STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20816 44th Ave West, Suite 240, Lynnwood, WA 98036-7744

February 21, 2020

CRP/CSH Mercer Island LLC
ISLAND HOUSE
7810 SE 30th St
Mercer Island, WA 98040

RE: ISLAND HOUSE License #2375

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on February 3, 2020 for the deficiency or deficiencies cited in the report/s dated November 6, 2019 and found no deficiencies.

The Department staff who did the follow-up inspection:
Scottie Sindora, ALF Licensor

If you have any questions please, contact me at (425) 670-6071.

Sincerely,

Susan Hajek

Susan Hajek, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20816 44th Ave West, Suite 240, Lynnwood, WA 98036-7744

Statement of Deficiencies	License #: 2375	Completion Date
Plan of Correction	ISLAND HOUSE	November 6, 2019
Page 1 of 11	Licensee: CRP/CSH Mercer Island LLC	

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 has completed data collection for the unannounced on-site full inspection on 11/1/2019 and 11/4/2019 of:

ISLAND HOUSE
7810 SE 30th St
Mercer Island, WA 98040

The following sample was selected for review during the unannounced on-site full inspection : 5 of 30 current residents and 0 former residents.

The department staff that inspected the assisted living facility:

Kirsten Biddle, Long Term Care Surveyor
Dahl Kim, Field Manager

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit J
20816 44th Ave West, Suite 240
Lynnwood, WA 98036-7744
(425)670-6071

As a result of the on-site full inspection 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 — 11/07/19 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) — 11/21/19 Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:
(2) Complete an assessment specifically focused on a resident's identified problems and related issues:
(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;
(b) 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 facility failed to complete an assessment focused on the resident's change of condition when 1 of 5 sampled residents' (Resident #5) negotiated service agreement no longer accurately addressed the resident's current medication management needs. This failure placed the resident at risk for not having proper care and services.

Findings included...

Record review showed the facility admitted Resident #5 on [redacted]/17 with multiple diagnoses including [redacted] The resident's October 2019 medication administration record (MAR) showed the resident was taking two as needed (PRN) medications in addition to routine medications: Acetaminophen (Tylenol) 325 mg, take 2 tabs by mouth twice a day as needed; Loperamide 2mg, take 1 capsule by mouth as needed for loose stool. Review of October 2019 MAR showed the resident was given Tylenol 13 times for pain and Loperamide twice.

Review of the "Assisted Living Facility Resident Characteristic Roster" received on 11/01/19, showed the resident received medication assistance. Review of the resident's assessment dated 07/17/19 showed under the heading of Medications, "Meds safely self-administered with assistance." Review of the resident's "Needs and Service Plan" signed by the facility staff on 07/17/19 and by the resident's representative on 09/20/19 showed the resident received "significant (total) assist by med tech" for medications.

Observation on 11/04/19 at 1:45 pm showed Resident #5 sitting in a chair in her apartment which she shared with her spouse. When asked how she liked living in the facility she did not answer. When asked what kind of help she received from facility staff she made a facial expression showed that she did not understand the question. The resident's spouse stated the resident was not feeling well. Soon thereafter, the resident fell asleep.

In an interview following the observation, the resident's spouse stated that the facility staff gave the resident her medications. When asked if the resident was able to request for PRN medications such as Tylenol, the resident's spouse stated that the resident would not know what to ask.

Review of the resident's progress note dated 10/04/19 showed the resident had a behavior change and that the resident was "combative during care in the morning & difficulty to redirect." The progress note dated 10/07/19 showed the facility staff had a care conference with the resident's representative discussing possibility of memory care unit placement. The progress notes showed the PRN medications were "given" to the resident.

In an interview on 11/04/19 at 2:37 pm, Staff J, Caregiver stated that she has been working at the facility for approximately 10 months and has been providing care for the resident. Staff J stated that she did not think the resident knew her medications and the resident sometimes did not recognize her.

On 11/04/19 at 4:45 pm when asked if Resident #5 knew she was taking medications Staff B, Director of Health Services stated the resident could put medications into her mouth when given a cup with medications. When asked if the resident was able to request for PRN medications Staff B stated the resident had deteriorated partly due to recent urinary track infection (UTI). When asked if the resident was deteriorated to the point where a placement into a memory care was discussed, Staff B stated it was brought up by the resident's representative.

There was no evidence that an updated resident assessment was completed when the resident's service plan no longer addressed the resident's abilities related to medication management since the last assessment dated 07/17/19.

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, ISLAND HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/3/20 . 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.

Administrator (or Representative) — Date: 11/21/19

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:
(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:
Based on interview and record review, the facility failed to complete a negotiated service agreement within 30 days of the resident's admission for 2 of 5 sampled residents (Resident #1 & Resident #4). This failure placed the residents at risk for not having proper care and services.

Findings included...

Resident #1:

Record review showed the facility admitted Resident #1 on [redacted]/18 with diagnoses including [redacted] and [redacted] Review of the resident assessment showed it was completed 11/28/18. Review of resident record did not show a negotiated service agreement.

In an interview on 11/04/19 at 1:45 PM Staff B, Director of Health Services stated Resident #1 was receiving medication assistance and blood sugar checks despite a negotiated service agreement not completed after the admission.

When requested the resident's a negotiated service agreement, at 4:45 pm on 11/04/19, Staff B provided the department staff an undated plan that showed print date of 11/04/19.

In a phone interview at 11:45 am on 11/06/19, Staff B referred to the discussion of the negotiated service agreement on 11/04/19 in their office.

There was no evidence that a negotiated service agreement was completed within 30 days of the resident's admission.

Resident #4:

Record review showed the facility admitted Resident #4 on [redacted]/19 with a primary diagnosis of [redacted]

On 11/04/19 when reviewed the resident record binder did not include a service agreement. Approximately 1/2 hour later Staff B, Director of Health Services provided the department staff the resident's "Need and Services Plan." Review of the plan showed no date on the document. The plan showed it was printed on 11/04/19.

In an interview at 4:15 pm, 11/04/19 the resident's representative who resided with the resident stated she managed the resident's medications and assisted him with most of what the resident needed.

In an interview at 4:45 pm, 11/04/19 Staff B stated whenever they print the service plan each category on each page would show the print date as "date added" with the exception of the first page. When mentioned there was no date of the plan on the first page, Staff B did not respond.

In a phone interview at 11:55 am, 11/06/19 Staff B confirmed the resident and the resident's representative moved in on [redacted]/19. The department staff asked Staff B to fax a copy of the negotiated service agreement if there was a negotiated service agreement. The department did not receive the requested document.

The resident's negotiated service agreement was not completed within 30 days of the admission.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 11/21/19

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
(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 facility failed to develop and implement a safe medication system when medications were administered by caregivers without the benefit of nurse delegation for 1 of 5 sampled residents (Resident #5). This failure placed the resident at risk of compromised health and wellbeing from receiving medications administered by caregivers not provided instructions and oversight by a registered nurse delegator (RND).

Findings included...

Note: The Nurse Delegation Program, under Washington State law, allows nursing assistants and Home Care Aides working in community based care settings to perform certain tasks such as administration of prescription medications or treatments such as administration of oral medications, which are normally performed by licensed nurses. A registered nurse must teach and supervise the nursing assistant as well as provide nursing assessments of the resident's condition. Nurse Delegation is specific to each resident, each caregiver, and each task and is not transferrable. Documentation must be specific and include all required information as listed in WAC 246-840.

Record review showed the facility admitted Resident #5 on [redacted]/17 with multiple diagnoses including [redacted] The resident's October 2019 medication administration record (MAR) showed the resident was taking two as needed (PRN)

medications in addition to routine medications: Acetaminophen (Tylenol) 325 mg, take 2 tabs by mouth twice a day as needed; Loperamide 2mg, take 1 capsule by mouth as needed for loose stool. Review of October 2019 MAR showed the resident was given Tylenol 13 times for pain and Loperamide twice.

Review of the "Assisted Living Facility Resident Characteristic Roster" received on 11/01/19, showed the resident received medication assistance. Review of the resident's assessment dated 07/17/19 showed under the heading of Medications,"Meds safely self-administered with assistance." Review of the resident's "Needs and Service Plan" signed by the facility staff on 07/17/19 and by the resident's representative on 09/20/19 showed the resident received "significant (total) assist by med tech" for medications.

Observation on 11/04/19 at 1:45 pm showed Resident #5 sitting in a chair in her apartment which she shared with her spouse. When asked how she liked living in the facility she did not answer. When asked what kind of help she received from facility staff she made a facial expression that showed she did not understand the question. The resident's spouse stated the resident was not feeling well. Soon thereafter, the resident fell asleep.

In an interview following the observation, the resident's spouse stated the facility staff gave the resident her medications. When asked if the resident was able to ask for PRN medications such as Tylenol, the resident's spouse stated that the resident was not able to ask.

Review of the resident's progress note dated 10/04/19 showed the resident had a behavior change and that the resident was "combative during care in the morning & difficulty to redirect." The progress note dated 10/07/19 showed the facility staff had a care conference with the resident's representative discussing possibility of memory care unit placement.

In an interview on 11/01/19 at 3:40 pm, Staff B, Director of Health Services stated the facility did not provide nurse delegation and medication technicians provided medication assistance to residents.

In an interview on 11/04/19 at 2:37 pm, Staff J, Caregiver stated that she has been working at the facility for approximately 10 months and has been providing care for the resident. Staff J stated that she did not think the resident knew her medications and the resident sometimes did not recognize her.

On 11/04/19 at 4:40 pm when asked if Resident #5 knew she was taking medications Staff B stated the resident could put medications into her mouth when given a cup with medications. When asked if the resident was able to ask for PRN medications Staff B stated the resident had deteriorated partly due to recent urinary track infection (UTI). When asked if the resident was deteriorated to the point where a placement into a memory care was discussed, Staff B stated it was brought up by the resident's representative. Staff A, Executive Director and Staff B confirmed that the resident's condition has changed requiring a nurse delegation. Staff A stated the corporate has a registered nurse who could provide nurse delegation.

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Administrator (or Representative) — Date: 11/21/19

WAC 388-78A-2850 Required reviews of building plans.
(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:
(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:
(vi) Carpeting;

This requirement was not met as evidenced by:
Based on observation, interview, and record review, the facility failed to notify the Department of Health (DOH) Construction Review Services (CRS) of the extended time needed to finish the two of two resident rooms (Rooms #210 and #307) for the project approved in September of 2017. This placed neighboring residents in the facility at risk of extended exposure to unknown building and carpet materials, dust, and debris for a longer period than initially approved from CRS.

Findings included...

While on the environmental tour made on 11/01/2019 at 10:45 AM, with Staff D, Director of Environmental Services, the smell of paint was noticeable walking up the stairs to the second floor. About 100 feet down the hall, a stronger odor of paint came from Room #210. Inside, absent of any resident belongings, it appeared that the removed cabinetry, non-existent countertops, flooring, and walls were in preparation for replacement and/or refurbishment. The Department Representative asked Collateral Contact#1 inside Room #210 if there was a window open in which he shook his head "no", getting up from the floor area to open one of the bedroom windows for ventilation.

In an interview about the room remodeling and Construction Review Services with Staff D on 11/01/2019 at 10:53 AM, Staff D stated, "I don't know anything about that".

In an interview with Staff A, Executive Director, on 11/01/2019 at 3:50 PM, Staff A stated he was not aware of the requirement for determination of reviewability by the CRS department. Staff A stated the "ownership group" completes the coordination of the CRS application process.

Record review of the CRS website on 11/01/2019 at 3:45 PM, showed there was a "Project Title: Unit Finishes (2yr)" with a "Project Start Date: 09/13/2017".

On 11/04/2019 at 09:25 AM, Staff A provided a "Letter of Transmittal" dated November 4, 2019, to Department of Health Construction Review Services.

Record review of this letter showed,"Project Info: CRS: 60796633 ... Unit Finishes (2yr) - Revised" with the facility name and location. On page 3 it showed the "Project Status: - Approved- " further showing, "Your project is approved for a two year period, beginning September 18, 2017 and ends September 18, 2019, for the installation of the exact same materials and observing the same infection control and safety plan as reviewed."

Contact by the Department to DOH Construction Review Services was made on 11/05/2019 at 11:17 AM. Collateral Contact #2 stated the project had approval for a two-year period and in order to continue to be in compliance, the facility is required to submit a new application listing the materials for finishing the project in addition to how they intend to keep the residents safe from exposure and disposal of the old materials. At this time, the facility must re-submit an application for continuing the project of "Unit Finishes".

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Administrator (or Representative) — Date: 11/21/19

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:
(1) Individual's recent medical history, including, but not limited to:
(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or
(c) Known allergies to foods or medications, or other considerations for providing care or services.
(2) Currently necessary and contraindicated medications and treatments for the individual, including:
(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;
(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and
(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.
(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.
(4) Individual's sensory abilities, including:
(a) Vision; and
(b) Hearing.
(5) Individual's communication abilities, including:
(a) Modes of expression;
(b) Ability to make self understood; and
(c) Ability to understand others.
(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:
(a) History of substance abuse;
(b) History of harming self, others, or property; or
(c) Other conditions that may require behavioral intervention strategies;
(d) Individual's ability to leave the assisted living facility unsupervised; and
(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.
(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:
(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;
(b) Developmental disability;
(c) Dementia. While screening a resident for dementia, the assisted living facility must:
(i) Base any determination that the resident has short-term memory loss upon objective evidence; and
(ii) Document the evidence in the resident's record.
(d) Other conditions affecting cognition, such as traumatic brain injury.
(8) Individual's level of personal care needs, including:
(a) Ability to perform activities of daily living;
(b) Medication management ability, including:
(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.
(9) Individual's activities, typical daily routines, habits and service preferences.
(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.
(11) Who has decision-making authority for the individual, including:
(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;
(b) The presence of any legal document that establishes a current substitute decision maker; and
(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:
Based on interview and record review, the facility failed to complete a full assessment within fourteen days of the resident's admission for 1 of 5 sampled residents (Resident #4). This failure placed the resident at risk for unmet needs.

Findings included...

Review of Resident #4's assessment dated 05/09/19 and progress notes showed the facility admitted Resident #4 on [redacted]19 with a primary diagnosis of [redacted]

In an interview at 4:15 pm, 11/04/19 the resident's representative who resided with the resident stated they moved into the facility in [redacted] of this year and she managed the resident's medications and assisted him with most of what the resident needed.

In a phone interview at 11:55 am, 11/06/19 Staff B confirmed the resident and the resident's representative moved in on [redacted]/19. The department staff asked Staff B to fax a copy of all of the resident's full assessment to the department.

The department staff received documents via FAX at 1:50 pm on 11/06/19. The faxed document showed that the facility completed a preadmission assessment for the resident, "AL Advantage Resident Assessment" on [redacted]19, two days prior to the admission. The faxed document also included a full assessment dated 05/09/19 which the department staff has already reviewed onsite.

The full assessment for the resident was not completed within fourteen days of the resident's admission. It was not completed until [redacted]19, three months after the admission.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 11/21/19