STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Caring Places Management, LLC
HERITAGE HOUSE MORTON
PO BOX 1329
Morton, WA 98356

RE: HERITAGE HOUSE MORTON License # 2010

Dear Administrator:

This letter addresses Compliance Determination(s) 26588 (Completion Date 07/18/2023) and 22234 (Completion Date 05/01/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/18/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2110

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: HERITAGE HOUSE MORTON
License/Cert.#: 2010
Compliance Determination #: 22234
Investigator: Anissa Bearden
Provider Type: Assisted Living Facility
Intake ID: 79290
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 04/19/2023 through 05/01/2023
Complainant Contact Date(s):

Allegation(s):

1) facility didn't assess the resident before she came back to the facility and she returned to the hospital less than 24 hours later.

Investigation Methods:

Sample:	Total residents: 28 Resident sample size: 1 Closed records sample size: 2
Observations:	Residents Activities Resident care equipment Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Nursing staff Administrative staff Residents Family members
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:

1) after interview and record review the facility failed to assess and involve the resident in the assessment during a hospital stay prior to the resident returning from the facility. The failure resulted the resident to return to the hospital less than 24 hours with the same acute condition.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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

The department completed data collection for an unannounced on-site complaint investigation on 04/19/2023 and 04/28/2023 of:

HERITAGE HOUSE MORTON
860 W Main
Morton, WA 98356

This document references the following complaint number(s): 73418, 78742, 79290

The following sample was selected for review during the unannounced on-site visit: 1 of 28 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Anissa Bearden, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Cory Cisneros
Residential Care Services

05/11/2023
Date

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

Tammi Elsswick
Administrator (or Representative)

5/24/2023
Date

WAC 388-78A-2110 Resident participation in assessments. The assisted living facility must directly involve each resident or prospective resident, to the extent possible, along with any appropriate resident representative to the extent he or she is willing and capable, in the preadmission assessment and on-going assessment process.

Tammi Elsswick by 6/30/2023

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to include the resident in the assessment process following a change in condition and hospitalization for 1 of 2 residents (Resident 1) reviewed. This failure contributed to the rehospitalization of Resident 1 and placed the resident at risk of unmet care needs and diminished quality of life.

Findings included...

Record review of the facility's document titled, "Service Agreement Policy", undated, showed the facility was to develop a Service Agreement for each resident as necessitated by a noted change of condition. Agreements were to be based on evaluated needs of the resident and were to be developed with the input and involvement of the resident, family, and case manager, and others as appropriate.

Record review of Resident 1's (R1) face sheet showed that R1 moved into the facility on [redacted]/2018 with multiple medical diagnoses including [redacted], and [redacted].

Record review of R1's Service Agreement, dated 12/20/2022, showed R1 was able to follow instructions and able to communicate well to others. R1 required delegation services for their blood sugar checks and administration of their insulin injections. R1's blood sugar were hard to regulate at times. R1 had a history of having low blood sugars at night. R1's doctor was to be notified with any changes. The Registered Nurse (RN) delegator was to be notified of any changes in insulin or health status. R1 was noncompliant at following a diabetic diet. R1 needed assistance as needed for transfers from staff when they were feeling weak or dizzy. R1 walked with a seated walker independently.

Record review of the hospital document titled, "Inpatient Occupation Therapy initial evaluation", dated [redacted]/2023, showed R1 was admitted to the hospital on [redacted]/2023

with diabetic Ketoacidosis (a condition when the body doesn't have enough insulin in the body to allow blood sugar in your cells). The occupation therapist documented that R1 needed one person assist with transfers and ambulation needs. R1 stated that they felt they were at their functional baseline. R1 would benefit from continued therapy services.

Record review of the hospital document titled, "Physical Therapy inpatient treatment note", dated [redacted]/2023, showed R1 required one person assist for safe bed mobility and transfers. R1 would benefit from continued therapy services to improve functional mobility.

Record review of the hospital document titled, "Inpatient Hospitalist Progress Note", dated [redacted]/2023, showed R1 continued to stay at the hospital for close monitoring of their blood sugars. R1's blood pressure had a reading of 152/47 (normal blood pressure reading measures 120/80).

Record review of an email from Collateral Contact 1, Registered Nurse (RN) Delegator, dated [redacted]/2023 at 6:36 PM, showed R1's blood sugars were reviewed and as of [redacted]/2023 at lunch time R1 was on a new insulin protocol for 48 hours. CC1 stated that they had no reason not to delegate if R1's blood sugars were stable. CC1 stated that the discharge planner was contacting R1's son for transportation back to the facility but didn't get any information regarding the situation.

Record review of the fax cover sheet from the hospital sent to CC1, dated [redacted]/2023, showed the discharge planner sent clinical notes and therapy notes for R1 with a pending discharge dated [redacted]/2023.

Record review of the hospital document titled, scheduled meds (medication) sorted by name, dated [redacted]/2023, showed R1 had a current order to receive long-acting insulin five units every night and short acting insulin as needed four times daily.

Record review of the facility's progress note, dated [redacted]/2023, showed R1 returned to the facility between 4 PM and 5 PM.

Record review of the facility's progress note, dated [redacted]/2023, written by Staff C, Medication Aide, showed R1's blood pressure was 131/37. R1 had long-acting insulin medication dosage change to administer eight units every night with short acting insulin as needed.

In an interview on 04/19/2023 at 1:25 PM, Staff A, Administrator, stated that there wasn't a nurse that had gone and assessed R1 when they were in the hospital for eight days. Staff A stated that the hospital informed the facility that R1 was at their baseline function (prior level of activity). Staff A stated that when R1 arrived at the facility with their son, R1 was unable to stand. They required two caregivers to assist them into the wheelchair. Staff A stated R1 had a difficult time holding their head up. They stated R1 was not at their prior

level of activity when they arrived from the hospital.

In an interview on 04/19/2023 at 2:20 PM, Staff B, Licensed Practical Nurse/Resident Care Coordinator, stated that they did not assess R1 before they returned to the facility. They stated that hospital reported to them that R1 was able to transfer and walk by herself as they were prior to them becoming sick.

In an interview on 04/19/2023 at 3:21 PM, CC1, RN delegator, stated that they did not complete an assessment on R1 prior to them returning to the facility. CC1 stated that they discussed R1's blood sugars with the discharge planner. CC1 stated that they reviewed the hospital records on [redacted]/2023 only for R1's blood sugars. CC1 stated that they were unaware of the resident's abnormal reading of blood pressure that were recorded at the hospital and when they had returned to the facility. CC1 stated that the facility hadn't notified her of the change in blood pressure, or the change in mobility, but had called to notified them that R1 refused to have their insulin administered. CC1 stated that they didn't document any of their conversations with the hospitals discharge planner about R1's blood sugars needing to be stable prior to returning to the facility.

In an interview on 04/28/2023 at 11:10 AM, Staff B, stated that they typically review the hospital notes, when a resident was ready to return back to the facility from a hospital stay. They stated that they don't talk or involve the resident until after they have returned to the facility.

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, HERITAGE HOUSE MORTON is or will be in compliance with this law and / or regulation on (Date) 6/30/2023 .

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

Tammi Elswick — Administrator (or Representative)

5/24/2023 — Date

Plan of Corrections 5/24/2023

WAC 388-78A-2110- Resident participation in assessment.

Heritage House Morton will work diligently to follow all guidelines and rules listed in the above WAC. Going forward we will strive to continue to provide the highest quality of care, being sure to always include residents in decisions regarding health and ongoing care assessments and placements. We will work as a team to be sure we are not missing vital information or needs using checks and balances, and documentation. Sherry Balderama, RN Oversight, [redacted] RCC/LPN, and Tammi Elswick, Administrator.