R5's progress notes dated 11/02/2023 through 01/25/2024, showed R5's primary care physician was faxed on 12/26/2023 at 9:09 PM and notified of R5's blood sugar reading and on 11/24/2023 at 4:55 PM, R5's physician was faxed. There was no further documentation to show the primary care physician was notified of the other 24 times R5's blood sugars were out of range.

In an interview on 01/24/2024 at 3:28 PM, Staff L, Regional Executive Director, stated all physicians fax directly to the pharmacy. Staff L stated the pharmacy would provide the physician's fax for the facility to review.

Plan of Correction 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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/12/24.

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

Lisa Carlock — Administrator (or Representative)

3/29/24 — Date

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 7 sampled residents (Resident 5 (R5)) medications were available to be administered. This failure resulted in Resident 5 not receiving their medications as ordered and placed the resident at risk for unmet care needs, increased pain and discomfort and medical complications associated with not receiving medications as ordered.

Findings included...

Record review of the facility's policy titled, "Medication Unavailable," dated 06/22/2021, showed it was the policy to order and reorder medications for residents receiving medication services in a timeframe and manner that promotes health and welfare. In an instance that a resident's medication was not available, the facility staff were to work with

showed the primary care physician was notified that R5's blood sugar readings were out of parameters.

Record review of R5's progress notes dated 11/02/2023 through 01/23/2024, showed R5's primary care physician was faxed on 12/28/2023 at 9:09 PM and notified of R5's blood sugar reading and on 11/24/2023 at 4:55 PM, R5's physician was faxed. There was no further documentation to show the primary care physician was notified of the other 24 times R5's blood sugars were out of range.

In an interview on 01/25/2024 at 3:28 PM, Staff I, Regional Executive Director, stated all physicians fax directly to the pharmacy. Staff I stated the pharmacy would provide the physician's fax for the facility to review.

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 7 sampled residents (Resident 5 [R5]) medications were available to be administered. This failure resulted in Resident 5 not receiving their medications as ordered and placed the resident at risk for unmet care needs, increased pain and discomfort and medical complications associated with not receiving medications as ordered.

Findings included...

Record review of the facility's policy titled, "Medication Unavailable," dated 06/22/2021, showed it was the policy to order and reorder medications for residents receiving medication services in a timeframe and manner that promotes health and welfare. In an instance that a resident's medication was not available, the facility staff were to work with

the resident or resident's responsible party, pharmacy, and physician to obtain medications. Staff were to monitor the resident when medications were unavailable to determine ill effects from missed doses. Staff would document circumstances in resident's record and efforts made to obtain the medications. The resident's responsible party and the resident's physician would be notified of the missed medications. The facility was to contact the dispensing pharmacy five to seven days prior to last dose for ongoing routine.

Record review of R5's "Move In Record," dated 01/24/2024, showed R5 moved into the facility on /2022 with multiple medical diagnoses that included and

Record review of R5's Service Plan dated 12/11/2023, showed R5 has history of pain. R5 had broken their humerus (long bone in the upper arm) recently on 09/17/2023 that caused R5 pain. R5 received assistance with their oral medications. R5's power of attorney helped coordinate outside provider appointments, transportation, and provide diabetic supplies.

Record review of R5's Medication Administration Record, dated 01/01/2024 through 01/25/2024, showed R5 had an order that stated 01/21/2024 for Lidocaine patch (a prescribed medicated patch to help prevent and reduce pain) to be applied every day for 12 hours. Review of the administrations showed R5 did not receive the lidocaine patch for dates 01/21/2024 through 01/15/2024 as it was not available for administration. R5 had an order for hydrocodone/tylenol (APAP) (a prescribed highly regulated pain medication) take one tablet three times daily. Review of administrations showed R5 did not receive their hydrocodone/APAP for dates 01/18/2024 through 01/23/2024, for 17 of 17 scheduled doses related to the medication not available for administration. R5 had an order for gabapentin (prescribed medication used to help treat pain) take one capsule three times daily. R5 did not receive their three doses of gabapentin on 01/15/2024 related to the medication not being available for administration. R5 had an order for furosemide (prescribed medication to help reduce fluid retention on the body) take one tablet daily. Review of the administrations showed R5 did not receive their furosemide for dates 01/13/2024 through 01/15/2024, related to the medication not being available for administration. R5 had an order for baclofen (medication to help relax the muscles and decrease pain) take one tablet daily three times daily. Review of the administrations showed R5 did not receive their baclofen medication for dates 01/22/2024 through 01/24/2024, for 8 of 9 administrations related to the medication not being available for administration.

Record review of R5's progress note dated 01/10/2024 at 7:54 PM showed R5's medication baclofen was not available for administration and was not in the drawer. The medication technician documented that the medication showed "ordered and on hand."

Record review of R5's progress note dated 01/10/2024 at 7:55 PM showed R5's medication hydrocodone/APAP was on hand, but not found in the drawer. The medication

s medication hydrocodone/APAP was not available for administration and waiting on discontinue order.

Record review of R5's progress note dated 01/22/2024 at 6:27 AM showed R5's medication lidocaine patch was not available for administration and waiting for delivery. R5's pain level of 6.

Record review of R5's progress note dated 01/22/2024 at 9:19 AM showed R5's medication hydrocodone/APAP was not available for administration and "will check with pharmacy about delivery."

Record review of R5's progress note dated 01/21/2024 at 9:28 AM showed R5's medication baclofen was not available for administration and "will reorder."

Record review of R5's progress note dated 01/22/2024 at 11:49 AM showed R5's medication hydrocodone/APAP was not available for administration and "waiting for delivery."

Record review of R5's progress note dated 01/22/2024 at 11:54 AM showed R5's medication baclofen was not available for administration and "waiting for delivery."

Record review of R5's progress note dated 01/23/2024 at 6:33 AM showed R5's medication lidocaine patch was not available for administration and "new order. waiting for delivery."

Record review of R5's progress note dated 01/23/2024 at 8:38 AM and 11:45 AM showed R5's medication hydrocodone/APAP was not available for administration and "waiting for delivery."

Record review of R5's progress note dated 01/23/2024 at 8:42 AM, 11:50 AM, and 5:13 PM showed R5's medication baclofen was not available for administration and waiting for delivery and on order.

Record review of R5's progress note dated 01/24/2024 at 8:26 AM showed R5's medication lidocaine patch was not available for administration and "not on cart."

Record review of R5's progress note dated 01/24/2024 at 8:26 AM showed R5's medication baclofen was not available for administration and "waiting on refill."

Review of R5's progress notes dated 01/10/2024 through 01/24/2024 showed R5's responsible party was not notified, that physician was notified, and resident was monitored

s medication hydrocodone/APAP was not available for administration and waiting on discontinue order.

Record review of R5's progress note dated 01/22/2024 at 6:27 AM showed R5's medication lidocaine patch was not available for administration and waiting for delivery. R5's pain level of 6.

Record review of R5's progress note dated 01/22/2024 at 9:19 AM showed R5's medication hydrocodone/APAP was not available for administration and "will check with pharmacy about delivery."

Record review of R5's progress note dated 01/21/2024 at 9:28 AM showed R5's medication baclofen was not available for administration and "will reorder."

Record review of R5's progress note dated 01/22/2024 at 11:49 AM showed R5's medication hydrocodone/APAP was not available for administration and "waiting for delivery."

Record review of R5's progress note dated 01/22/2024 at 11:54 AM showed R5's medication baclofen was not available for administration and "waiting for delivery."

Record review of R5's progress note dated 01/23/2024 at 6:33 AM showed R5's medication lidocaine patch was not available for administration and "new order. waiting for delivery."

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Statement of Deficiencies	License # 2619	Compliance Determination # 34586
Plan of Correction	The Arbor at Bremerton	Completion Date
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for increase in pain or possible negative effects from not receiving the four medications for multiple days.

In an interview on 01/25/2024 at 10:40 AM, Staff D, Med Tech, stated if a resident's medication was not available at the facility to be administered, the medication technicians were to mark the medication as unavailable, write a description of the action taken to get the medication, call the pharmacy to reorder the medication or to follow up with the pharmacy as to when the medication would be delivered, and put the resident on alert charting.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/12/24

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

Administrator (or Representative) — Date: 3/12/24

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

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

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that medication assistants were Nurse Delegated (Registered Nurse specialized training for administering residents' medication) before administering medications for 4 of 13 residents (Residents 2, 3, 5, and 7). This failure placed all 4 residents at risk for serious negative health consequences due to inadequate/poor disease management and poor quality of life.

Findings included...

Record review on 01/25/2024 showed Resident 2 (R2) was admitted to this facility on [redacted] 2018 with diagnoses to include [redacted]. Medication orders and treatments included wound care, eye drops, liquid pain medications and a suppository (medication given rectally). No R2 specific instructions had been written. There

for increase in pain or possible negative effects from not receiving the four medications for multiple days.

In an interview on 01/25/2024 at 10:40 AM, Staff D, Med Tech, stated if a resident's medication was not available at the facility to be administered, the medication technicians were to mark the medication as unavailable, write a description of the action taken to get the medication, call the pharmacy to reorder the medication or to follow up with the pharmacy as to when the medication would be delivered, and put the resident on alert charting.

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, The Arbor at Bremerton 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-2320 Intermittent nursing services systems.

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

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that medication assistants were Nurse Delegated (Registered Nurse specialized training for administering residents' medication) before administering medications for 4 of 10 residents (Residents 2, 3, 5, and 7). This failure placed all 4 residents at risk for serious negative health consequences due to inadequate/poor disease management and poor quality of life.

Findings included...

Record review on 01/25/2024 showed Resident 2 (R2) was admitted to the facility on [redacted]/2018 with diagnoses to include [redacted] Medication orders and treatments included wound care, eye drops, liquid pain medications and a suppository (medication given rectally). No R2 specific instructions had been written. There

was no documentation of Staff F (Med Tech) and Staff G (Med Tech) for training or monitoring of R2's related delegated tasks.

An interview on 1/24/2024 at 10:00 AM, R2's Collateral Contact (CC1), said R2 cannot take medications, perform eyedrops or treatments on his own.

Record review on 01/25/2024 showed Resident 3 (R3) was admitted to the facility on [redacted]/2023 with diagnoses to include [redacted]. Medication orders on 12/28/2023 included an as needed suppository (medication given rectally) for constipation. No R3 specific instructions had been written. There was no documentation of Staff F and Staff G, for training or monitoring of R3's related delegated tasks.

A record review on 01/25/2024 showed Resident 5 (R5) was admitted to the facility on [redacted]/2022 with diagnoses to include [redacted]. Negotiated service agreement revision dated 09/07/2023 said staff oversees resident self-injecting insulin pen. Staff dial up and prepare pen for resident. No documentation for Staff F and Staff G as being trained and monitored for R5's delegated tasks.

A record review on 01/25/2024 showed Resident 7 (R7) was admitted to the facility on [redacted]/2018 with diagnoses to include [redacted] Negotiated Service Agreement dated as revised on 01/21/2024 said the resident has an ostomy site. Medication records said staff are responsible for monitoring, cleansing, and applying the bag to the stoma area. No documentation for Staff F and Staff G as being trained and monitored for R7's delegated tasks.

A record review on 01/25/2024 of the nurse delegation records for sampled medication technicians, Staff F and Staff G, showed no documentation for resident specific training was found for any of the sampled residents, R2, and R3. Also, Staff F and Staff G had not been added to resident specific training for R5 and R7. Both staff members worked as medication technicians.

In an interview on 01/25/2024 at 11:00 AM, Staff P, the Nurse Delegator said she had just started the position; she was aware there were issues and was trying to get the nurse delegation system up to date.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2619	Compliance Determination #: 36385
Plan of Correction	The Arbor at Bremerton	Completion Date
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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 4/29/24

4/3/24 jc

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

Administrator (or Representative) — Date: 3/27/24

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton 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