



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
316 W Boone Ave., Suite 170, Spokane, WA 99201

October 25, 2017

Upriver Place Inc
Upriver Place Inc
9111 E Upriver Dr
Spokane, WA 99206

RE: Upriver Place Inc License #1000001

Dear Administrator:

The Department completed a follow-up inspection of your enhanced services facility on October 17, 2017 for the deficiency or deficiencies cited in the report/s dated July 18, 2017 and found no deficiencies.

The Department staff who did the follow-up inspection:
Kelly Sturtevant, Licensor

If you have any questions please, contact me at (509) 323-7324.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Bergeron".

Susan Bergeron, Field Manager
Region 1, Unit B
Residential Care Services



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 316 W Boone Ave., Suite 170, Spokane, WA 99201

Statement of Deficiencies

License #: 1000001

Completion Date

Page 1 of 24

Upriver Place Inc

July 18, 2017

Licensee: Upriver Place Inc

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

The department has completed data collection for the unannounced on-site full inspection on 6/27/2017, 6/28/2017, 6/29/2017, 6/30/2017, 7/10/2017 and 7/11/2017 of:

Upriver Place Inc
 9111 E Upriver Dr
 Spokane, WA 99206

The following sample was selected for review during the unannounced on-site visit: 6 of 6 current residents and 1 former residents.

The department staff that inspected the Enhanced Services Facility:

Kelly Sturtevant, RN, BSN, Licenser
 Mara Ryan, BSW, Licenser

From:

DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 1, Unit B
 316 W Boone Ave., Suite 170
 Spokane, WA 99201
 (509)323-7324

RECEIVED

AUG 16 2017

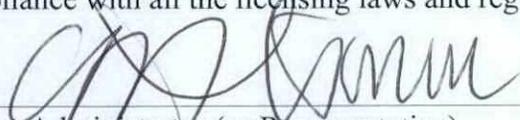
DSHS ADSA RCS
 SPOKANE WA

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


 Residential Care Services

7/31/17
 Date

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


 Administrator (or Representative)

8/10/17
 Date

WAC 388-107-0160 Behavioral support plan. The enhanced services facility must ensure that each resident's person-centered service plan has interventions for behavioral support that are used immediately when a resident's behavior escalates in the ESF or community. The behavioral support plan must include, at the minimum the following:

- (4) Steps to be taken by each of the facility staff if the prevention or intervention strategies are unsuccessful in diverting the resident from a behavior or action that leads to crisis;
- (7) A statement that the resident may not be secluded or isolated as part of the behavior support plan.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the behavior support plan for 6 of 6 sample residents (#1, 2, 3, 4, 5, 6) included steps to be taken by each staff member if the intervention strategies were unsuccessful and a statement that the resident may not be secluded or isolated as part of the behavior support plan. This failure placed residents and staff members at potential risk for injury in the event a resident was not able to de-escalate. Findings include:

1. Per the behavior support plan dated 6/20/17, Resident #1 had diagnoses including [REDACTED] and was identified as having intrusive and at times aggressive/assaultive behavior.
2. Per the behavior support plan dated 5/17/17, Resident #2 had diagnoses including [REDACTED]. The resident was identified as having behaviors related to [REDACTED] and a history of [REDACTED].
3. Per the behavior support plan dated 5/30/17, Resident #3 had diagnoses including [REDACTED]. The resident was identified as having [REDACTED] and at times aggressive/assaultive behavior.
4. Per the behavior support plan dated 5/23/17, Resident #4 had diagnoses including [REDACTED]. The resident was identified as having aggression/agitation including threatening, intimidating, and physically striking out at others.
5. Per the behavior support plan dated 5/23/17, Resident #5 had diagnoses including [REDACTED]. The resident was identified as having aggression/assaultiveness towards peers and staff related to [REDACTED] and an increase in [REDACTED].
6. Per the behavior support plan dated 6/01/17, Resident #6 had diagnoses including [REDACTED]. The resident was identified as having agitation/aggression and becomes threatening to peers, raise [REDACTED] voice, [REDACTED] or call people names when responding to [REDACTED].

On 6/28/17 after dinner was finished Resident #1, 3, and 5 were observed in the television room. Observations were made of residents and staff between 5:30 p.m. and 7:00 p.m. At one point Resident #5 was standing at the water cooler and started becoming agitated swearing about all of the [REDACTED] in the facility saying that it was "[REDACTED] ridiculous" pointing to Resident #1 and Resident #3. Resident #5 then called Resident #1 an idiot but Resident #1 did not engage. Staff M was observed in and out of the television room during these observations and did not make

any attempt to intervene or provide any intervention strategies to help the resident de-escalate.

Per record review, the behavior plans for the 6 sample residents did not include steps to be taken by each staff member when prevention/intervention strategies were unsuccessful and there was no statement that the resident may not be secluded/isolated as part of the behavior support plan.

When interviewed on 6/29/17, Staff F, caregiver, stated if a resident's behavior escalated too much they called 911 and the [REDACTED] professionals.

In an interview on 7/11/17, Staff A, the administrator, was informed of the missing information related to the behavior support plans and did not have any further information to provide.

The facility opted out of utilizing holding techniques as a method of de-escalation however, there were no clear directives to staff members on steps to be taken when identified intervention strategies were not effective.

WAC 388-107-0130 Ongoing comprehensive person-centered service plan.

- (1) The enhanced services facility must ensure the person-centered service planning team reviews and updates each resident's comprehensive person-centered service plan as follows:
- (a) Within a reasonable time consistent with the resident's needs following any significant change in the resident's physical, mental, emotional, or behavioral functioning;
 - (e) At least once every one hundred eighty days.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to complete the ongoing person-centered service plan for 6 of 6 residents (Resident #1, 2, 3, 4, 5, 6) at least every 180 days and 1 of 1 resident (Resident #5) who had a change in behavioral functioning and was found [REDACTED] in [REDACTED] room twice. This placed the residents at risk of unmet care needs and in an unsafe living environment. Findings include:

1. Per record review, Resident #1, 2, 3, 4, 5, and 6 did not have ongoing comprehensive patient-centered service plans at least every 180 days.

Per interview with the licensed nurse, Staff I, she stated she updated the ongoing comprehensive assessments but was not aware the facility was required to have an ongoing comprehensive patient-centered service plan that was updated every 180 days.

2. Per review of Resident #5's pre-admission assessment dated [REDACTED] 16 the resident had several [REDACTED] diagnoses with behaviors. The resident was identified as a [REDACTED] and the facility did a [REDACTED] assessment upon admission and indicated the resident agreed to and was willing to participate in the [REDACTED] dispensing and have [REDACTED] and [REDACTED] locked up for safety. Per review of the progress notes and incident reports dated 4/25/17 and 5/27/17, the resident was found [REDACTED] in [REDACTED] room. Per the notes on 5/27/17 the staff removed a [REDACTED] and [REDACTED] from [REDACTED] room.

Review of the resident's record noted the facility had not updated Resident #5's patient-centered service plan related to the two episodes of [REDACTED] in [REDACTED] room and interventions for staff to ensure safety for other residents.

During the exit interview with Staff A, administrator and Staff L, the Chief Executive Officer (CEO), acknowledged and confirmed the facility had not implemented the ongoing comprehensive patient-centered service plan in their system and therefore had not completed/updated them every 180 days. The administrative staff acknowledged Resident #5's plan had not been updated to include [REDACTED] in [REDACTED] room and the risk factors involved.

WAC 388-107-0120 Initial comprehensive person-centered service plan.

(1) The enhanced services facility must ensure that when the person-centered service planning team develops the initial comprehensive person-centered service plan, the team integrates the information contained in the following documents:

(d) The medicaid client's comprehensive assessment reporting evaluation (CARE) assessment.

(3) The enhanced service facility must ensure the person-centered service planning team:

(a) Completes the initial comprehensive person-centered service plan within fourteen days of the resident's move-in date;

(4) The enhanced services facility must ensure the person-centered service planning team includes the following in each resident's initial comprehensive person-centered service plan:

(a) A list of the care and services to be provided;

(b) Identification of who will provide the care and services;

(c) When and how the care and services will be provided;

This requirement was not met as evidenced by:

Based on observations, interview and record review, the facility did not ensure there was a system in place to develop the initial comprehensive person-centered service plans for 6 of 6 sample residents (#1,2,3,4,5,6). This failure resulted in 2 of 6 residents (Resident #1, 4) having no plan to manage [REDACTED], [REDACTED] testing and [REDACTED] injections. This placed the residents at risk for unmet care needs. Findings include:

1. Resident #1's initial CARE assessment (comprehensive assessment reporting evaluation) was completed [REDACTED] 16 by the community case manager prior to the resident's admission to the facility on [REDACTED] 16. The assessment identified the resident had a history of [REDACTED]. The CARE assessments completed 8/31/16 and 2/16/17 also identified the resident was at risk for [REDACTED] and documented the resident had [REDACTED] in December of 2016 while residing at the facility.

Per a progress note dated 4/2/17, the resident had a [REDACTED] which lasted between [REDACTED] or [REDACTED] and resulted in him/her falling and hitting his/her [REDACTED]. When the resident [REDACTED] [REDACTED] s/he appeared to be unaware of his/her surroundings and had [REDACTED].

The facility was aware of the resident's medical history upon admission and his/her ongoing [REDACTED] but did not develop a plan identifying possible risk factors, steps for prevention or interventions to protect the resident from possible injury.

In an interview on 7/11/17, Staff A did not have any further information to share related to the missing information.

2. Per review of Resident #4's initial person-centered service plan dated [REDACTED] 16, the resident required [REDACTED] monitoring and [REDACTED] injections. The [REDACTED] injections indicated it was a nurse required treatment but did not specify how often or when the injections would occur.

The [REDACTED] monitoring did not specify who or how often the task was to be completed.

During observations on 6/28/17 at 11:30 a.m., Resident #4 completed the tasks of checking his/her [REDACTED] and gave his/her [REDACTED] injection with staff supervision.

During an interview on 6/28/17 with Staff I, licensed nurse, she confirmed the resident checked [REDACTED] three times a day and took [REDACTED] based on [REDACTED] levels. The resident also administered his/her routine [REDACTED] in the evening. Staff I stated staff just confirmed the amount of [REDACTED] the resident took to ensure accuracy. She stated she addressed it on the comprehensive assessment but did not think to put it into the person-centered service plan.

During an interview with Staff A, administrator, and Staff L, Chief Executive Officer, they confirmed staff only updated the initial patient-centered service plan and had not included the comprehensive patient-centered service plan.

WAC 388-107-0350 Medication refusal.

(1) When a resident who is receiving medication administration services from the enhanced services facility chooses to not take his or her medications, the enhanced services 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;

(i) Conducts an evaluation; and

(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.

(2) The enhanced services facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the enhanced services facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The enhanced services facility documents such directions; and

(c) The enhanced facility is able to fully comply with such directions.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to conduct an evaluation, notify the physician of a pattern of medication refusals and/or have specific directions from the physician to address the refusals for 2 of 2 residents (Resident #4, 6). This placed residents at risk of health complications. Findings include:

1. Per record review, Resident #6 had diagnoses of [REDACTED]. Review of the resident's June 2017 medication administration record (MAR) noted the resident was prescribed two oral [REDACTED] medications daily, [REDACTED] routinely once a day and two medications daily for [REDACTED]. The staff documented on a daily basis that the resident refused both [REDACTED] medications, both oral [REDACTED] medications and [REDACTED]. During June 2017 the resident's [REDACTED] was elevated 6 out of 10 times s/he allowed it to be taken; [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] (normal was [REDACTED]), and the resident's [REDACTED] was elevated 5 out of 5 times s/he allowed staff to test it; [REDACTED], [REDACTED], [REDACTED], [REDACTED] (normal was [REDACTED]).

Per review of the progress notes from 4/01/17 to 6/27/17, there was no documentation that the licensed nurse conducted an evaluation of the resident related to the medication refusals and/or

the effects the refusals had on the resident. There was also no documentation the physician had been notified of the refusals in lieu of an evaluation.

Review of the resident's patient-centered service plan dated 6/18/16 and the ongoing comprehensive assessment dated 5/31/17, did not include directions for staff related to evaluation of the medication refusals and/or notifying the physician.

The resident declined an interview with department staff.

Staff I, licensed nurse, was interviewed on 6/29/17 and acknowledged the resident frequently refused [REDACTED] and [REDACTED] medications. She stated she did not really do an evaluation of the resident refusing [REDACTED] medications each time and was aware [REDACTED] and [REDACTED] ran high. Staff I stated she informed the physician when the physician made rounds about once a month, but did not notify the physician each time the resident refused. She stated there was no specific directions from the physician related to the refusals of medications; she just encouraged the resident to take them.

Staff J, licensed nurse, was interviewed on 7/10/17 and stated Resident #6 always refused [REDACTED] because [REDACTED] told her [REDACTED] did not think [REDACTED] was [REDACTED] and did not want to get addicted to [REDACTED]. She stated sometimes s/he will take the medications, but most of the time s/he won't. She stated the physician was aware of the refusals but she did not notify the physician every time the resident refused.

2. Per record review, Resident #4 had [REDACTED] and was prescribed a [REDACTED] medication three times a day. Review of the May 2017 and June 2017 medication administration record (MAR) noted the resident routinely refused the [REDACTED] medication.

Review of the progress notes for May 2017 and June 2017 did not contain documentation that an evaluation was conducted by qualified staff related to the resident's [REDACTED] and/or that the physician was notified of the refusals until 6/26/17 when the medication was discontinued.

Further review of the May and June 2017 MARs noted the resident routinely refused a [REDACTED] medication that was ordered to [REDACTED]. Review of the MARs noted the resident had an [REDACTED] ordered on an as needed basis and the [REDACTED] was administered on 5/29/17 and 6/18/17. The resident also had [REDACTED] ([REDACTED] - [REDACTED]) ordered on an as needed basis and this was given on 6/17/17.

Review of the progress notes dated 5/29/17 noted the resident requested the [REDACTED]. On 6/17/17, the progress note indicated the resident requested [REDACTED] and an [REDACTED] on 6/18/17 due to [REDACTED].

Review of the undated ongoing comprehensive assessment noted staff were to report any refusals of [REDACTED] and/or [REDACTED] checks and to follow up within 8 hours with the registered nurse, administrator, or doctor for refusals. It did not specify the resident refusing [REDACTED] or [REDACTED] medications.

Per review of the progress notes during May 2017 and June 2017, there was no documentation that an evaluation was conducted or that the physician was notified when the resident refused

his/her routine [REDACTED] order.

When interviewed on 6/28/17, Staff I, licensed nurse, stated she reviewed the medication refusals with the physician when the physician came to see the resident about once a month, but had not conducted an evaluation when the resident refused the [REDACTED] medications.

WAC 388-107-0360 Medication refusal Antipsychotics.

(1) When a resident who is being administered antipsychotic medication, chooses to not take his or her medications after two or three attempts, the enhanced services facility must:

(c) Notify the physician within eight hours of the refusal.

(d) Notify the DSHS case manager within twenty four hours of the refusal.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the physician within 8 hours of refusal of an [REDACTED] medication for 1 of 6 sample residents (#1). This failure placed the resident at risk for increased behaviors and signs/symptoms of withdrawal. Findings include:

Per the ongoing assessment dated June 2017, Resident #1 had a history of placement at a [REDACTED] and had been on a LRA (less restrictive alternative) placement at the facility since [REDACTED] of 2016. The resident had diagnoses including [REDACTED] and was identified as having intrusive and, at times, aggressive/assaultive behavior. The assessment directed staff to notify the physician within 8 hours of refusal of an [REDACTED] medication.

Review of the June 2017 medication administration record (MAR) showed the resident was prescribed [REDACTED] (an [REDACTED] medication used to treat [REDACTED]). The physician orders were for the resident to receive a total of 12 milligrams (mg) of [REDACTED] (a 3 mg and a 9 mg tablet) at bedtime. The MAR showed the resident refused both the 3 mg and 9 mg tablets on 6/2/17 and 6/3/17 and the 9 mg tablet on 6/4/17.

Per review of progress notes dated 6/2/17, the resident stated s/he was not taking anything that his/her [REDACTED] prescribed and planned to refuse the [REDACTED] "from now on". The resident voiced how angry s/he was about his/her medications and was noted to be [REDACTED] on this date.

The progress note for 6/3/17 documented the resident had many delusions and refused [REDACTED]. On 6/4/17 the resident was described as unsteady on [REDACTED] feet, incoherent, and [REDACTED]. The resident was sent out of the facility for a [REDACTED] evaluation and treatment on 6/5/17 secondary to breaking the LRA by refusing [REDACTED] medication. There was no documentation in the record to show the physician was notified within 8 hours of the resident refusing this medication as required.

In an interview on 6/30/17, Staff I confirmed there was no documentation to show the physician was notified within the time frame required.

WAC 388-107-0210 Care and services. The enhanced services facility must develop and implement a program to meet the needs of each resident and to ensure each resident receives:

- (2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status, and potential for improvement or decline;
- (4) The care and services in a manner and in an environment that:
 - (a) Actively supports, maintains or improves the resident's quality of life;
 - (b) Actively supports the resident's safety; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 1 of 6 sample residents (#2) received care and services that supported the resident's quality of life and safety related to ongoing verbally aggressive interactions with another resident (Resident #3) in the facility. The facility was aware of the behavior exhibited by Resident #3 and failed to take timely action to address this behavior which placed Resident #2 at risk for exposure to ongoing potentially abusive interactions. Findings include:

The behavioral support plan dated 5/17/17 for Resident #2 documented s/he had increased [REDACTED] when other residents were loud and disruptive. The plan contained the resident's statement that when [REDACTED] were loud, verbally abusive, or hit and slammed things, that symptoms of [REDACTED] were triggered within him/her.

The behavioral support plan dated 5/30/17 for Resident #3 documented s/he had aggressive/assaultive behaviors at times including gesturing as if s/he was going to hit someone. The resident sometimes yelled if someone got in [REDACTED] way and at times had [REDACTED] that could increase especially when watching certain television shows.

A progress note dated 6/14/17 documented that Resident #3 "continues" to have a difficult time with another resident watching a show that s/he did not like and made it impossible for the other resident to enjoy it. Resident #3 was noted to be [REDACTED] while the other resident was trying to watch the show.

A progress note dated 6/26/17 documented that Resident #3 and Resident #2 yelled and shouted at each other because Resident #3 did not like the television show s/he was watching.

In an interview on 6/27/17, Resident #2 stated that s/he had problems with Resident #3 at times. S/he reported that the night before (6/26/17) s/he was watching one of his/her favorite television shows in the day room when Resident #3 told her "I'm going to [REDACTED] if you watch that show". Resident #2 said that for some reason Resident #3 disliked the show and became really angry when it was on television. The resident stated staff were aware of the incident and it was not the first time Resident #3 had become agitated over the television show.

On 6/28/17 Resident #2 and Resident #3 were observed in the dining room eating lunch. Resident #3 started making comments to Resident #2 including: Telling Resident #2 s/he was "still in hot water", and that s/he was upset with resident #2 because s/he ran errands and didn't wait for the regular shopping day with the group. Staff A intervened and informed Resident #3 it was not his/her concern, but Resident #3 continued to make comments to Resident #2 about

how much s/he disliked the television shows that Resident #2 liked and that, "they never should have [REDACTED] [Resident #2]." By this time Resident #2 was upset and removed [REDACTED] self from the eating area.

Immediately following the above observation, Resident #2 told Staff B, one of the Mental Health Professionals (MHP) that s/he was tired of all the negativity and said "it's hard to live like that". Resident #2 said that was why s/he wanted to get away so bad, and that s/he never knew where Resident #3 was going to be and that s/he just "keeps on [REDACTED]". Resident #2 said s/he told Staff A, the administrator, that Resident #3 told him/her to "shut [his/her] mouth" and said "I'm going to [REDACTED]".

In an interview on 6/28/17, Staff M, a caregiver, said she worked the evening of 6/26/17 when the incident occurred between the two residents. Staff M stated she intervened when she overheard Resident #3 yelling at Resident #2 and redirected Resident #3 to his/her room. Staff M stated she did not speak directly with the administrator about the incident and identified Staff J, a registered nurse, as being the other staff member on shift that evening.

In an interview on 6/28/17, Staff A, the administrator stated she did not complete an incident report or call the altercation into the state hotline until this date (2 days after it occurred). Staff A also met with Resident #3 on 6/28/17 and completed a behavioral contract with the resident (an agreement in which the resident agrees to refrain from certain behaviors).

WAC 388-107-1580 Policies and procedures.

- (3) The facility must ensure that the policies and procedures include, at a minimum the following:
- (g) Suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement the policy/procedure on suspected abuse/neglect for an incident involving 2 of 6 sample residents (#2,3) related to verbal abuse. This failure resulted in a delayed reporting to the state hotline and completion of the incident report. Findings include:

Per the facility abuse policy/procedure dated February 2017, staff who observe or suspect any person of being physically, mentally or sexually abusive of a resident, is responsible for reporting the information to the facility administrator, the state hotline and the appropriate law enforcement agency. The policy/procedure states the report to the hotline is to take place immediately and be followed-up by an incident report.

The behavioral support plan dated 5/17/17 for Resident #2 documented s/he had increased [REDACTED] when other residents were loud and disruptive. The resident's symptoms of [REDACTED] were triggered when [REDACTED] were loud, verbally abusive, or hit and slam into things.

In an interview on 6/27/17, Resident #2 stated that s/he had problems with Resident #3 at times. S/he reported that the night before (6/26/17) [REDACTED] was watching a favorite television show in the day room when Resident #3 said, "I'm going to [REDACTED] if you watch that show".

The resident stated staff were aware of the incident and it was not the first time Resident #3 had become agitated over the television show.

Resident #2 said s/he talked with Staff A, the administrator, and told her that Resident #3 told him/her to "shut [his/her] mouth" and said "I'm going to [REDACTED]".

On 6/28/17 during the noon meal, Resident #3 was observed making upsetting comments to Resident #2 causing him/her to get up and leave the room.

In an interview on 6/28/17, Staff M, a caregiver, said she worked on the evening of 6/26/17 when the incident occurred between Resident #2 and Resident #3 in the day room. Staff M stated that she did not report the incident to the administrator or call it into the state hotline.

On 6/28/17 (two days after the incident), Staff A, the administrator completed an incident report and called the incident into the hotline. Resident #2 was faced with Resident #3's behaviors toward him/her for two days after the initial altercation occurred.

WAC 388-107-0290 Activities. The enhanced services facility must:

(1) Provide space and staff support necessary for:

- (a) Each resident, at any time, to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, choices, functional abilities, preferences, and individualized treatment plan; and
- (b) Group activities at least five times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure group activities were available for 6 of 6 residents (Resident #1, 2, 3, 4, 5, 6). This placed residents at risk for decreased quality of life and increased behaviors. Findings include:

Per review of the June 2017 activity calendar labeled "Upriver Place", the facility had scheduled a lake day and movie on 6/26/17, birthday lunch and crafts on 6/27/17, bingo on 6/28/17, resident choice activity on 6/29/17, and craft and movie on 6/30/17.

In an interview on 6/27/17, Resident #2 said there was nothing to do at the facility. The resident said s/he liked to go places and see things but, "we never do that". The resident said s/he was depressed and had no hope, "all I do is just exist day after day". The resident said s/he loved spending time with animals and shopping, but rarely got to do either. The resident also said the daily activities depended on whether staff followed through with it or not.

During an interview with Resident #1, #2, #3, and #5 on 6/28/17, the residents stated they did not have a lake day or movie on 6/26 and did not have a birthday lunch or crafts on 6/27/17. The residents stated the facility often cancelled or didn't hold the activities when they were scheduled.

Observations made on 6/27/17 confirmed the birthday lunch was not provided.

Per the activity calendar for 6/28/17, the 6:00 p.m. activity was listed as bingo. Observations

were made of residents and staff from 5:30 p.m. until 7:00 p.m. and no activity was offered. Residents wandered in and out of the television room and at one point Resident #5 became agitated and was swearing about all the [REDACTED] in the facility. Staff M was observed to enter the television room intermittently, but made no attempt to provide any diversional activities for the residents.

In an interview on 6/28/17, Staff M said she was not going to do bingo because 2 residents had an incident earlier in the day and were not supposed to be in the same room. There was no other activity offered in place of bingo. Staff M went on to say that it was sometimes difficult to find activities that interest the residents and that the caregivers were in charge of providing the activities.

When interviewed on 6/29/17, Staff F stated he tried to do movies sometimes in the evenings and verified it was the caregiver's responsibility to initiate activities. Staff F was not aware of any specific schedule for activities, but said he tried to do a movie night at least once a week but that it hadn't always happened.

The administrator was interviewed on 6/30/17 regarding the activity schedule and stated she thought that particular activity schedule was for the adjoining assisted living (ALF) facility, not Upriver Place. The administrator stated the residents from Upriver Place were not to mingle with residents from the ALF so the lake day and birthday lunch were activities scheduled for the ALF and not this facility. When it was pointed out to the administrator that the activity schedule had Upriver Place written on the top indicating it was for this facility, she stated she would have to talk to the activity director because the activities on the schedule did not happen.

WAC 388-107-1100 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the enhanced services facility premises:

(ii) The name, address and telephone number of:

(B) Appropriate resident advocacy groups; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to post advocacy group information used by or available to residents. This did not allow residents access to information about support groups needed to maintain their mental health issues. Findings include:

Observations of the facility noted a list of advocacy groups was not posted in the facility accessible by residents except the ombuds number.

Per review of residents' records noted residents had [REDACTED] issues and a history of [REDACTED]. All six residents were involved in [REDACTED] services in the community and had different peer groups/advocates they were involved in. The residents' records noted some of the residents wanted to get involved in [REDACTED] groups. Information related to the advocacy/support groups were not posted or available to residents.

When interviewed on 6/29/17, Staff A, administrator, Staff B, mental health professional, and

Staff I, licensed nurse, stated they never thought to post advocacy groups so residents would have access to them.

On 7/11/17, Staff L, CEO stated they did not think to post advocacy groups other than the ombuds.

WAC 388-107-0070 Comprehensive assessment. The enhanced services facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a comprehensive assessment. The assessment addresses the following, within fourteen days of the resident's move-in date:

- (2) Currently necessary and contraindicated medications and treatments for the individual, including any prescribed medications, over-the-counter medications, and antipsychotic medications.
- (4) Significant known challenging behaviors or symptoms of the individual causing concern or requiring special care, including:
 - (d) Individual's ability to leave the enhanced services facility unsupervised;
- (6) Individual's activities, typical daily routines, habits and service preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a comprehensive assessment for 6 of 6 sample residents (#1,2,3,4,5,6), related to prescribed medications, resident's ability to leave the facility unsupervised and daily routines, habits, and preferences for each resident. This failure placed residents at risk for unmet needs and a decrease in quality of care. Findings include:

1. Per the comprehensive assessment dated 8/2/16, Resident #1 had diagnoses including [REDACTED]. The assessment did not include any information related to the resident's current medications, both necessary and contraindicated (a condition/factor that serves as a reason to withhold a certain medical treatment). In addition the assessment did not have information on whether or not the resident was able to leave the facility without supervision and did not address the resident's daily routine, habits and/or preferences.
2. Per the comprehensive assessment dated 6/16/16, Resident #2 had diagnoses including [REDACTED]. The assessment did not include any information related to the resident's current medications, both necessary and contraindicated, whether the resident could leave the facility without supervision and did not address the resident's daily habits, routines, or preferences.
3. Per the comprehensive assessment dated 8/2/16, Resident #3 had diagnoses including [REDACTED] (a [REDACTED] condition that may include [REDACTED] and [REDACTED]). The assessment did not include any information related to the resident's current medications, both necessary and contraindicated. In addition the assessment did not have information on whether or not the resident was able to leave the facility without supervision and did not address the resident's daily routine, habits and/or preferences.
4. Per the undated comprehensive assessment, Resident #4 had diagnoses including [REDACTED] and [REDACTED]. The assessment did not include the current necessary medications, challenging

behaviors, and/or the resident's ability to leave the facility unsupervised.

5. Per the comprehensive assessment dated 5/16/17, Resident #5 had diagnoses of [REDACTED]

[REDACTED] and [REDACTED]. The assessment did not include the current necessary medications, challenging behaviors, and/or the resident's ability to leave the facility unsupervised.

6. Per the comprehensive assessment dated 5/31/17, Resident #6 had diagnoses including

[REDACTED] and [REDACTED]. The assessment did not include the current necessary medications, challenging behaviors, and/or the resident's ability to leave the facility unsupervised.

In an interview on 7/11/17, Staff A, the administrator was informed of the missing information on the comprehensive assessments. Staff A did not have any additional information to provide.

WAC 388-107-0080 Ongoing comprehensive assessments. The enhanced services facility must:

- (3) Review each resident's needs to evaluate discharge or transfer options when the resident:
- (b) Expresses the desire to move to a different type of community based setting;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to utilize the ongoing comprehensive assessment for 1 of 6 sample residents (#2) to review the resident's needs in order to evaluate discharge/transfer options. This failure placed the resident at risk for a decline in mood and sense of well-being. Findings include:

Per the ongoing comprehensive assessment most recently updated on 6/21/17, Resident #2 had diagnoses including [REDACTED]. The resident required assistance with some activities of daily living, management of medications, and assistance with coordination of appointments and transportation. The resident had short term memory problems and poor impulse control.

Review of progress notes from 4/1/17 to 6/28/17 revealed there was discussion regarding the resident's wish to move out of the facility. A progress note dated 4/17/17 documented the resident's desire to move to an assisted living and involvement in planning by the resident's case manager. Staff B, the licensed nurse, documented that the case manager developed strategies and steps to the resident moving out. Staff B also documented a discussion with the resident related to certain staff helping [REDACTED] with certain tasks toward achieving [REDACTED] goals.

A progress note dated 5/10/17 documented the resident toured an assisted living facility in the community and wanted to continue to look at other assisted living facilities for possible placement.

The ongoing comprehensive assessment dated 6/21/17 did not identify the resident's desire to

move to a different type of community based setting. There was no documentation outlining the specific goals that needed to be met in order for the resident to have a safe, appropriate discharge, and no approaches identified to meet those goals.

In an interview on 6/27/17, the resident stated s/he was [REDACTED] all the time and wanted to move somewhere else. The resident said s/he was looking at assisted living facilities in the community but was not sure if s/he would be able to move.

In an interview on 7/11/17, Staff A, the administrator, was informed there was no information on the ongoing assessment related to the resident's wish to discharge. Staff A did not have any more information to provide.

WAC 388-107-0110 Initial person-centered service plan. The enhanced services facility must develop the initial person-centered service plan prior to the resident's admission to the ESF, using information from the resident, the resident's representative if the resident has one, the comprehensive assessment reporting evaluation assessment for medicaid clients, and the preadmission assessment. The ESF must ensure that each resident has an initial person-centered service plan that describes:

- (5) What the facility will do to ensure the resident's health and safety related to the refusal of any care or service;
- (6) Resident defined goals and preferences;
- (7) How the facility will provide behavioral support to prevent a crisis and maintain placement in the facility while respecting the resident's rights;
- (8) What the facility will do to ensure resident and community safety when the resident is in the community;
- (9) Factors that prevent the resident from accessing less restrictive community based services; and
- (10) When and how the resident may transfer or transition from the enhanced services facility to a more independent living situation in the community.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure all of the components were included in the initial person centered service plan for 6 of 6 sample residents (#1,2,3,4,5,6). Failure to include these topics in the initial plan placed the residents at risk for unmet needs, decreased quality of life and repeat hospitalizations for stabilization. Findings include:

1. Per the initial person-centered service plan dated [REDACTED] 16, Resident #1 had diagnoses including dementia. The initial plan did not include information related to resident's goals, personal preferences or a plan if the resident refused any care or services. In addition the plan did not outline factors preventing the resident from accessing less restrictive community based services or when the resident could transfer from the facility to a more independent living situation.

Per a progress note dated 6/4/17 the resident was described as unsteady on [REDACTED] feet, [REDACTED] and [REDACTED]. The resident was sent out of the facility for [REDACTED] evaluation and treatment on [REDACTED] 17 secondary to breaking [REDACTED] LRA (less restrictive alternative) placement by refusing [REDACTED] medication. The resident did not return to the facility until [REDACTED] 17. As noted above there was no plan developed to deal with the resident if [REDACTED] refused [REDACTED] medications. The resident refused [REDACTED] medication for 3 days prior to being

2. Per the initial person-centered service plan dated [REDACTED] 16, Resident #2 had diagnoses including [REDACTED]. The initial plan did not include information related to the resident's goals while in the facility. There was no information related to when the resident could transfer from the facility to a more independent living situation or factors preventing the resident from accessing less restrictive community based services.

3. Per the initial person-centered service plan dated [REDACTED] 16, Resident #3 had diagnoses including [REDACTED]. The initial plan did not include information related to the resident's goals while in the facility. There was no information related to when the resident could transfer from the facility to a more independent living situation or factors preventing the resident from accessing less restrictive community based services.

4. Per the initial person-centered service plan dated [REDACTED]/16, Resident #4 had diagnoses including [REDACTED]. The plan did not include information on how to address refusal of medications and review of the resident's medication administration record noted the resident refused medications throughout May and June 2017. The initial person-centered service plan also did not contain goals/preferences, plan to provide behavioral support to prevent a crisis and maintain placement, ensure resident safety in the community, factors that prevent less restrictive placement, and transferability/transitioning into the community.

5. Per Resident #5's initial person-centered service plan dated [REDACTED] 16, there was no plan on how to address refusals of medications, goals/preferences, ensure resident/community safety when in the community, factors that prevent less restrictive placement, and transferability/transitioning into the community. The service plan also did not include a plan to provide behavioral support to prevent a crisis and maintain placement in the facility. Per the progress notes dated 4/26/17 the resident was [REDACTED] due to making threats towards [REDACTED] counselor and another resident. The resident was [REDACTED] transported to the hospital for evaluation, and transferred to a [REDACTED] where [REDACTED] remained until [REDACTED] 17; almost three weeks.

6. Per Resident #6's initial person-centered service plan dated [REDACTED] 16, there was no plan to address refusal of medications, goals/preferences, plan to provide behavioral support to prevent a crisis and maintain placement, ensure resident safety in the community, factors that prevent less restrictive placement, and transferability/transitioning into the community.

In an interview on 7/11/17, Staff A, the administrator, was informed of the missing information on initial person centered service plans and did not have any more information to provide.

WAC 388-107-0080 Ongoing comprehensive assessments. The enhanced services facility must:

(1) Complete a comprehensive assessment, addressing the elements set forth in WAC 388-107-0070 , upon a significant change in the resident's condition or at least every 180 days if there is no significant change in condition;

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews the facility failed to complete a [REDACTED] assessment for 1 of 6 residents (Resident #5) who was caught [REDACTED] in [REDACTED] room twice. This had the potential to put others at risk in the event of unsafe [REDACTED] in [REDACTED] room. Findings include:

The facility kept all the residents' [REDACTED] in the medication room and staff handed them out to the residents approximately every hour.

Throughout the inspection on 6/27-30/17, Resident #5 was observed to ask staff for [REDACTED] throughout the day. The resident would be given 1-2 [REDACTED] at designated [REDACTED] times. When the resident voiced increased anxiety and/or anger outside of the designated [REDACTED] times, [REDACTED] would occasionally get an extra 1-2 [REDACTED]. At no time did staff give or ask the resident to return [REDACTED] and/or [REDACTED].

Review of the resident's record noted a [REDACTED] assessment was completed on 11/10/16 and indicated the resident agreed to and was willing to participate in the [REDACTED] dispensing plan and have [REDACTED] and [REDACTED] locked up for safety.

Per review of progress notes dated 4/25/17, the resident was upset throughout the morning and early afternoon and was telling staff they were "worthless". The resident was given his last [REDACTED] about 3 p.m., returned to [REDACTED] room and [REDACTED] the [REDACTED] in [REDACTED] room. Staff confronted [REDACTED] and [REDACTED] stated [REDACTED] would quit [REDACTED] in [REDACTED] room.

Review of the investigation of the incident on 4/25/17 noted the resident came and got [REDACTED] last [REDACTED] for the day at 3:30 p.m. After the two nurses on duty walked out in the hall and smelled [REDACTED] knocked on Resident #5's door, and [REDACTED] admitted to [REDACTED] in [REDACTED] room.

On 5/27/17 a documented progress note indicated the resident was caught [REDACTED] in [REDACTED] room. At that time [REDACTED] and [REDACTED] were removed and staff had a discussion with [REDACTED] related to unsafe [REDACTED] behaviors and the danger that this presents to the facility and other residents.

Review of the resident's record did not show an updated [REDACTED] assessment had been completed for Resident #5 after two separate incidents of [REDACTED] in [REDACTED] room.

When interviewed on 6/28/17, Resident #5 stated [REDACTED] usually had a [REDACTED] or [REDACTED] in [REDACTED] room. [REDACTED] confirmed staff gave [REDACTED] but did not ask for [REDACTED] back after [REDACTED]

WAC 388-107-0120 Initial comprehensive person-centered service plan.

(4) The enhanced services facility must ensure the person-centered service planning team includes the following in each resident's initial comprehensive person-centered service plan:
(m) A plan that maximizes the opportunities for independence, maintaining health and safety, recovery, employment, the resident's participation in treatment decisions, collaboration with peer-supported services, and care and treatment provided in the least restrictive manner appropriate for the resident and consistent with any relevant court orders with which the resident must comply;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to include in the patient-centered service plan the least restrictive alternative (LRA) stipulated in the court order for 4 of 6 residents (Resident #1, 4, 5, 6). This had the potential for residents to not receive necessary care/services to ensure they comply with the LRA. Findings include:

1. Per record review, Resident #1 was admitted to the facility on an LRA (least restrictive alternative) that described specific things the resident could/could not do and maintain housing in the community. The patient-centered service plan dated [REDACTED] 16 did not include the content of the LRA as required.

2. Per record review, Resident #4 was admitted to the facility on an LRA (least restrictive alternative) that described specific things the resident could/could not do and maintain housing in the community. Review of the ongoing comprehensive assessment dated 6/14/17 noted the resident was on an LRA. Review of the patient-centered service plan dated [REDACTED] 16 did not include the resident was on an LRA or the specific details of the LRA.

3. Per record review, Resident #5 was admitted to the facility on an LRA (least restrictive alternative) that described specific things the resident could/could not do to maintain housing in the community. Review of the ongoing comprehensive assessment dated 5/16/17 noted the resident was on an LRA. Review of the patient-centered service plan dated [REDACTED] 16 did not include the resident was on an LRA or the specific details of the LRA.

4. Per record review, Resident #6 was admitted to the facility on an LRA (least restrictive alternative) that described specific things the resident could/could not do to maintain housing in the community. Review of the ongoing comprehensive assessment dated 5/31/17 noted the resident was on an LRA. Review of the patient-centered service plan dated [REDACTED] 16 did not include the resident was on an LRA or the specific details of the LRA.

Per interview with Staff A, administrator, Staff I, licensed nurse, and Staff L, Chief Executive Officer, they acknowledged the LRA specifications were not included in the patient-centered service plan. Staff I stated she indicated on the ongoing comprehensive assessments if the resident was on the LRA but did not include specifics of the LRA in the assessment.

WAC 388-107-0390 Use of routine psychopharmacologic medications. When the resident is using a psychopharmacologic medication on a routine basis, the facility must ensure that:

(5) The resident's record includes documentation that the resident, guardian, or legal representative, if any, was informed of the need for the psychopharmacologic medication; and

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure 6 of 6 residents (Resident #1, 2, 3, 4, 5, 6) and/or resident representatives consented to the use of routine [REDACTED] medications. This had the potential to infringe on residents' rights. Findings include:

Per review of Resident #1, #2, #3, #4, #5, and #6 comprehensive assessments noted all the residents had a [REDACTED] diagnosis and per the medication records were prescribed routine [REDACTED] medications. Review of the residents' medical records noted they did not contain a signed consent by the resident and/or resident representative for the use of routine

██████████ medications.

During an interview with Staff A, administrator, and Staff I, licensed nurse, they indicated the ██████████ agency had the residents sign a consent for use of ██████████ medications but the facility did not have one.

WAC 388-107-0430 Food services. The enhanced services facility must provide or contract out food services for residents. If the facility chooses to contract out the food service, the contracted services must meet all of the applicable food codes and requirements.

(1) The enhanced services facility must:

(f) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC regarding food service;

(i) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value; however the enhanced services facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide food in compliance with chapter 246-215 WAC, Food service; related to adequately cooking ground beef to ensure all parts reached the required temperature of 155 degrees Fahrenheit (F) and to ensure that, once cooked, the meat was held at a temperature of 135 degrees F. This placed 6 of 6 current residents at risk for food borne illness. Findings include:

Cooking:

Observation of the lunch meal was conducted on 6/27/2017. The main entree for the meal was chili burgers. The burgers were placed in a heated metal container for hot holding after they were cooked. Per review of the temperature log, staff recorded the burgers were cooked to 165 degrees F.

At 12:20 p.m., staff started serving lunch to the residents. At 12:25 p.m. Resident #2 returned ██████████ burger to the kitchen staff because s/he said it was raw in the middle. At this time Staff K, the dietary manager, was asked to take the temperature of the burger. The temperature of Resident #2's burger read 100 degrees F and was observed to be red and uncooked in the middle. Two more temperature checks were done at this time of burgers still in the warmer, and they registered at 108 degrees and 123 degrees F.

In an interview on 6/27/17, Staff E said she was in charge of cooking the burgers that day and said some of them must have gotten cooked more than others. Staff E said she did not take the temperature of all of the burgers, just some of them. At this time the kitchen stopped serving the burgers and Staff E started re-cooking the meat to ensure it reached the required 155 degrees F to prevent food borne illness.

At 1:00 p.m. on 6/27/17, temperatures of the burgers were taken and were at 165 degrees or above. Staff K confirmed the meat should have been cooked to at least 155 degrees F and held at 135 degrees.

Meal alternatives:

On 6/27/17 the monthly menu for the facility was observed posted in the dining room area. The alternate for each lunch and dinner meal read "cook's choice". In an interview on 6/27/17, Staff K, the dietary manager, said the alternate was usually a sandwich or left overs from the day before, it just depended on the day. Staff K did not have a system in place to ensure residents at the facility were informed of the alternates.

In an interview on 6/27/17, Resident #2 said s/he and other residents bought some of their own meals from the store because they didn't always like the food the facility served. The resident also said staff did not let the residents know what the daily alternate was for the lunch and dinner meals.

WAC 388-107-0400 Use of as needed psychopharmacologic medications. If the physician has ordered an as-needed psychopharmacologic medication for a resident, the facility must ensure that:

(2) The resident's person-centered service plan includes behavioral intervention strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to use non-pharmacological interventions for 1 of 6 resident (Resident #5) prior to administering a [REDACTED] medication and non-pharmacological interventions were not addressed in the patient-centered service plan. This placed the resident at risk for [REDACTED]. Findings include:

Per review of the resident #5's comprehensive assessment dated 5/23/17, the resident had diagnoses including [REDACTED]. Review of the resident's behavioral support plan dated 5/23/17 noted the resident had behaviors including agitation, aggression, and [REDACTED].

Review of the June 2017 medication administration record noted the resident was prescribed [REDACTED] 50 mg every six hours as needed for [REDACTED] and [REDACTED] 5 mg twice a day as needed for [REDACTED].

Resident #5 was observed on 6/27/17, 6/28/17, and 6/29/17 walking throughout the facility independently. The resident was talking to department staff, facility staff, and other residents appropriately. On two occasions the resident went to the nurses station and asked for a "prn" (as needed medication). The nurse asked the resident if s/he wanted one or both. The resident requested both and was given both. The resident took the medications and walked away. The nurse did not question the resident as to why s/he was requesting the medication and did not attempt to do any non-pharmacological interventions before giving the medications. The nurse gave both medications at once verses giving one medication and waiting to see if it alleviated the symptoms before giving the second medication.

When interviewed on 6/28/17, the resident stated s/he takes two "prn" medications; [REDACTED] and [REDACTED]. The resident stated when s/he gets [REDACTED] s/he takes them. The resident could not

explain how s/he felt [REDACTED] and stated s/he just asked for both of the medications together and got them. S/he stated s/he never tried to take one at a time. The resident stated s/he sometimes went for walks or listened to music and that helped him/her, but staff did not suggest these alternatives.

Review of the May and June 2017 medication administration record (MAR) noted the resident was given the two [REDACTED] medications at the same time 1-2 times a day. The MAR did not indicate if other interventions were attempted prior to the medication being given.

Review of the patient-centered service plan dated 6/16/16 did not address [REDACTED] and/or have interventions to use when the resident exhibited [REDACTED] in lieu of [REDACTED] medications.

Review of the progress notes for May and June 2017 did not contain documentation to support alternative means were used prior to the [REDACTED] medication being given.

The licensed nurse, Staff I was interviewed on 6/29/17 and stated she did not try other interventions prior to the administration of the [REDACTED] medications to the resident. Staff I said the resident asked for them so she gave them.

WAC 388-107-1230 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012, and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

(3) The enhanced services facility may accept a copy of the national fingerprint background check results letter and any additional information from the department's background check central unit from an individual who previously completed a national fingerprint check through the department's background check central unit, provided the national fingerprint background check was completed after January 7, 2012.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow department procedures to obtain the national fingerprint background checks for 2 of 8 staff members reviewed (E, H). The facility also failed to obtain the findings for 2 of 8 staff members (E,H) when sources were identified as the national fingerprint background check and showed convictions and/or negative actions. Findings include:

1. Staff E was hired on 5/11/16 as a caregiver and activity person. Staff E's duties allowed her unsupervised access to residents in the facility. Date of birth background check results on 10/7/16 showed Staff E had convictions and/or negative actions that were not automatically disqualifying. One source of the convictions and/or negative actions was identified as the national fingerprint background check. The results did not include details or specifics for the crimes and/or negative actions that showed on Staff E's fingerprint check. The facility did not obtain the actual fingerprint background check that was completed or ensure the staff member completed a new fingerprint background check as required.

2. Staff H was hired on 11/14/16 as a caregiver. Date of birth background check results on 2/24/17 showed Staff H had convictions and/or negative actions that were not automatically disqualifying. One source of the convictions and/or negative actions was identified as the

national fingerprint background check. The results did not include details or specifics for the crimes and/or negative actions that showed on Staff H's fingerprint check. The facility did not obtain the actual fingerprint background check that was completed or ensure the staff member completed a new fingerprint background check as required.

On 7/11/17, Staff A, the administrator, and Staff L, the CEO, confirmed the fingerprint background checks were not in the employee files as required and there was no documentation to show the facility had taken the additional steps to obtain the detailed findings from the fingerprint background checks for Staff E or Staff H.

WAC 388-107-0330 Pharmacy services.

(4) The enhanced services facility must ensure:

(a) Education and training for enhanced services facility staff by the licensed pharmacist on medication-related subjects including, but not limited to:

(i) Recognized and accepted standards of pharmacy practice and applicable pharmacy laws and rules;

(ii) Appropriate monitoring of residents to determine desired effect and undesirable side effects of medication regimens; and

(iii) Use of psychotropic medications.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to train 7 of 8 staff (Staff A, B, C, D, E, F, H) on medication-related subjects by the pharmacist. This placed residents at risk for unmet care needs. Findings include:

Per review of staff records on 6/30/17 and 7/10/17, Staff A, B, C, D, E, F, and H did not have documentation of training by the pharmacist on medication-related subjects.

Per interview with the Administrator, Staff A, she stated the facility policy was to have the pharmacist train staff quarterly. The administrator reviewed the pharmacy notebook and found one in-service sheet of a training that occurred on 3/14/17 and only one of the eight sample staff had the training. No further trainings had been completed since the facility opened in 6/09/16.

Per interview with Staff L, CEO, she confirmed the trainings are quarterly but had no explanation as to why they had not been done quarterly.

WAC 388-107-0460 Tuberculosis Testing Required. The enhanced services facility must:

(1) Develop and implement a system to ensure staff have TB testing upon employment or starting service; and

(2) Ensure that staff have an annual risk assessment completed using the Washington state department of health approved criteria.

This requirement was not met as evidenced by:

The facility failed to ensure 3 of 8 staff (Staff B, D, G) were screened for Tuberculosis (TB) upon hire and annually. This placed all 6 residents at risk of exposure to a communicable disease. Findings include:

Staff records were reviewed on 6/30/17 and 7/10/17.

Per record review, Staff B was hired on 4/10/17. The staff record did not include a documented TB screening completed per the requirements.

Per record review, Staff D was hired on 2/10/17. The staff record noted she had a one step TB test on 2/10/17 but the second step was not given until 3/16/17; more than three weeks apart. Further record review noted the staff person had a 2-step on 6/08/17 and 6/25/17, however it was not completed within 3 days of hire.

Staff G was hired on 11/1/16 as a caregiver and had a history of a negative result from a previous two-step TB test, however there was no record of a one step TB test being completed on hire as required.

Staff A, administrator, was interviewed on 7/11/17 and acknowledged Staff B and Staff D had not had TB testing completed per the requirements. Staff A and Staff L, CEO, were asked to fax any documentation pertaining to TB testing of either staff person to the department. As of 7/18/17 no documentation had been sent.

WAC 388-107-0640 Staff development trainings.

(2) The enhanced services facility must:

(b) Ensure all employees receive appropriate in-service and continuing education to maintain a level of knowledge appropriate to, and demonstrated competence in, the performance of ongoing job duties consistent with the principle of assisting the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. To this end, the enhanced services facility must:

(iii) Ensure that each employee is trained on deescalating challenging behaviors, including the use of a manual technique intended to interrupt or stop a behavior from occurring.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 9 staff (Staff D) completed de-escalation training prior to having routine interaction with the residents. This placed the residents at risk for unmet care needs in the event of a crisis. Findings include:

Review of Staff D's record noted she was hired on 2/10/17 as a caregiver. The caregiver did not have de-escalation training (therapeutic options) until 16 days later on 2/26/17.

Staff A, the administrator, was interviewed on 7/11/17 and stated it was facility policy for staff to have the therapeutic options training in the orientation class which was done the first couple days of hire. She did not have an explanation as to why the training for Staff D was not done within that time frame.

Staff L, Chief Executive Officer, was interviewed on 7/11/17 and confirmed the therapeutic options training was supposed to be completed during the new facility orientation within the first few days of hire. She had no explanation why Staff D did not have the training until 16 days later.

WAC 388-107-0070 Comprehensive assessment. The enhanced services facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a comprehensive assessment. The assessment addresses the following, within fourteen days of the resident's move-in date:

- (4) Significant known challenging behaviors or symptoms of the individual causing concern or requiring special care, including:
- (f) 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 outdoors in a specific location on the premises.

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to complete a [REDACTED] assessment for 1 of 5 residents (Resident #4) that [REDACTED]. This placed the resident at risk for unmet care needs related to unsafe [REDACTED]. Findings include:

Resident #4 was observed on 6/27/17 at 2:15 p.m. and 6/29/17 at 4:25 [REDACTED] in the designated [REDACTED] area.

Review of the resident's record contained a [REDACTED] safety assessment that was signed by the resident and the administrator on 6/22/17. The form was blank and not filled out.

During an interview with Staff A, administrator and Staff L, CEO, they stated the [REDACTED] assessments were supposed to be completed on admit.

WAC 388-107-0610 Reporting fires and incidents. The enhanced services facility must immediately report to the department:

- (3) Any unusual incident that requires implementation of the enhanced services facility's disaster plan, including any evacuation of all or part of the residents to another area of the enhanced services facility or to another address; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the department on two occasions when the facility had to be evacuated due to a fire alarm. Findings include:

Review of progress notes for Resident #6 dated 4/01/17 and 6/07/17 noted the facility had a fire alarm that required the residents be evacuated from the building.

During an interview with Staff I on 7/11/17, she confirmed one time the fire alarm when off because a resident burned popcorn in the microwave and all residents had to be evacuated. She stated the staff fill out an incident report and let maintenance know about the incident, and initiated a fire watch if needed. Staff I was unaware the department was to be notified of the incident.

Review of the Complaint Resolution Unit reports noted the facility did not report either incident when the facility's disaster plan was initiated and the building had to be evacuated.

WAC 388-107-0400 Use of as needed psychopharmacologic medications. If the physician has ordered an as-needed psychopharmacologic medication for a resident, the facility must ensure that:

(5) The resident, guardian, or legal representative has given informed consent for the medication; and

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure 6 of 6 residents (Resident #1, 2, 3, 4, 5, 6) and/or resident representatives consented to the use of as needed [REDACTED] medications. This had the potential to infringe on residents' rights.

Findings include:

Per review of Resident #1, #2, #3, #4, #5, and #6 comprehensive assessments noted all the residents had a [REDACTED] diagnosis and per the medication records were prescribed as needed [REDACTED] medications. Review of the residents' medical records noted they did not contain a signed consent by the resident and/or resident representative for the use of as needed [REDACTED] medications.

During an interview with Staff A, administrator, and Staff I, licensed nurse, they indicated the [REDACTED] agency had the residents sign a consent for use of [REDACTED] medications but the facility did not have one.

Plan of Correction- Annual Survey 2017

Enhanced Services Facility - Upriver Place

WAC 388-107-0160 Behavioral support plan.

Behavioral Support Plans to be updated to contain more detail regarding staff response to behavior. Person-centered Service Plan to also be updated to include more detailed information based on client's identified needs and requested interventions. Statement to be added to all behavioral support plans "Residents may not be secluded or isolated as part of a behavioral support plan". Steps will be added for staff response if interventions are not effective and staff will be provided training and review all updated behavioral support plans.

WAC 388-107-0130 Ongoing comprehensive person-centered service plan. – Correction implemented.

When a change of condition occurs, an addendum will be added to the ongoing comprehensive person-centered service plan. They will also be updated at least every 180 days.

WAC 388-107-0120 Initial comprehensive person-centered service plan.

1. Resident has a [REDACTED] accessible to him/her on the unit. Common areas are kept free of tripping/fall hazards. Nurse call lights are available in numerous places throughout the facility including the resident's room. This information to be added to Initial comprehensive person-centered service plans as an addendum. It will also be included in future service plans.
2. Initial comprehensive person-centered service plans to include details regarding [REDACTED] testing and [REDACTED] injections such as how often each activity occurs and who does what activity.
3. Initial Person-Centered Service Plans will be completed within 14 days of admission, to include a list of CARE and services to be provided, who will provide the service, when and how the services will be provided according to the resident's preferences and incorporating the information provided in the HCS CARE Assessment and ESH Records.
4. Person-centered service plans to include details of LRA.

WAC 388-107-0350 Medication refusal. – Correction implemented.

When a resident refuses a medication provided by a medical provider the RN/LPN will conduct an assessment to determine if the client is at risk for adverse effects of the refusal. If so, they will notify the medical provider right away to request further instruction. If there is no imminent or immediate risk the RN/LPN will monitor for a pattern of refusals and then inform the medical provider. Any instruction received from the provider will be documented and follow accordingly. Resident BSP and PSCP will be updated related to a pattern of medication refusals and how to encourage residents to follow their caregiver instructions and communicate about the reasons for their refusals with their prescribers.

WAC 388-107-0360 Medication refusal. Antipsychotics. – Correction implemented.

When a resident refuses a medication provided by a [REDACTED] provider the RN/LPN will attempt to offer the medication two to three times. If the resident continues to refuse, the RN/LPN notify the [REDACTED] provider within eight hours of the refusal. Any instruction received from the provider will be documented and follow accordingly. The DSHS case manager will be notified within twenty-four hours of the refusal. Resident BSP and PSCP will be updated related to a pattern of medication refusals and how to encourage residents to follow their caregiver instructions and communicate about the reasons for their refusals with their prescribers.

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WAC 388-107-0210 Care and services. – Correction implemented.

Staff to ensure that residents are receiving the necessary care and services for residents to have a satisfactory quality of life and that their health and safety needs are met. When there is a safety concern an investigation will be conducted in a timely manner. If during the investigation it is determined that there is abuse, neglect, or exploitation, the administrator will submit an online incident report to Residential Care Services or call it into their hotline.

WAC 388-107-1580 Policies and procedures. – Correction implemented.

When there is a safety concern an investigation will be conducted in a timely manner. If during the investigation it is determined that there is abuse, neglect, or exploitation, the administrator (or their designee to adhere to mandatory reporting timeframes) will submit an online incident report to Residential Care Services or call it into their hotline. Upriver Place policy was updated to include clear reporting standards for suspected abandonment, exploitation, abuse, neglect, or financial exploitation and staff were trained to this policy and procedure.

WAC 388-107-0290 Activities. – Correction implemented.

Upriver Place has now assumed sole responsibility for activities rather than contracting with the activity staff from the adjoining ALF to ensure consistent follow through with activities. Now, the MHP facilities (or other designated Upriver Staff) or coordinates at least five activities per week. Residents will be given regular opportunities to give feedback and suggestions into the specific activities that they would like to participate in.

WAC 288-107-1100 Licensure's Responsibilities. – Corrected by 9/1/17.

Facility to post groups that will support client's quality of life such as advocacy groups or support groups. National Alliance for Mental Illness (NAMI), First Call for Help, and Ombudsman information is posted in common areas of the facility. Administrator to post Alcoholics Anonymous (AA) group information. However, during the Exit Interview surveyors reported they would research this regulation as the definition of an advocacy group was not clearly defined. The facility already had posted information for the Ombudsman.

WAC 388-107-0070 Comprehensive assessment.

Upriver Place has now implemented new documents that include information regarding medications including contraindicated medications, daily routine, habits, or preferences for the resident, and their ability to leave the facility unsupervised. The initial documents provided to the facility by DSHS did not include this information but have been updated in subsequent forms. Facility to ensure required documentation is contacted in all resident Comprehensive Assessments.

WAC 388-107-0080 Ongoing comprehensive assessment.

Upriver Place to include information regarding the resident's desire to move out of the facility in the ongoing comprehensive assessment. Collaborative efforts with HCS Case Worker and Resident to seek alternative placements will be included in Monthly case staffing notes or in client record when attempts at locating appropriate housing that are willing to accept the resident, and that the Guardian or Court (LRA) deems to be an acceptable and appropriate setting. Information about safe smoking assessments will be included in the On-going Comprehensive Assessment for each resident.

WAC 388-107-0120 Initial person-centered service plan.

Upriver Place to update service plans when there is a change of condition or every 180 days if there is not a change of condition. In the initial person-centered service plan, it will include information about the resident identified goals, preferences, how to support them in a crisis, maintain placement, respect their rights, what their plan for transition from the facility is, and what is preventing them from accessing less restrictive community based services. Information about residents LRA and how to support their compliance with their LRA will be included in each resident's initial PCSP.

WAC 388-107-0390 Use of routine psychopharmacologic medications. – Corrected by 9/1/17.

Upriver Place to obtain a copy of the signed consent for medications used by their outpatient [REDACTED] provider. This will be placed in their Upriver records.

WAC 388-107-0430 Food services. – Correction implemented.

Upriver staff to ensure food is cooked to appropriate temperature every time by temping the food when it arrives from the contracted provider and returning it to be corrected to an appropriate temperature or re-issued if the meal needs to be wasted. Alternative meal choices for lunch and dinner will be posted daily and will be of comparable nutritional value to the meal offered. Upriver Place will also provide daily snack options to residents incorporating their choices and preferences which has been on-going with a special weekly Walmart order to accommodate preferences of Upriver Place Residents.

WAC 388-107-0400 Use of as needed psychopharmacologic medications. – Correction implemented.

Upriver staff including RN/LPN and MHP(s) to utilize behavioral interventions in lieu of PRN offer the resident alternative, inquire about the need for the medication, discuss symptom management skills employed. Staff to discuss the concern(s) for which they are requesting PRN(s) with the resident. If behavioral interventions cease to be successful or the resident insists on having a PRN rather than utilizing symptom specific coping skills PRN(s) will be utilized as directed by the provider.

WAC 388-107-1230 Background Checks. – Correction implemented.

When there is a source(s) identified on the national fingerprint background check the facility will ensure that the findings are obtained by the employee through the BBCU or alternative source and that those records remain in the employee file. For the staff identified a Character Competency and Suitability screening will be completed.

WAC 388-107-0330 Pharmacy services. – Corrected 7/13/17.

Upriver Place will ensure that all staff receive education and training regarding medication-related subjects by a licensed pharmacist according the facilities internal policy and that this information is documented in the employee file or electronic training system (LMS).

WAC 388-107-0460 Tuberculosis Testing Required. – Correction implemented.

Upriver staff will be required to have TB testing upon employment or starting service according to WAC and the 2 step process will be monitored. Any staff that do not complete a required 2 step will be removed from the schedule until proper TB Testing is completed. Annual risk assessment will be completed using the WA DOH approved criteria.

WAC 388-107-0640 Staff development trainings.

All staff of Upriver will be required to complete Therapeutic Options de-escalation training or other approved DSHS de-escalation training prior to starting services at the facility.

WAC 388-107-0070 Comprehensive assessment. – Correction implemented.

A [REDACTED] safety assessment is completed prior to admission and when there is a change of condition(s). The citation of resident #4 not having a complete [REDACTED] safety assessment on file was not mentioned during Exit Interview. Review of resident #4's record does in fact contain a completed [REDACTED] safety assessment dated 11/14/16. However, this was after the date of the admission. Please see attached.

WAC 388-107-0610 Reporting fires and incident. – Correction implemented.

Upriver Place will notify DSHS when there is an implementation of a disaster plan such as a fire alarm evacuation. During one of the reported evacuations a DSHS staff, Sandy Spiegelberg, was present and aware of the situation.