STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

December 18, 2018

CSH Maple Leaf Lessee LLC
Maple Leaf Assisted Living and Memory Care
9001 LAKE CITY WAY NE
SEATTLE, WA 98115

RE: Maple Leaf Assisted Living and Memory Care License #2364

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on December 18, 2018 for the deficiency or deficiencies cited in the report/s dated November 9, 2018 and found no deficiencies.

The Department staff who did the follow-up inspection:
Maureen Valentine, Community Complaint Investigator

If you have any questions please, contact me at (360) 651-6863.

Sincerely,

Jayne Hill

Jayne Hill, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: Maple Leaf Assisted Living and Memory Care (947768)
Intake ID(s): 3581373
License/Cert. #: AL2364
Investigator: Howard, Kelly
Region/Unit: RCS Region 2/Unit B
Investigation Date(s): 11/02/2018 through 11/09/2018
Complainant Contact Date(s):

Allegations:

It was alleged:
1. The Assisted Living Facility (ALF) was not providing adequate care to the named resident who [redacted]
2. The ALF took away the named resident's [redacted] and did not care of the [redacted]

Investigation Methods:

☒ **Sample:**	3 residents (including the named resident)	☒ **Observations:**	Environment, care provision, staff to resident interactions
☒ **Interviews:**	The named resident, residents, Administration, Director of Nursing, caregivers	☒ **Record Reviews:**	Assessments, negotiated service agreements (NSA), progress notes, policies, medication logs, medical records

Allegation Summary:

1. The named resident was hospitalized for an electrolyte imbalance which resulted from the resident's attempt to harm self by intentionally withholding food. After the resident returned from the hospital, the ALF failed to monitor the resident's safety, body weight, vital signs and oral intake.
2. The named resident lived at the ALF with her [redacted] The named resident had unlimited access to her [redacted] The ALF assisted the named resident with taking the [redacted] out of the building walks and toileting. The [redacted] appeared to be well-nourished and well cared for.

Unalleged Violation(s): ☐ **Yes** ☒ **No**

None

Conclusion / Action: ☒ **Failed Provider Practice Identified / Citation(s) Written** ☐ **Failed Provider Practice Not Identified / No Citation Written**

WAC 388-78A-21210 (2)(3)(a)(4) Monitoring residents' well-being

Residential Care Services

Investigation Summary Report

Provider/Facility:	Maple Leaf Assisted Living and Memory Care (947768)	**Intake ID(s):**	3580475		
License/Cert. #:	AL2364				
Investigator:	Howard, Kelly	**Region/Unit:**	RCS Region 2/Unit B	**Investigation Date(s):**	11/02/2018 through 11/09/2018
Complainant Contact Date(s):					

Allegations:

1. It was alleged the named resident attempted to elope from the Assisted Living Facility (ALF).

Investigation Methods:

☒ **Sample:**	3 residents (including the named resident)	☒ **Observations:**	Environment, care provision, staff to resident interactions
☒ **Interviews:**	The named resident, residents, Administrator, nurse, caregivers	☒ **Record Reviews:**	Assessments, negotiated service plans (NSP), progress notes, ALF policies/procedures

Allegation Summary:

The named resident removed the locking mechanisms from his window on the memory care unit and attempted to crawl out. The named resident was observed by police officers patrolling the area and stopped from exiting. The ALF immediately placed the named resident on close supervision and re-secured the windows on the unit. The named resident recalled the incident and

Unalleged Violation(s): ☐ **Yes** ☒ **No**

The ALF failed to monitor the well-being of a resident with suicidal ideation and gestures.

Conclusion / Action: ☒ **Failed Provider Practice Identified / Citation(s) Written** ☐ **Failed Provider Practice Not Identified / No Citation Written**

388-78A-2120 (2)(3)(a)(4) Monitoring residents' well-being.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 2364	Completion Date
Plan of Correction	Maple Leaf Assisted Living and Memory Care	November 9, 2018
Page 1 of 4	Licensee: CSH Maple Leaf Lessee LLC	

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

This document references the following complaint numbers: 3580475 , 3581373

The department has completed data collection for the unannounced on-site complaint investigation on 11/2/2018 of:

Maple Leaf Assisted Living and Memory Care
9001 LAKE CITY WAY NE
SEATTLE, WA 98115

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

The department staff that inspected and investigated the assisted living facility:

Kelly Howard, RN, MSN, Licensor

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223
(360)651-6863

As a result of the on-site complaint investigation 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.

Brenda Haney
Residential Care Services

11/13/2018
Date

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

11-26-18
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:
(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
(a) Departure from the resident's customary range of functioning; or
(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.
(3) Evaluate, in order to determine if there is a need for further action:
(a) The changes identified in the resident per subsection (2) of this section; and
(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:
Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to monitor the physical and mental well-being of 1 of 2 sampled resident (Resident 1) who refused to eat in an attempt to self-harm. Failure to monitor the resident placed her at risk for additional health issues.

Findings included:

Observations, interviews and record review occurred on 11/02/18 unless otherwise indicated.

Resident 1 was admitted on [redacted]18 with multiple medical diagnoses including [redacted] and [redacted].

Review of Resident 1's assessment, dated 07/31/18, revealed Resident 1 had a history of [redacted] and gestures. The assessment indicated Resident 1 was independent with eating.

Review of Resident 1's negotiated service agreement (NSA), dated 07/31/18, revealed staff were directed to perform safety checks four times each shift and report any suicidal ideation to the nurse. The NSA directed caregivers to observe the resident for "any difficulties with not eating" and to notify the LN (licensed nurse).

Review of hospital records revealed Resident 1 was admitted to a hospital with an electrolyte abnormality from poor oral intake and with [redacted] on [redacted]18. Resident 1 remained hospitalized until [redacted]18, when she returned to the ALF with an increased dosage of antidepressant and instructions to follow-up with outpatient behavioral therapy.

Review of a Temporary Service Plan (TSP), dated 10/26/18, revealed the ALF's staff were directed to monitor Resident 1's vital signs - blood pressure and pulse- at least daily for 3 days. There were no instructions regarding what would be considered an abnormal vital sign reading and should necessitate a call to the nurse or physician.

The TSP directed staff to monitor and report any safety problems or mood issues observed or reported by Resident 1. There were no directives for the staff to monitor Resident 1's nutritional intake or body weight after she returned from the hospital on [redacted]18.

Observation at 12:30 PM of Resident 1 in the hallway of the ALF revealed Resident 1 appeared to be extremely thin. Her pants were hanging off her and her cheeks appeared to be sunken in. During lunch, Resident 1 was appeared to move her food around on her plate but only consumed a few bites of the meal.

When interviewed, the ALF's Director of Wellness/Registered Nurse (RN) stated Resident 1 was admitted to the hospital on [redacted]/18 because the resident was refusing to eat. The RN stated Resident 1 verbalized a plan to end her life by starvation. The RN stated Resident 1 did "okay" for a day or two after returning from the hospital but then started to refuse to leave her room and partake in meals. The RN stated Resident 1 experienced significant weight loss since mid-October 2018.

Record review revealed the ALF last took Resident 1's weight on 10/08/18. She weighed [redacted] pounds at that time. No body weights for Resident 1 were found in the resident's hospital records. The ALF staff was requested to take Resident 1's weight during the investigative visit on 11/02/18. Resident 1 weighted [redacted] pounds, which meant Resident 1 lost 15 pounds in less than 1 month.

Review of the vital signs log revealed Resident 1 experienced hypotension (low blood pressure with a reading less than 90/60). Resident 1's readings were: 83/56 at 6:42 PM on 10/27/18, 70/50 on 10/29/18, 79/56 at 8:38 AM on 10/30/18 and 80/57 at 11:32 AM on 10/31/18. The ALF's documentation contained no information to indicate the licensed nurse or Resident 1's physician were notified about Resident 1's hypotension.

Record review revealed no evidence to indicate the facility conducted the safety checks each shift (per the NSA). Review of progress notes revealed Caregiver A documented Resident 1 refused dinner on 10/27/18. There were no entries on 10/30/18 or 10/31/18 regarding Resident 1's nutritional intake.

When interviewed, the ALF's RN stated she had been in contact with Resident 1's physician on multiple occasions to request additional behavioral support. The RN stated the ALF had not developed system to monitor Resident 1's weights or nutritional intake at each meal. She stated she would immediately implement a system for staff to more closely monitor Resident 1's nutritional intake, body weight, and safety.

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, Maple Leaf Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 12-1-18 . In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

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

Cindy Adam
Administrator (or Representative)

11-26-18
Date