



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**1200 Alder Street, Union Gap, WA 98903**

Highgate Yakima LP  
HIGHGATE SENIOR LIVING  
5605 W CHESTNUT AVE  
YAKIMA, WA 98908

RE: HIGHGATE SENIOR LIVING License # 2224

Dear Administrator:

This letter addresses Compliance Determination(s) 38261 (Completion Date 03/13/2024) and 36023 (Completion Date 01/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/13/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-c, WAC 388-78A-2140-5, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3-e, WAC 388-78A-2290-3, WAC 388-78A-2290-4, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d, WAC 388-78A-2320-2-b, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2483-2

The Department staff who did the on-site verification:

Jessica Clapp, Assisted Living Facility Licensors  
Tracy Ramirez, Assisted Living Facility Licensors

If you have any questions, please contact me at (509)208-5231.

Sincerely,

*Gwin Kaercher*

Gwin Kaercher, Field Manager

HIGHGATE SENIOR LIVING # 2224

03/13/2024

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Region 1, Unit G

Residential Care Services



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies License #: 2224 Compliance Determination # 36023  
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 01/22/2024, 01/23/2024, 01/24/2024 and 01/25/2024 of:  
HIGHGATE SENIOR LIVING  
5605 W CHESTNUT AVE  
YAKIMA, WA 98908

The following sample was selected for review during the unannounced on-site visit: 7 of 60 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tracy Ramirez, Assisted Living Facility Licensor  
Anna Cairns, ALF Long Term Care Surveyor  
Jessica Clapp, Assisted Living Facility Licensor

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 1 , Unit G  
1200 Alder Street  
Union Gap, WA 98903

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.

*Quin Kaercher*  
Residential Care Services

02/07/2024  
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.

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

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*Carla Bianchi*  
Administrator (or Representative)

2-9-2024  
Date

**WAC 388-78A-2100 Ongoing assessments.**

(2) The assisted living facility must:

- (a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;
- (b) Complete an assessment specifically focused on a resident's identified problems and related issues:
  - (i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;
  - (ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

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

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete a full assessment addressing the required elements for 4 of 4 residents (Residents 3, 4, 5, 6). This failure placed the residents at risk of unmet care needs.

**Resident 6**

Review of Resident 6's alert charting showed that they started to have paranoid delusions on 11/04/2022, that continued on 11/10/2022, and 11/20/2022. In addition, it showed that Resident 6 was having suicidal ideation on 11/24/2022.

On 01/25/2024 at 9:50 AM, Staff E, Registered Nurse stated the facility would send residents out for further evaluation if they had concerns of self-harm. They stated that for Resident 6, they were not sent out, that they often verbalized suicidal ideation with a weapon that Staff E stated they did not have access to.

On 01/25/2023 at 11:15 AM, Staff E stated that Resident 6 had a traumatic event and had fears regarding what had occurred in the past.

Review of Resident 6's November 2023-January 2024 Medication Administration Records (MARs) showed that the resident was prescribed donepezil (a medication used for difficulties with cognition).

Review of the facility characteristic roster, undated, showed that Resident 6 lived in an

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assisted living apartment.

Observation on 01/25/2023 at 8:54 AM showed that Resident 6 was in the memory care section of the facility and was being taken to their apartment on the assisted living section of the facility to use the bathroom.

Review of Resident 6's facility assessment dated 11/04/2023 showed diagnoses of [REDACTED] and [REDACTED]. In the section, "Mood and Behavioral Patterns," there are no behaviors documented and in the "Comments," box below it states, "Likes to joke with people." In the Montreal cognitive assessment (MoCA-used to test signs of dementia) portion on the assessment, it showed that there was not a MoCA completed for Resident 6. In the section to document hallucinations, suicidal thoughts, hopelessness, and fears, there is no documentation on the assessment noting any of those. The assessment did not include any history of trauma. In the section documenting diagnoses, Resident 6 was shown to be at risk for falls. The assessment does not check if the resident had falls with injury or list any fall preventions. Additionally, the assessment did not show that Resident 6 spent time in the memory care portion of the facility.

On 01/23/2024 at 9:52 AM Staff E, RN, acknowledged that were not any behaviors, significant medications, interventions, or fall interventions documented in Resident 6's facility assessment.

Resident 5

Review of Resident 5's facility assessment, dated 12/05/2023, showed diagnoses of [REDACTED]

and [REDACTED]

Review of Resident 5's November 2023-January 2024 Medication Administration Records (MARs) it showed that the resident was prescribed carvedilol (treats high blood pressure), haloperidol (medication for abnormal thoughts and behaviors), levothyroxine (hormone medication), losartan potassium (medication for high blood pressure), and sertraline (medication for depression or anxiety).

Review of Resident 5's facility nurse communication to their physician, dated 07/25/2023 showed that they had improved behaviors. However, they started, "Biting, hitting, and spitting, again."

Review of Resident 5's facility nurse communication to their physician, dated 07/31/2023 showed that their behaviors worsened, and they had started going after other residents, which resulted in caregivers being hit on multiple dates when trying to intervene.

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Review of Resident 5's facility nurse communication to their physician, dated 08/14/2023 showed that their behaviors from the previous date had not changed, that a caregiver was hit multiple times when re-directing from going towards another resident, and caused injury to the caregiver.

Review of Resident 5's facility nurse communication to their physician, dated 10/03/2023, showed they started to have increased behaviors, which included hitting care staff, resisting care and biting.

Review of Resident 5's facility nurse communication to their physician, dated 12/04/2023, showed that they started having increased behaviors, which included hitting care staff, pulling their hair, resisting care, and biting.

On 01/24/2023 at 10:56, Staff F, Care Partner, stated that Resident 5 took their medications crushed in applesauce or chocolate syrup.

Review of Resident 5's assessment, dated 12/05/2023, showed that they had severely impaired cognition. In the MoCA portion on the assessment showed that there was not one completed for Resident 5. In the section of the assessment for their cognitive assessment, the score and date were not completed. In the section of the assessment for, "Behaviors and mood," it stated that Resident 5, "Will kick, bite spit, hit and scratch caregivers." There were no interventions for the behaviors documented in the assessment. The assessment documents that Resident 5 had falls with injury and falls without injury. There were no safety interventions documented in the assessment. In the section under, "Medication use and levels," there was no documentation of the significant medications, risks, what to look for, and how the resident would take their medications safely. In the section under, "Health problems," Resident 5's significant diagnoses were not explained or addressed, including [REDACTED] and [REDACTED]. Additionally, the assessment showed that Resident 5's medications were taken whole.

On 01/25/2024 at 9:50 AM, Staff E, stated that they did not complete the MoCA due to cognitive state of Resident 5 for their assessment, that they had removed the behaviors from the resident assessments, and stated that Resident 5 took their medications crushed and acknowledged their assessment did not reflect that.

Resident 3

Review of Resident 3's physician's note dated 09/27/2023 showed that there was a diagnosis of [REDACTED]

Review of Resident 3's assessment dated 10/18/2023 did not show a MoCa was completed to show their cognitive impairment. The assessment showed diagnoses of [REDACTED]

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██████████ and did not include ██████████

On 01/25/2024 at 9:23 AM with Staff E, RN, acknowledged Resident 3's assessment was missing a MoCa and the diagnosis of ██████████

Resident 4

Review of Resident 4's physician visit note dated 12/06/2023 showed they had a diagnosis of ██████████

Review of Resident 4's updated assessment dated 12/10/2023 did not include the diagnosis of ██████████

On 01/23/2024 at 11:45 AM Resident 4 was observed to be sitting in their chair. Resident 4 was observed to have tight fitting stockings due to the swelling in their lower legs.

On 01/25/2024 at 8:51 AM with Staff E, RN, acknowledged Resident 4's assessment did not have the diagnosis of ██████████ Staff E stated that their process after physician visits was to review the notes and add any new diagnosis if needed and was not completed.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) <u>3-1-2024</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Carlo J. Bianchi</u> Administrator (or Representative)	<u>2-9-2024</u> Date

**WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:**

- (1) The care and services necessary to meet the resident's needs, including:
  - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

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(ii) The resident's full assessments;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(5) Appropriate behavioral interventions, if needed;

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

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to develop a Negotiated Service Agreement (NSA) that addressed the resident's needs and interventions for risks which included diagnoses, activities of daily living, and intermittent nursing services for 5 of 7 residents (Residents 3, 4, 5, 6, 7). This failure placed the residents at risk of unmet needs and complications from their chronic medical conditions.

Findings included...

**Resident 3**

Review of Resident 3's Assessment dated 10/18/2023 showed the resident had diagnoses of [REDACTED] and [REDACTED]

Review of Resident 3's physician note dated 09/27/2023 showed there was a diagnosis of [REDACTED]

Review of Resident 3's progress note dated 11/15/2023 showed that there was a dark spot on the heel. The progress note did not show which heel had the wound, what the staff should monitor for and report, and no interventions were implemented.

Review of Resident 3's a physician order dated 01/16/2024 showed pressure relief boots were prescribed related to the wound on the left heel.

Review of Resident 3's NSA dated 10/18/2023 showed the resident had a wheelchair for mobility. The NSA did not show that Resident 3 had skin issues, a wound or who was responsible for providing the wound care.

On 01/25/2024 at 9:06 AM, Staff E, Registered Nurse (RN), stated that Resident 3's NSA did not contain information about their wound, who was responsible for completing the wound care, and did not document diagnoses, which included what staff are to monitor for, report, and interventions needed. Staff E, RN, acknowledged that the pressure relief

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boots were not in the NSA.

Review of Resident 4's skilled nursing facility rehabilitation summary from prior placement showed the resident had [REDACTED]

Resident 4

Review of Resident 4's assessment dated 11/08/2023 showed the resident had diagnoses of a [REDACTED] and [REDACTED]

Review of Resident 4's NSA dated 11/08/2023 showed the resident had a wheelchair and walker for mobility. The NSA did not show that Resident 4 had [REDACTED] and [REDACTED]. The NSA had included only one diagnosis of [REDACTED] and showed the resident had [REDACTED], not the [REDACTED].

On 01/25/2024 at 9:00 AM Staff E stated that Resident 4's NSA showed the resident was not a fall risk and had no fall interventions in place to prevent similar occurrences that previously caused the right lower leg fracture. Staff E stated that Resident 4 had a previous fall with the right lower leg fracture prior to admission. Staff E stated that unless a resident had falls in their facility, they would not include that they were a fall risk in their NSA. Additionally, Staff E acknowledged that Resident 4's NSA had not included their diagnoses of a [REDACTED] and or what to monitor for, report and had no interventions for staff to follow.

Resident 5

Review of Resident 5's facility assessment dated 12/05/2023 showed diagnoses of [REDACTED] and [REDACTED]

Review of Resident 5's November 2023 - January 2024 Medication Administration Records (MARs) it showed that the resident was prescribed carvedilol (treats high blood pressure), haloperidol (medication for abnormal thoughts and behaviors), levothyroxine (hormone medication), losartan potassium (medication for high blood pressure), and sertraline (medication for depression or anxiety).

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Review of Resident 5's physician orders dated 07/15/2022 showed that the resident had been found wandering on a busy street and was unable to remain at the previous facility. It showed that Resident 5 had issues with speech from aphasia, memory problems, and wandering history. Additionally, Resident 5 was ordered to take their medications orally. It did not document that they needed their medications crushed.

On 01/24/2023 at 10:56, Staff F, Care Partner, stated that Resident 5 took their medications crushed in applesauce or chocolate syrup.

Review of Resident 5's NSA, dated 12/05/2023, showed that the resident was not oriented to date and time. In the section, "Special Instructions and Critical Health Information," Resident 5's NSA did not include diagnoses from their assessment and what staff are to look for in relation to them. In the section, "Safety concerns," it stated that Resident 5 could not leave the facility with an escort. This section did not address that Resident 5 was had a history of elopement did not include preventative measures that were put in place. In the section, "Communication," their verbal communication challenges are not documented as related to their diagnosis of [REDACTED]. Additionally, in the section, "Medication," the NSA did not list Resident 5's medications and showed their medications were taken whole with water.

#### Resident 6

Review of Resident 6's facility assessment dated 11/04/2023 showed diagnoses of [REDACTED] and [REDACTED].

Review of Resident 6's physician's orders, dated 12/19/2023 showed that the resident had been seen for paranoid delusions. Additionally, it showed that Resident 6 had a medical history of memory difficulties, was at risk for falls, and chronic kidney disease.

Review of Resident 6's alert charting showed that they started to have paranoid delusions on 11/04/2022, that continued 11/10/2022, and 11/20/2022. In addition, it showed that Resident 6 was having suicidal ideation on 11/24/2022.

Observation on 01/25/2023 at 8:54 AM showed Resident 6 was in the memory care section of the facility and was being taken to their apartment on the assisted living section of the facility to use the bathroom.

Review of Resident 6's NSA, dated 11/04/2023, did not document their diagnoses from their assessment, medications and what risks were associated, or their history of hallucinations and suicidal ideation. In the section under medication, it did not document the name of the medication taken for dementia or what staff were to do if the resident had reoccurring hallucinations.

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Resident 7

Review of Resident 7's facility assessment, dated 11/27/2023, showed that the resident had diagnosis of [REDACTED] and [REDACTED]. In the section, "Medication use and level," it showed that Resident 7 required blood sugar testing and insulin.

Review of Resident 7's facility nurse delegation consent form, dated 03/01/2022, showed that the resident required nurse delegation.

On 01/24/2024 at 3:10 PM, Staff E, RN stated that Resident 7 would take two to three hours to eat and had been yelling at their husband who was also at the facility, when they had their meals in the main dining room. Staff E, RN, stated that Resident 7 was vocal, would get on tangents, would stop eating, and picked at their face, that is why they now at in the memory care section of the facility for meals.

Review of Resident 7's NSA, dated 11/27/2023, showed that the resident was diabetic and not oriented to date and time. Diagnoses of [REDACTED] and [REDACTED] from their assessment were not documented on their NSA. In the section, "Medication," it did not show that the resident required insulin and blood sugar checks daily. In addition, it did not show that the resident also required nurse delegation. The NSA for Resident 7 did not document the behaviors the facility nurse stated they had, if eating in the memory care section of the facility for meals was their preference, or was part of their care need.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) <u>3-1-2024</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u><i>Carla J. Bianchi</i></u> Administrator (or Representative)	<u>2-9-2024</u> Date

**WAC 388-78A-2230 Medication refusal.**

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

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(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

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

Based on interview and record review, the Assisted Living Facility (ALF) failed to take appropriate action and notify the prescriber or primary care practitioner (PCP) for 1 of 2 residents (Resident 5). This failure placed residents at risk of increased negative behaviors, distress, and decline in health conditions.

**Resident 5**

Review of Resident 5's facility assessment dated 12/05/2023 showed diagnoses of [REDACTED]

and [REDACTED]

Review of Resident 5's November 2023 Medication Administration Record (MAR) showed that Resident 5 had refused their medication as prescribed on 11/06/2023, 11/11/2023, and 11/12/2023.

Review of Resident 5's progress note dated 11/09/2023 showed that the resident had tripped and fell. There was no documentation that showed that the PCP had been contacted.

Review of Resident 5's December 2023 MAR showed that the resident had refused their medication as prescribed on 12/07/2023, 12/09/2023, 12/10/2023, 12/11/2023, 12/15/2023 and 12/22/2023. Additionally, it showed that on 12/10/2023 the resident, "Spit out and swung at medtech," on 12/15/2023, "Attempted twice but became violent," and on 12/15/2023, "Attempted twice but became violent, spit in my face."

Review of Resident 5's progress notes from 11/12/2023-01/06/2024 showed that there was no progress notes or alert charting documented for Resident 5 between those dates. Additionally, there was not any documentation that showed the PCP had been contacted regarding medication refusals or behaviors noted on the MAR.

Review of Resident 5's January 2024 MAR showed that the resident refused their medication as prescribed on 01/12/2024 and 01/19/2024.

Review of Resident 5's progress notes dated 01/07/2024 showed that the resident had a fall incident.

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On 01/25/2024 at 12:18 PM, Staff E, Registered Nurse (RN), stated that they did not notify Resident 5's PCP, that the family had taken responsibility to do so. However, they were not able to provide documentation to show notification to the family or PCP when there were medication refusals or behaviors changes.

<b>Plan/Attestation Statement</b>	
<p>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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) <u>3-1-2024</u>.</p>	
<p>In addition, I will implement a system to monitor and ensure continued compliance with this requirement.</p>	
<p><u><i>Carla Bianchi</i></u> Administrator (or Representative)</p>	<p><u>2-9-2024</u> Date</p>

**WAC 388-78A-2290 Family assistance with medications and treatments.**

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

- (a) By name, the family member who will provide the medication or treatment assistance or administration;
  - (b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;
  - (c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;
  - (d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and
  - (e) Other information determined necessary by the assisted living facility.
- (4) The plan for family assistance with medications or treatments must be signed and dated by:
- (a) The resident, if able;
  - (b) The resident's representative, if any;
  - (c) The resident's family member responsible for implementing the plan; and
  - (d) A representative of the assisted living facility authorized by the assisted living facility to

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sign on its behalf.

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

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop a written plan for family medication assistance for 1 of 1 resident (Resident 2). This failure placed the resident at risk of not receiving their prescribed medications if the resident representative was not available.

**Findings included...**

Review of the facility's disclosure statement, updated, showed that a resident's representative could provide a resident with medication assistance. It showed that the representative would work with the facility to develop a written plan that included the process, contact information and a backup plan should the representative not be available.

On 01/25/2024 at 10:45 AM, Resident 2 stated that their representative assisted their medications. They stated that their representative ordered refills, pre-filled their pill box and brought it them at the facility monthly. Resident 2 stated they kept the pill box in a secured area in the room.

Review of Resident 2's facility assessment dated 08/25/2023, showed that the resident was able to independently take prescription and over-the-counter medications. The assessment did not show that the resident's representative assisted with their medications.

Review of Resident 2's Negotiated Service Plan (NSA) dated 08/25/2023, showed that the resident was independent with medication use and that they were responsible for ordering prescription refills. The NSA did not show that the resident's representative assisted them with ordering medications and setting up the resident's pill box. Additionally, the NSA did not show an alternate plan if the representative was unable to assist the resident.

Review of the facility's document titled, "Medication Self-Administration Assessment" dated 01/17/2019, showed that Resident 2 was able to take their medications independently. The resident's record did not show that an updated assessment was completed in the last five years.

Review of Resident 2's January 2024 Medication Administration Record (MAR), showed that the most recent update to the medications was completed on 02/27/2020.

On 01/25/2024 at 2:16 PM, Staff E, Registered Nurse (RN), stated that there was no written agreement signed between the facility and Resident 2's representative for their assistance with the resident's medications. They stated the physician orders signed by the doctor

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showed that the resident was able to do their own medications.

On 01/25/2023 at 2:25 PM, Staff E, RN, stated that the self-medication assessments were not updated unless a change of condition occurred. They stated they were notified of medication changes by the resident or sometimes by the doctor. Additionally, Staff E stated that they had not been in contact with Resident 2's representative about the resident's medications.

**Plan/Attestation Statement**

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 3-1-2024.

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

Carla J. Bianchi  
Administrator (or Representative)

2-9-2024  
Date

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

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

- (a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and
- (b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(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 observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that the Registered Nurse Delegator (RND) followed the requirements for nurse delegation which included assessing the resident, documenting specific medication to be delegated, providing directions for each task, and reviewing the appropriateness of continuation for those who received delegated task assistance from staff of delegation, for 1 of 1 resident (Resident 7). This failure placed residents at risk of complications of their medical conditions and potential for delegated tasks to be performed incorrectly.

Findings included...

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Review of WAC 246-840-930, Criteria for delegation, showed that the RND was to assess the resident for the need and appropriateness for each delegated task and obtain written consent from the resident or their representative for the delegation. Additionally, the RND had to provide training and direction to qualified staff and ensure that reevaluation and documentation of delegated tasks occurred for the first four weeks for insulin, and at least every 90 days for all delegated tasks.

On 01/22/2024 at 10:16 AM Staff A, Executive Director, stated that the facility provided intermittent nursing services to residents, which included delegation of medications and treatments. Staff A stated that Staff E, Registered Nurse, was the RND at the facility.

Review of Resident 7's facility assessment, dated 11/27/2023, showed that they had diagnosis of [REDACTED] and [REDACTED] and that they required blood sugar testing and insulin injections.

Review of Resident 7's November 2023-January 2024 Medication Administration Records (MARs) showed that they were prescribed insulin injections and blood sugar checks daily.

Review of Resident 7's physician orders showed that the resident had insulin injections and blood sugar checks daily.

Review of the facility's nurse delegation nursing visit form showed that there were seven staff delegated to perform delegated tasks for Resident 7. Four of the seven staff did not have four weeks of training as required. Additionally, the three staff that had four weeks of training documented, did not have dates for when the trainings occurred.

Review of the facility's nurse delegation instructions, dated 03/01/2022, did not include the name of the delegated medications and dosages, delegated tasks that needed to be performed, or the range for blood sugar levels to monitor. Additionally, the nurse delegation instructions were not updated every 90 days as required.

On 01/25/2024 at 9:52 AM, Staff E, RN/RND, acknowledged that there were no directions for tasks, medication names or dosages, or how many units of insulin on the facility nurse delegation form for Resident 7. Staff E stated that they were told by an outside agency, that they did not have to include those details in the delegation forms. Additionally, they did not recall their name or the organization that had given them that information.

**Plan/Attestation Statement**

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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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 3-1-2024.

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

Carla Bianchi  
 Administrator (or Representative)

2-9-2024  
 Date

**WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:**

- (2) A documented negative result from one skin or blood test in the previous twelve months.

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

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure a one-step test for Tuberculosis (TB) was completed 1 of 2 staff (Staff B). This failed practice placed residents at risk of potential exposure of a communicable disease.

**Findings included...**

On 01/25/2023 a staff record review was completed with Staff G, Manager. Staff G stated that they were responsible for maintaining and updating staff records .

Review of Staff B's file showed that they were hired on 12/20/2023. Staff B's record showed that there was no documentation of a TB test completed upon hire.

On 01/25/2024 at 1:07 PM, Staff E, Registered Nurse, stated that they had record of a TB test being completed for Staff B by a prior employer on 02/10/2023. They stated that they did not do a TB test for Staff B because it was within a year of the last documented test.

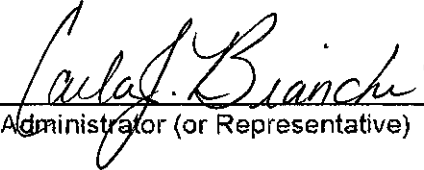
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