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

Humangood Washington
JUDSON PARK RETIREMENT COMMUNITY
23600 MARINE VIEW DR S
DES MOINES, WA 98198

RE: JUDSON PARK RETIREMENT COMMUNITY License # 681

Dear Administrator:

This letter addresses Compliance Determination(s) 43503 (Completion Date 07/02/2024) and 39269 (Completion Date 04/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/02/2024 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-2466-1, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2381-2-b-iii, WAC 388-78A-2680-2-a-ii, WAC 388-78A-3000-3, WAC 388-78A-2703-4-a

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor

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

Sincerely,

Laurie Anderson

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

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

Statement of Deficiencies	License #: 681	Compliance Determination # 39269
Plan of Correction	JUDSON PARK RETIREMENT COMMUNITY	Completion Date
Page 1 of 9	Licensee: Humangood Washington	04/25/2024

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 04/04/2024, 04/04/2024, 04/10/2024 and 04/10/2024 of:
JUDSON PARK RETIREMENT COMMUNITY
23600 MARINE VIEW DR S
DES MOINES, WA 98198

The following sample was selected for review during the unannounced on-site visit: 7 of 38 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

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

Laurie Anderson — Residential Care Services

04/25/2024 — Date

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

Administrator (or Representative) 5.3.2024 Date

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

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

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility failed to complete a Washington state name and date of birth background inquiry (BGI) every two years for 2 of 5 sampled staff (Staff B and Staff G). This failure placed all residents at risk of potential abuse, neglect, or exploitation from caregivers and staff persons with unknown backgrounds.

Findings included...

STAFF B
Review of the facility's Employee Roster showed the facility hired Staff B, Certified Nurse Assistant, on 03/04/2022. Review of Staff B's employee records showed that Staff B's previous Washington state name and date of birth BGI expired on 02/21/2024. The records showed on 04/05/2024, the facility completed a BGI, 44 days after the previous BGI expired.

STAFF G
Review of the facility's Employee Roster showed the facility hired Staff G, Cook, on 07/13/2021. Review of Staff G's employee records showed that Staff G's previous Washington State name and date of birth BGI expired on 06/24/2023. The records showed on 10/10/2023, the facility completed a BGI, 108 days after the previous BGI expired

During an interview on 04/08/2024 at 11:40 AM, Staff H, Human Resources Generalist, stated that they were responsible for the completion of the staff background checks for all employees. Staff H stated that they were aware the facility was required to maintain a valid Washington state name date of birth BGI for all staff. Staff H stated that they had a process to keep track of the BGI and nobfied the staff to complete a new BGI before the previous

Administrator (or Representative) Date

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

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility failed to complete a Washington state name and date of birth background inquiry (BGI) every two years for 2 of 5 sampled staff (Staff B and Staff G). This failure placed all residents at risk of potential abuse, neglect, or exploitation from caregivers and staff persons with unknown backgrounds.

Findings included...

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Review of the facility's Employee Roster showed the facility hired Staff B, Certified Nurse Assistant, on 03/04/2022. Review of Staff B's employee records showed that Staff B's previous Washington state name and date of birth BGI expired on 02/21/2024. The records showed on 04/05/2024, the facility completed a BGI, 44 days after the previous BGI expired.

STAFF G
Review of the facility's Employee Roster showed the facility hired Staff G, Cook, on 07/13/2021. Review of Staff G's employee records showed that Staff G's previous Washington State name and date of birth BGI expired on 06/24/2023. The records showed on 10/10/2023, the facility completed a BGI, 108 days after the previous BGI expired.

During an interview on 04/08/2024 at 11:40 AM, Staff H, Human Resources Generalist, stated that they were responsible for the completion of the staff background checks for all employees. Staff H stated that they were aware the facility was required to maintain a valid Washington state name date of birth BGI for all staff. Staff H stated that they had a process to keep track of the BGI and notified the staff to complete a new BGI before the previous

BGI expired. Staff H stated that they did not know why the staff did not complete a BGI on time.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5.24.24.

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

Jessica Ellis
Administrator (or Representative)

5.3.24
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

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 3 of 3 sampled care staff (Staff B, Staff C, and Staff D) completed all required training. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

CONTINUING EDUCATION (CE)
STAFF B
Review of the facility's Employee Roster showed the facility hired Staff B, Certified Nurse Assistant (CNA), on 03/04/2022. Review of the facility's employee records showed that from their 2022 birthday to their 2023 birthday, Staff B only completed four hours of the 12 required hours of the Department of Social and Health Services (DSHS) approved CE trainings. Staff B was eight hours short of the required CE hours.

STAFF C
Review of the facility's Employee Roster showed the facility hired Staff C, Certified Nurse Assistant, on 04/27/2020. Review of the facility's employee records showed that from their 2022 birthday to their 2023 birthday, Staff C completed 8.5 hours of the 12 required

BGI expired. Staff H stated that they did not know why the staff did not complete a BGI on time.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 3 of 3 sampled care staff (Staff B, Staff C, and Staff D) completed all required training. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

CONTINUING EDUCATION (CE)
STAFF B
Review of the facility's Employee Roster showed the facility hired Staff B, Certified Nurse Assistant (CNA), on 03/04/2022. Review of the facility's employee records showed that from their 2022 birthday to their 2023 birthday, Staff B only completed four hours of the 12 required hours of the Department of Social and Health Services (DSHS) approved CE trainings. Staff B was eight hours short of the required CE hours.

STAFF C
Review of the facility's Employee Roster showed the facility hired Staff C, Certified Nurse Assistant, on 04/27/2020. Review of the facility's employee records showed that from their 2022 birthday to their 2023 birthday, Staff C completed 8.5 hours of the 12 required

hours of the DSHS approved CE trainings. Staff C was 3.5 hours short of the required CE hours.

During an interview on 04/08/2024 at 11:40 AM, Staff H, Human Resources Generalist, stated that it was a joint responsibility between the Human Resources and the department supervisor to ensure the care staff completed their required CE hours. Staff H stated that stated they were unaware the staff were required to complete the DSHS approved CE courses. Staff H stated that the facility provided staff the online CE training from a contracted vendor. Staff H stated that the employee records showed staff completed the CE trainings with their contracted vendor.

During an interview on 04/08/2024 at 2:30 PM, Staff A, Director of Wellness, stated that they were unaware the staff was required to complete the DSHS approved CE courses. Staff A stated that they kept track of the CE credits completed by the staff with their contracted vendor. Staff A stated that the records showed both Staff B and Staff C were short of the required 12 CE hours of training, from their 2022 birthday to their 2023 birthday.

FIRST AID
Review of the facility's Job Descriptions showed that the facility required that all Certified Nursing Assistants and Medication Aides maintain current first aid certification.

STAFF D
Review of the facility's Employee Roster showed that the facility hired Staff D, CNA, on 09/11/2023. Review of the facility's Care Staff Schedule showed that Staff D worked in February 2024 and March 2024, and was scheduled to work in April 2024. Review of the employee records showed that as of 04/08/2024, there was no documentation that showed Staff D maintained a valid first aid card. Review showed Staff D's first aid card expired on 11/11/2023.

During an interview on 04/08/2024 at 10:30 AM, Staff H stated that Staff D did have a first aid card. When Staff H produced a copy of Staff D's first aid card they stated, "it's expired". Staff H stated that they needed to inform Staff D that their first aid card on file was expired.

Plan/Attestation Statement

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

hours of the DSHS approved CE trainings. Staff C was 3.5 hours short of the required CE hours.

During an interview on 04/08/2024 at 11:40 AM, Staff H, Human Resources Generalist, stated that it was a joint responsibility between the Human Resources and the department supervisor to ensure the care staff completed their required CE hours. Staff H stated that stated they were unaware the staff were required to complete the DSHS approved CE courses. Staff H stated that the facility provided staff the online CE training from a contracted vendor. Staff H stated that the employee records showed staff completed the CE trainings with their contracted vendor.

During an interview on 04/09/2024 at 2:30 PM, Staff A, Director of Wellness, stated that they were unaware the staff was required to complete the DSHS approved CE courses. Staff A stated that they kept track of the CE credits completed by the staff with their contracted vendor. Staff A stated that the records showed both Staff B and Staff C were short of the required 12 CE hours of training, from their 2022 birthday to their 2023 birthday.

FIRST AID
Review of the facility's Job Descriptions showed that the facility required that all Certified Nursing Assistants and Medication Aides maintain current first aid certification.

STAFF D
Review of the facility's Employee Roster showed that the facility hired Staff D, CNA, on 08/11/2023. Review of the facility's Care Staff Schedule showed that Staff D worked in February 2024 and March 2024, and was scheduled to work in April 2024. Review of the employee records showed that as of 04/08/2024, there was no documentation that showed Staff D maintained a valid first aid card. Review showed Staff D's first aid card expired on 11/11/2023.

During an interview on 04/08/2024 at 10:30 AM, Staff H stated that Staff D did have a first aid card. When Staff H produced a copy of Staff D's first aid card they stated, "it's expired". Staff H stated that they needed to inform Staff D that their first aid card on file was expired.

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) 5.3.24 Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in (e) of this subsection, the facility must provide an outdoor area for residents that:

(iii) Has areas protected from direct sunshine and rain throughout the day;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide 13 of 13 Memory Care residents (Resident 1, Resident 2, Resident 4, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17) with an outdoor area protected from rain. This failure placed the residents at risk of a diminished quality of life by limiting the residents' freedom of movement.

Findings included...

Observations of the memory care unit on 04/04/2024 at 12:30 PM, showed several ambulatory memory care residents walked independently throughout the unit. Observations of the memory care unit outdoor area on 04/04/2024 at 12:35 PM, and on 04/08/2024 at 12:30 PM, on 04/09/2024 at 8:45 AM, and on 04/10/2024 at 8:50 AM, showed the facility provided no protected areas that accommodated and encouraged outside participation of memory care residents.

During an interview on 04/10/2024 at 12:30 PM, Staff O, Resident Life Aid, stated that the memory care unit used umbrellas that work for sun protection. Staff O stated that the facility had no coverings that worked to shield the residents from the rain.

During an interview on 04/10/2024 at 12:30 PM, Staff A, Director of Wellness, stated that the facility was aware the Memory Care outdoor area required a covered area to protect resident from the rain. Staff A stated that the facility was working on a plan.

Plan/Attestation Statement

Administrator (or Representative) _____ Date _____

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Based on observation and interview, the facility failed to provide 13 of 13 Memory Care residents (Resident 1, Resident 2, Resident 4, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17) with an outdoor area protected from rain. This failure placed the residents at risk of a diminished quality of life by limiting the residents' freedom of movement.

Findings included...

Observations of the memory care unit on 04/04/2024 at 12:30 PM, showed several ambulatory memory care residents walked independently throughout the unit. Observations of the memory care unit outdoor area on 04/04/2024 at 12:35 PM, and on 04/08/2024 at 12:30 PM, on 04/09/2024 at 8:45 AM, and on 04/10/2024 at 8:50 AM, showed the facility provided no protected areas that accommodated and encouraged outside participation of memory care residents.

During an interview on 04/10/2024 at 12:30 PM, Staff O, Resident Life Aid, stated that the memory care unit used umbrellas that work for sun protection. Staff O stated that the facility had no coverings that worked to shield the residents from the rain.

During an interview on 04/10/2024 at 12:30 PM, Staff A, Director of Wellness, stated that the facility was aware the Memory Care outdoor area required a covered area to protect resident from the rain. Staff A stated that the facility was working on a plan.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5.3.24 .

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

Administrator (or Representative) 5-3-24 Date

WAC 388-78A-2680 Electronic monitoring equipment Audio monitoring and video monitoring.

(2) The assisted living facility may video monitor and video record activities in the facility or on the premises, without an audio component, only in the following areas.

(a) Entrances, exits, and elevators as long as the cameras are:

(ii) Not focused on areas where residents gather.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to prevent video recording of the bistro dining area where residents gathered for 1 of 1 bistro. This video recording violated the residents right to privacy.

Finding included...

Observation on 04/04/2024 at 9:30 AM showed a video camera located on the main floor in the hallway, lobby, and bistro area where residents gathered. Observation showed residents sat at tables in the bistro, eating breakfast.

During the entrance conference interview on 04/04/2024 at 9:45 AM, Staff J, Executive Director, stated that the assisted living residents had full access to all common areas in the facility, which included the bistro located on the main floor.

Observations on 04/08/2024, 04/09/2024, and 04/10/2024 at 9:00 AM, 12:00-1:00 PM, showed the video cameras located in the bistro area.

During an interview on 04/09/2024 at 2:57 PM, Resident 6 stated they go to the bistro to get fresh fruit and other items from time to time. Resident 6 stated that the fruit was fresher in the bistro compared to the fruit they received on the assisted living side.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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During an interview on 04/08/2024 at 2:57 PM, Resident 6 stated they go to the bistro to get fresh fruit and other items from time to time. Resident 6 stated that the fruit was fresher in the bistro compared to the fruit they received on the assisted living side.

Statement of Deficiencies	License #: 681	Compliance Determination # 39265
Plan of Correction	JUDSON PARK RETIREMENT COMMUNITY	Completion Date
Page 7 of 9	Licensee: Humangood Washington	04/25/2024

Observation on 04/10/2024 at 9:47 AM, with Staff K, Maintenance Director, showed a laptop computer with a video of the bistro counter area and seating areas. The video camera showed residents seated at the tables, eating. Staff K confirmed the video cameras showed residents gathered in the bistro, seated at tables.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5.3.24.

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

Administrator (or Representative) — Date: 5.3.24

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide a ~~sixteen-mesh screen~~ on 1 of 2 operable windows (parlor room window 1) used for ventilation in the secured memory care unit. This failure placed the 13 memory care residents at risk for potential insect stings and bites or exposure to diseases carried by insects.

Findings included...

Observation during the initial facility tour on 04/04/2024 at 12:30 PM, showed a large window with two handles in the parlor room. The handles allowed the window to be opened without restriction. Observation showed there was no screen in place to prevent insects or other objects from entering the facility.

Observation on 04/09/2024 at 8:45 AM, showed the window in the parlor room remained screenless.

During an interview on 04/09/2024 at 8:50 AM, Staff A, Director of Wellness, stated that they were surprised there was no screen for the window.

Observation on 04/10/2024 at 9:47 AM, with Staff K, Maintenance Director, showed a laptop computer with a video of the bistro counter area and seating areas. The video camera showed residents seated at the tables, eating. Staff K confirmed the video cameras showed residents gathered in the bistro, seated at tables.

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, JUDSON PARK RETIREMENT COMMUNITY 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-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide a sixteen-mesh screen on 1 of 2 operable windows (parlor room window 1) used for ventilation in the secured memory care unit. This failure placed the 13 memory care residents at risk for potential insect stings and bites or exposure to diseases carried by insects.

Findings included...

Observation during the initial facility tour on 04/04/2024 at 12:30 PM, showed a large window with two handles in the parlor room. The handles allowed the window to be opened without restriction. Observation showed there was no screen in place to prevent insects or other objects from entering the facility.

Observation on 04/09/2024 at 8:45 AM, showed the window in the parlor room remained screenless.

During an interview on 04/09/2024 at 8:50 AM, Staff A, Director of Wellness, stated that they were surprised there was no screen for the window.

Observation on 04/10/2024 at 8:55 AM, showed the parlor room window remained screenless.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5.3.24.

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

Jessica Cobb
Administrator (or Representative)

5.3.24
Date

WAC 388-76A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(4) Providing door hardware to ensure:

(a) Residents cannot lock themselves in, or out of, rooms or areas accessible to them; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that 2 of 2 doors (Door 1 and Door 2), that opened to the secured memory care outdoor courtyard, were unlocked to allow all residents free access to and from the courtyard. This failure placed the 13 memory care residents at risk of being locked out of the facility.

Findings included...

Observation during the initial facility tour on 04/04/2024 at 12:30 PM, showed the secured memory care unit had a secured outdoor area for the residents. Observation showed the outdoor area had two access doors. Door 1 was located off the living room/activity room and Door 2 located in the Parlor room. Both doors were equipped with a push bar that allowed residents to access the outdoor space independently, without setting off alarms or that required staff assistance. Observation showed both doors were locked from the outside, which prevented residents from independently re-entering the facility.

Observation on 04/09/2024 at 8:45 AM, showed Door 1 and Door 2 allowed memory care residents unrestricted access to the secured outdoor area. Observation showed the two doors remained locked from the outside, which prevented the residents' access to re-enter the building.

Observation on 04/10/2024 at 8:55 AM, showed the parlor room window remained screenless.

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, JUDSON PARK RETIREMENT COMMUNITY 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-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(4) Providing door hardware to ensure:

(a) Residents cannot lock themselves in, or out of, rooms or areas accessible to them; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that 2 of 2 doors (Door 1 and Door 2), that opened to the secured memory care outdoor courtyard, were unlocked to allow all residents free access to and from the courtyard. This failure placed the 13 memory care residents at risk of being locked out of the facility.

Findings included...

Observation during the initial facility tour on 04/04/2024 at 12:30 PM, showed the secured memory care unit had a secured outdoor area for the residents. Observation showed the outdoor area had two access doors. Door 1 was located off the living room/activity room and Door 2 located in the Parlor room. Both doors were equipped with a push bar that allowed residents to access the outdoor space independently, without setting off alarms or that required staff assistance. Observation showed both doors were locked from the outside, which prevented residents from independently re-entering the facility.

Observation on 04/09/2024 at 8:45 AM, showed Door 1 and Door 2 allowed memory care residents unrestricted access to the secured outdoor area. Observation showed the two doors remained locked from the outside, which prevented the residents' access to re-enter the building.

During an interview on 04/09/2024 at 8:50 AM, Staff A, Director of Wellness, stated that the two access doors to the secured memory care outdoor area were to be unlocked during the daytime, to allow memory care residents independent access back into the building. Observation showed Staff A stepped outside into the secured outdoor space and attempted to re-enter the facility. Observation showed Staff A was unable to re-enter the facility from either Door 1 or Door 2 without assistance from someone inside to open the door for them. During the interview, an unidentified care staff showed an Allen wrench key that staff were able to use to unlock the two doors to allow access from the outside. The unidentified care staff stated that the staff had not unlocked the doors on this day.

Observation on 04/10/2024 at 8:55 AM, showed Door 1 and Door 2 remained locked from the outside. The locked doors allowed memory care residents access to the outdoor area without alarms or staff assistance. The locked doors prevented the residents from re-entry into the building without assistance.

Review of an email from Staff A, dated 04/16/2024, showed confirmation that Door 1 and Door 2 provided the memory care residents 24-hour access to the secured outdoor courtyard, even when the doors were locked at night. The email confirmed that when the doors were locked at night, the memory care residents did not have access to re-enter the facility without staff assistance.

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, JUDSON PARK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5.17.24.

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

Jessica Collins — Administrator (or Representative)

5.3.24 — Date

During an interview on 04/09/2024 at 8:50 AM, Staff A, Director of Wellness, stated that the two access doors to the secured memory care outdoor area were to be unlocked during the daytime, to allow memory care residents independent access back into the building. Observation showed Staff A stepped outside into the secured outdoor space and attempted to re-enter the facility. Observation showed Staff A was unable to re-enter the facility from either Door 1 or Door 2 without assistance from someone inside to open the door for them. During the interview, an unidentified care staff showed an Allen wrench key that staff were able to use to unlock the two doors to allow access from the outside. The unidentified care staff stated that the staff had not unlocked the doors on this day.

Observation on 04/10/2024 at 8:55 AM, showed Door 1 and Door 2 remained locked from the outside. The locked doors allowed memory care residents access to the outdoor area without alarms or staff assistance. The locked doors prevented the residents from re-entry into the building without assistance.

Review of an email from Staff A, dated 04/16/2024, showed confirmation that Door 1 and Door 2 provided the memory care residents 24-hour access to the secured outdoor courtyard, even when the doors were locked at night. The email confirmed that when the doors were locked at night, the memory care residents did not have access to re-enter the facility without staff assistance.

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, JUDSON PARK RETIREMENT COMMUNITY 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

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

04/25/2024

Humangood Washington
JUDSON PARK RETIREMENT COMMUNITY
23600 MARINE VIEW DR S
DES MOINES, WA 98198

RE: JUDSON PARK RETIREMENT COMMUNITY # 681

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/25/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

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

Kent, WA 98032

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

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

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

The Assisted Living Facility failed to ensure that 1 of 7 sampled kitchen staff (Staff I) maintained a current food handlers' card. Review of staff records showed Staff I did not have a food a valid food handlers' card completed through a Washington state Public Health Department. On 04/10/2024, Staff I completed the online food handler training through the Public Health department for Seattle and King County.

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

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

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

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

If You Have Any Questions:
• Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

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

Enclosure