STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

SEA MAR COMMUNITY HEALTH CENTERS
THE CANNON HOUSE
113 23rd AVENUE SOUTH
SEATTLE, WA 98144

RE: THE CANNON HOUSE License # 2056

Dear Administrator:

This letter addresses Compliance Determination(s) 42312 (Completion Date 06/07/2024) and 38703 (Completion Date 04/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/07/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-2, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210, WAC 388-78A-2600-2, WAC 388-78A-2600-2-f

The Department staff who did the on-site verification:
Lisa Hauk, Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: THE CANNON HOUSE
Provider Type: Assisted Living Facility
License/Cert.#: 2056
Compliance Determination #: 38703
Intake ID: 120733
Investigator: Lisa Hauk
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 03/21/2024 through 04/11/2024
Complainant Contact Date(s): 03/01/2024

Allegation(s):
Named Staff (NS) at the Assisted Living Facility (ALF) made a medication error.

Investigation Methods:

Sample:
Total residents: 61
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Administration
Identified resident
Identified staff
Nursing staff
Residents

Record Reviews:
Medical records
Hospital records
Grievance log
Incident investigation
Facility policies
Staff training records

Investigation Summary:
Interview showed there was a medication error at the ALF. Record review showed no documentation of the medication error. Staff at the ALF were aware of the medication error and took corrective action. Staff did not follow the ALF's medication policy or physician's orders. See citation WAC 388-78-2210(1)(a)(b)(2).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE CANNON HOUSE
Provider Type: Assisted Living Facility
License/Cert.#: 2056
Compliance Determination #: 38703
Intake ID: 123985
Investigator: Lisa Hauk
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 03/21/2024 through 04/11/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) was found on the floor at the Assisted Living Facility (ALF) and staff delayed a 911 call.
2. The NR had multiple seizures due to a medication error at the ALF.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Administration Identified resident Identified staff Nursing staff Residents
Record Reviews:	Medical records Hospital records Grievance log Incident investigation Facility policies Staff training records

Investigation Summary:

1. Interview and record review showed the NR laid on the floor for over 3 hours before staff at the ALF called 911. The ALF did not follow their policy or obtain medical attention for the NR in a timely manner during a health crisis. See citation WAC 388-78-2600(2)(f)(3).
2. Interview and record review showed the ALF gave the NR incorrect doses of a medication. The ALF did not follow their policy or physician's orders. See citation WAC

388-87-2210(1)(a)(b)(2).

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2056	Compliance Determination # 38703
Plan of Correction	THE CANNON HOUSE	Completion Date
Page 1 of 6	Licensee: SEA MAR COMMUNITY HEALTH CENTERS	04/11/2024

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 03/21/2024 and 03/21/2024 of:

THE CANNON HOUSE
113 23rd AVENUE SOUTH
SEATTLE, WA 98144

This document references the following complaint number(s): 120733, 123985

The following sample was selected for review during the unannounced on-site visit: 3 of 61 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

04/18/2024
Date

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

Administrator (or Representative)

4/19/24
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 3 residents (Resident 1 and 2) received their medications as prescribed. This failure resulted in Resident 1 receiving a medication not authorized by a physician and Resident 2 not receiving his full dosage of medication that may have resulted in hospitalization.

Findings included...

Record Review of the ALF's undated Medication Administration Policy stated, "Staff will compare the medication sheet with the label of each medication for the following: a. Right person b. Right medication c. Right date d. Right time e. Right route f. Right does g. Expiration date. If there is a discrepancy, the medication will not be administered."

Resident 1

Record review of an undated Admission Record showed the ALF admitted Resident 1 on [redacted]/2019 with multiple medically disabling diagnoses. Review of an Assessment dated 02/12/2024, showed Resident 1 received medication assistance from the ALF.

Record review of a physician's order showed Resident 1 did not have a physician's order for lidocaine on 02/21/2024. The ALF received an order for Lidocaine patches for Resident 1 on 02/23/2024. Two days after the lidocaine patch was administered.

In interview, on 03/25/2024 at 3:00 PM, Staff B confirmed the ALF gave Resident 1 lidocaine on 02/21/2024 without an authorized prescription.

Resident 2

Record review of an Admission Record showed the ALF admitted Resident 2 on [redacted]/2018 with multiple medically disabling diagnoses including [redacted]. Review of an Assessment, dated 03/21/2024, showed that the ALF managed Resident 2's medications via a medication organizer (container with compartments labeled with days and times to store pills) that would be filled by ALF nursing staff on a weekly basis and kept in the ALF medication cart.

Record review of Resident 2's Medication Administration Record (MAR) showed orders for Levetiracetam (used to help control seizures) give 1000 milligrams (mg) by mouth in the morning and 1500 mg by mouth in the evening.

In interview on 03/28/2024 at 2:52 PM, Staff A (Administrator) stated Resident 2's levetiracetam came in two separate doses. Resident 2 had a supply of 500 mg tablets which two tablets were to be given in the morning for the 1000 mg dose. And a supply of 750 mg tablets which two tablets were to be given in the evening for the 1500 mg dose.

Record review of an ALF incident document, dated [redacted]/2024, showed that Resident 2 was found unresponsive and was sent to the hospital via an ambulance.

In interview, on 04/09/2024 at 4:05 PM, Staff A stated that the three days prior to [redacted]/2024, there was a medication error and Resident 2 did not receive his full dose of levetiracetam.

In interview on 03/21/2024 at 12:53 PM, Staff B stated that the medication error occurred because Staff D (Agency LPN) filled Resident 2's medication organizer on 03/15/2024 incorrectly. Staff B stated that Staff D only put one 500mg tablet in the morning section of the medication organizer and only one 750mg tablet in the evening section. Staff B stated this was only half of Resident 2's dose of levetiracetam.

Record review of an After Visit Summary from the Emergency Department (ED) showed Resident 2 had a seizure in the ambulance while being transported to the ED. Review of Hospital Notes, dated [redacted]/2024, showed a diagnosis of [redacted] and Resident 2 was treated with intravenous (administering medication into a vein) anti-seizure medication.

This is a recurring deficiency previously cited on 02/11/2022, 06/06/2022, 08/26/2022, 02/08/2023 and 07/27/2023.

Statement of Deficiencies	License #: 2056	Compliance Determination # 38703
Plan of Correction	THE CANNON HOUSE	Completion Date
Page 4 of 6	Licensee: SEA MAR COMMUNITY HEALTH CENTERS	04/11/2024

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, THE CANNON HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~6/3/2024~~ 5/26/2024

SB confirmed ammended POC date with provider on 4/30/2024.

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

Administrator (or Representative) 4/19/24 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their policy for medical emergencies for 1 of 3 sampled residents (Resident 2). This failure resulted in a three hour and 45 minute delay in summoning of Emergency Medical Services (EMS) after Resident 2 fell and became unresponsive and placed the resident at risk of serious harm.

Findings included...

Review of a Medical Emergencies policy, reviewed June 2009, showed that for all injuries or medical emergencies at non-clinical facilities, staff should contact 911 and use their judgment in applying appropriate skills to any emergency situations.

Review of an Admission Record showed the ALF admitted Resident 2 on [redacted]/2018 with multiple medically disabling diagnoses including [redacted] ([redacted]).

Record review of an Incident Report (IR), dated [redacted]/2024, showed Resident 2 was found in his apartment unresponsive. The IR detailed the timeline of events as follows:
07:45 AM – Staff E (Certified Nursing Assistant – CNA) found Resident 2 on the floor of his apartment. Resident 2 was breathing, but not responding. Staff E reported to Staff C (Agency LPN). Staff C told Staff E that he would check on Resident 2.
08:30 AM – After serving breakfast, Staff E asked Staff C how Resident 2 was doing. Staff C

responded that he had been too busy to check on Resident 2. Staff C , Staff E and Staff F (CNA) went to Resident 2's apartment and together they could not lift Resident 2 off the floor.
09:00 AM – Staff C and Staff F told Staff E that Resident 2 was still laying on the floor unresponsive. Staff F suggested someone call 911. No staff called 911.
Record review of a witness statement from Staff E showed after Staff F suggested 911 be called, Staff C responded, "Since he's [Resident 2] is not bothering anybody, he is fine in his room."
09:30 AM – Staff E checked on Resident 2 and noted he had changed positions on the floor but was still unresponsive.
10:40 AM – Staff C reported to Staff B (Agency LPN) that Resident 2 was intoxicated, and staff were not able to lift him off the floor.
10:45 AM – Staff B assessed Resident 2.
10:56 AM – Staff B called 911.
11:30 AM – Emergency Medical Services arrived to assess Resident 2 and transport him to the hospital.

Review of the IR, dated [redacted]/2024, showed Resident 2 was unresponsive and experienced an acute medical event for three hours and 45 minutes before the ALF contacted 911.

In interview, on 04/10/2024 at 09:36 AM, Staff E stated that she did not call 911 for Resident 2 because, "The nurse has to call 911."

In interview, on 04/10/2024 at 10:10 AM, Staff F stated that he did not call 911 for Resident 2 because, "Nursing decides whether or not to call 911."

In interview, on 04/09/2024 at 4:05 PM, Staff A (Administrator) stated, "Staff should call 911. This policy has been in place and that's always been the expectation."

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, THE CANNON HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~6/21/2024~~ · 5/26/2024

SB confirmed ammended POC date with provider on 4/30/2024.

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

Jennifer Smith
Administrator (or Representative)

4/19/24
Date

Statement of Deficiencies	License #: 2056	Compliance Determination # 38703
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