STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

B.C. PARKER INC
THE BLAIR HOUSE
W 2718 SINTO AVE
SPOKANE, WA 99201

RE: THE BLAIR HOUSE License # 2127

Dear Administrator:

This letter addresses Compliance Determination(s) 40615 (Completion Date 05/01/2024) and 37865 (Completion Date 03/06/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/01/2024 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-2474-2-e, WAC 388-78A-2730-1-b, WAC 388-78A-2730-2-b-iii

The Department staff who did the on-site verification:
Veronica Jackson, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2127	Compliance Determination #:37866
Plan of Correction	THE BLAIR HOUSE	Completion Date
Page 1 of 4	Licensee: B C. PARKER INC	03/06/2024

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 follow-up on 03/06/2024 and 03/06/2024 of:
THE BLAIR HOUSE
W 2718 SINTO AVE
SPOKANE, WA 99201

This document references the following SOD dated: 03/06/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 8 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Antonietta Lettieri-Parkin, Long Term Care Surveyor
Patty Ford, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S.M
Residential Care Services

03/12/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 follow-up on 03/06/2024 and 03/06/2024 of:

THE BLAIR HOUSE
W 2718 SINTO AVE
SPOKANE, WA 99201

This document references the following SOD dated: 03/06/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 8 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Antonietta Lettieri-Parkin, Long Term Care Surveyor
Patty Ford, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Residential Care Services _____ 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.

Statement of Deficiencies	License #: 2127	Compliance Determination #:37865
Plan of Correction	THE BLAIR HOUSE	Completion Date
Page 2 of 4	Licensee: B.C. PARKER INC	03/06/2024

BLR

Administrator (or Representative)

3-19-24

Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 12 hours of continuing education was completed by 1 of 3 sampled staff (Staff D). This failure placed residents at risk of receiving care and services from staff without ongoing professional development.

Findings included...

Per WAC 388-112A-0611, certified nursing assistants (NACs) employed in an assisted living facility are required to complete 12 hours of continuing education (CE) by their birthday each year.

Review of the facility's undated staff list showed Staff D, Caregiver, was hired on 09/12/2016.

Review of Staff D's personnel file showed Staff D had a NAC credential and no documentation to support that they had completed 12 hours of CE during the required time frame.

In an interview on 03/06/2024 at 8:40 AM, Staff D provided the department licensor a copy of a training certificate for two hours of CE.

This is an uncorrected deficiency previously cited on 01/16/2024.

Plan/Attestation Statement

Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 12 hours of continuing education was completed by 1 of 3 sampled staff (Staff D). This failure placed residents at risk of receiving care and services from staff without ongoing professional development.

Findings included…

Per WAC 388-112A-0611, certified nursing assistants (NACs) employed in an assisted living facility are required to complete 12 hours of continuing education (CE) by their birthday each year.

Review of the facility's undated staff list showed Staff D, Caregiver, was hired on 09/12/2016.

Review of Staff D's personnel file showed Staff D had a NAC credential and no documentation to support that they had completed 12 hours of CE during the required time frame.

In an interview on 03/06/2024 at 9:40 AM, Staff D provided the department licensor a copy of a training certificate for two hours of CE.

This is an uncorrected deficiency previously cited on 01/16/2024.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2127	Compliance Determination # 37865
Plan of Correction	THE BLAIR HOUSE	Completion Date
Page 3 of 4	Licensee: B C. PARKER INC	03/06/2024

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date) 4-20-24 .

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

BCP 3-19-24

Administrator (or Representative) Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules, and

(2) The licensee must:

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

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a respiratory protection program as required. This failure placed residents and staff at risk for respiratory infection should an outbreak occur.

Findings included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (proper seal), and provide effective training before employees are assigned duties that may require the use of respirators (filtered face mask).

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long-term care settings were responsible to "follow regulations pertaining to respiratory protection."

In an interview on 03/06/2024 at 10:12 AM, Staff A, Administrator stated they developed a policy for respiratory protection, but it had not yet been implemented. Staff A stated some of the facility staff obtained medical clearance to be fit tested. No staff had been fit tested as of that date.

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(2) The licensee must:

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

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a respiratory protection program as required. This failure placed residents and staff at risk for respiratory infection should an outbreak occur.

Findings included…

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (proper seal), and provide effective training before employees are assigned duties that may require the use of respirators (filtered face mask).

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long-term care settings were responsible to “follow regulations pertaining to respiratory protection.”

In an interview on 03/06/2024 at 10:12 AM, Staff A, Administrator stated they developed a policy for respiratory protection, but it had not yet been implemented. Staff A stated some of the facility staff obtained medical clearance to be fit tested. No staff had been fit tested as of that date.

Statement of Deficiencies	License #: 2127	Compliance Determination # 37865
Plan of Correction	THE BLAIR HOUSE	Completion Date
Page 4 of 4	Licensee: B C. PARKER INC	03/06/2024

This is an uncorrected deficiency previously cited on 01/16/2024 for subsections (1) (b).

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date) 4-20-24 .

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

BCP

Administrator (or Representative)

3-19-24

Date

This is an uncorrected deficiency previously cited on 01/16/2024 for subsections (1) (b).

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
Plan of Correction	THE BLAIR HOUSE	Completion Date
Page 1 of 18	Licensee: B.C. PARKER INC	01/16/2024

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 the unannounced on-site full inspection on 01/04/2024, 01/05/2024, 01/09/2024 and 01/10/2024 of:
THE BLAIR HOUSE
W 2718 SINTO AVE
SPOKANE, WA 99201

The following sample was selected for review during the unannounced on-site visit: 4 of 8 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Antonietta Lettieri-Parkin, Long Term Care Surveyor
Patty Ford, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S.M 01/25/2024

Residential Care Services 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.

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
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Administrator (or Representative) 2-2-24 Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service:

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain on-site food service in compliance with Washington State Retail Food Code WAC 246-215 related to hand hygiene/glove use and cross contamination of ready to eat foods. This failure placed residents at increased risk of food borne illness.

Findings included....

Per the Washington State Retail Food Code 246-215-02310 (9), food workers shall clean their hands after engaging in other activities that contaminate the hands or gloves.

Review of the facility's menu for 01/05/2024 showed a lunch entrée of hot dogs, bean and bacon soup, saltines, and milk.

Observation of lunch preparation and service on 01/05/2024 from 10:53 AM through 12:15 PM showed the following:

-With a gloved right hand, Staff F, Caregiver, opened cabinet drawers, obtained a spoon, and used the spoon to stir the soup.

-With the same gloved right hand, Staff F opened the refrigerator door, handled a bottle of ketchup, a jar of mayonnaise, and placed them on the counter. With their gloved hand, Staff F then unwrapped a package of hot dog buns and saltine crackers, and then touched the buns and saltine crackers with their gloved hand and placed them on the residents' plates.

-With the same gloved hand, Staff F obtained a hot dog bun from the bag, opened containers of mustard and ketchup, placed the mustard and ketchup on the hot dogs, handled saltines from the sleeve, and placed them on plates.

Review of the facility's menu for 01/09/2024 showed a lunch entrée of bean and cheese burritos, tortilla chips, salsa, fruit cocktail, and milk.

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
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Page 3 of 18	Licensee: B.C. PARKER INC	01/16/2024

Observation of lunch preparation and service on 01/09/2024 from 10:35 AM through 12:15 PM showed the following:

-With ungloved hands, Staff D, Caregiver, opened cabinet drawers and then opened the refrigerator door and pulled out bags of beans and shredded cheese. Staff D placed the beans and shredded cheese on the counter. With their ungloved hands, Staff D's pointer finger went into the canned fruit and syrup as they opened the can.

-Staff D washed their hands with water only and put on a glove on their left hand.

-With gloved hands, Staff D touched the microwave door handle, the button settings on the microwave, opened the refrigerator door, touched the microwave settings again, and then touched a resident's microwaved lunch entrée item with their gloved finger to check the temperature.

-With bare hands, Staff D touched the microwave door handle and the button settings on the microwave. Staff D then obtained a piece of buttered bread from a plate with their bare hand.

-With a gloved right hand, Staff D touched the refrigerator door handle and obtained a bottle of ranch dressing with the gloved hand. Staff D used the same gloved hand to obtain chips from a bag.

In an interview on 01/09/2024 at 1:54 PM, Staff D stated they used one glove during food preparation and service.

This is a recurring deficiency previously cited on 10/13/2022 and 08/23/2022.

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date) 3-1-24 .

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

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
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BCK 2-2-24

Administrator (or Representative) Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure tuberculosis screening was completed upon hire for 1 of 6 sampled staff (Staff F). This failure placed residents at risk of exposure to tuberculosis, a communicable disease.

Findings included...

Review of the facility's undated staff list showed Staff F, Caregiver, was hired on 08/01/2016.

Review of Staff F's undated personnel file showed Staff F had a negative two step skin test completed on 03/16/2016 and 03/23/2016.

In an interview on 01/10/2024 at 2:12 PM, Staff A, Administrator, stated Staff F did not have a TB test upon hire.

This is a recurring deficiency previously cited on 10/13/2022 and 08/23/2022.

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date) 3-1-24 .

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

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
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Page 5 of 18	Licensee: B.C. PARKER INC	01/16/2024

Administrator (or Representative) 2-2-24 Date

WAC 388-78A-2210 Medication services.

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

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to correctly document and provide medications as prescribed to ensure a safe medication delivery system for 4 of 4 sampled residents (Residents 1, 2, 3 and 4). These failures resulted in residents not receiving their prescribed medications and inaccurate documentation which placed the residents' health at risk.

Findings included...

<Resident 1>

Review of Resident 1's department Comprehensive Assessment and Reporting Evaluation (CARE) assessment, dated 07/26/2023, showed the resident required medication assistance.

Review of Resident 1's December 2023 and January 2024 Medication Administration Records (MARs) showed the resident was prescribed the following:

-Folic Acid (Vitamin B supplement) TAB every morning.

-Loratadine (antihistamine to treat allergies) TAB every morning.

-Senna-Time (laxative) TAB, two tablets, twice a day.

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
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Review of Resident 1's December 2023 MAR showed the following medications were "withheld per DR/RN orders" on the following dates:

Folic Acid: 12/16/2023, 12/17/2023, 12/21/2023 through 12/24/2023, 12/28/2023, and 12/29/2023 through 12/31/2023.

Loratadine: 12/16/2023, 12/17/2023, 12/21/2023 through 12/24/2023, and 12/28/2023 through 12/31/2024.

Senna-Time: 12/15/2023 through 12/17/2023, 12/21/2023 through 12/24/2023, and 12/28/2023 through 12/31/2023.

Review of Resident 1's January 2024 MAR showed the following medications were "withheld per DR/RN orders" on the following dates:

Folic Acid: 01/04/2024.

Loratadine: 01/04/2024.

Senna-Time: 01/02/2024 (PM), 01/03/2024 (PM), 01/04/2024 (AM and PM), 01/07/2024 (PM), and 01/08/2024 (PM).

Review of Resident 1's undated facility file showed no doctor's orders to hold the medication.

In an interview on 01/10/2024 at 11:30 AM, Staff E, House Manager, confirmed that facility staff provided medication assistance to Resident 1, as medication assistance was not identified in Resident 1's negotiated service plan dated 07/11/2023.

In an interview on 01/09/2024 at 1:11 PM, Staff E stated there was no such order to hold Resident 1's medications. Staff E stated that Resident 1 became employed and their state funding stopped paying for the identified medications. The facility eventually obtained Resident 1's medications. When asked why Resident 1's Senna evening dose was held (per DR/RN orders) on 01/07/2024 and 01/08/2024, Staff E stated they should not have been as the medication was in the facility's medication cart. Observation of the medication cart at that time showed Resident 1's Senna was available.

<Resident 2>

Review of Resident 2's Negotiated Service Plan/Assessment (NSP/A, the facility's titled

negotiated service agreement), dated 10/16/2023, showed the resident required medication assistance.

Review of Resident 2's December 2023 and January 2024 MARs showed the following medications were prescribed:

-Aspirin, 1 tab by mouth once daily, with a stop date of 12/12/23.

-Atrovent HFA (inhaler for difficulty breathing), inhale 2 puffs into the lungs 3 times a day for chronic obstructive pulmonary disease (COPD, a lung condition that makes it hard to breath).

-Fluoxetine (antidepressant), take 1 capsule by mouth once daily.

-Incruse ELPT (inhaler to treat COPD), inhale 1 puff into the lungs once daily.

-Invokana (medication to treat diabetes, a condition with too much sugar in the blood), take 1 tablet by mouth every morning before breakfast.

-Losartan Potassium (medication to treat high blood pressure), take 1 tablet by mouth once daily.

-Metoprol SUC (medication to treat high blood pressure), take 1 tablet by mouth once daily *hold if heart rate less than 60.

-Nicotine TD (supplement to stop smoking), apply 1 patch to clean, dry skin once every 24 hours.

-Oxymetazoline (used to treat nasal congestion), instill 2 sprays into left nostril twice daily.

-Potassium CL ER (supplement) , take 2 tablets by mouth once daily with food for hypertension.

-Spiriva (inhaler to treat COPD) , inhale the contents of one capsule once daily via handihaler for 30 days. Original order 08/26/2023, stop date 12/12/2023.

Review of Resident 2's December 2023 MAR showed the following medications were "withheld per DR/RN orders" and/or missing entry/initials on the MAR on the following dates:

Aspirin: 12/03/2023 through 12/12/2023.

Atrovent : 12/01/2023 (AM) , 12/07/2023 (AM) , and 12/08/2023 (AM).

Fluoxetine: 12/09/2023.

Incruse: 12/22/2023, 12/24/2023, 12/29/2023, and 12/31/2023.

Invokana: 12/04/2023 through 12/17/2023, 12/19/2023, and 12/21/2023.

Metoprolol: 12/16/2023, 12/17/2023, 12/19/2023, 12/21/2023 through 12/24/2023, 12/28/2023, and 12/29/2023 through 12/31/2023.

Nicotine TD: 12/01/2023 through 12/17/2023, 12/19/2023, 12/21/2023 through 12/26/2023, and 12/28/2023 through 12/31/2023.

Oxymetazoline: 12/05/2023 (PM), 12/06/2023 (PM), 12/07/2023 (AM and PM), 12/08/2023 (AM and PM) , 12/09/2023 (AM and PM), 12/10/2023 (AM), 12/13/2023 (PM), 12/14/2023 (AM and PM), 12/15/2023, (AM and PM), 12/16/2023, (AM and PM), 12/17/2023, (AM and PM), 12/19/2023 (PM), 12/20/2023 (PM), 12/21/2023 (AM and PM), 12/22/2023 (AM and PM), 12/23/2023 (AM and PM), 12/24/2023 (PM), 12/26/2023 (PM), 12/27/2023 (PM), 12/28/2023 (AM and PM), 12/29/2023 (AM and PM), 12/30/2023 (AM and PM), and 12/31/2023 (AM and PM).

Potassium: 12/01/2023.

Spiriva: 12/01/2023, 12/02/2023, 12/03/2023, 12/04/2023, 12/05/2023, 12/06/2023, 12/10/2023, 12/11/2023, and 12/12/2023.

Review of Resident 2's January 2024 MAR showed the following medications were "withheld per DR/RN orders" and/or missing entry/initials on the MAR on the following dates:

Metoprolol: 01/04/2024 through 01/07/2024.

Nicotine TD: 01/01/2024 through 01/09/2024.

Oxymetazoline: 01/02/2024 (PM), 01/03/2024 (PM), 01/04/2024 (AM), 01/05/2024 (AM), 01/06/2024 (AM), 01/07/2024 (PM), and 01/08/2024 (AM and PM).

Review of Resident 2's December 2023 and January 2024 MARs showed Metoprolol was provided and no heart rate (HR) was documented (as ordered by the prescriber).

Review of Resident 2's progress notes, dated 11/01/2023 through 01/09/2023, showed no documentation to support Resident 2's HR was taken prior to being provided their medication.

Observation of Resident 2's medication administration on 01/09/2023 at 08:10 AM, showed Staff D, Caregiver, did not measure Resident 2's HR.

Review of Resident 2's undated facility file showed no doctors order to hold the medications.

In an interview on 01/09/2024 at 1:11 PM, Staff E stated staff incorrectly documented the "held per doctor's orders" and should have been coded differently as the medications were in the cart. Resident 2 does refuse medication related to funding and medical coverage issues.

In an interview on 01/16/2024 at 10:38 AM, Staff A, Administrator, stated staff used an oximeter (measures oxygen and heart rate) or a blood pressure cuff to check Resident 2's heart rate. Staff A stated Resident 2's heart rate would only be documented if it was below 60. Staff would provide the medication if the heart rate was within the parameters. There was no documentation to support this. Regarding Resident 2's oxymetazoline 0.05%, Staff A stated that the medication was discontinued, though there was no documentation to support this.

<Resident 3>

Review of Resident 3's NSP/A, dated 01/13/2023, showed the resident required medication assistance.

Review of Resident 3's November 2023, December 2023, and January 2024 MARs showed the following medications were prescribed:

-Buspirone, one tablet by mouth every morning an afternoon at 2:00 PM.

-Olanzapine, twice a day.

Review of Resident 3's November 2023 MAR showed the resident's 2:00 PM Buspirone was not given as ordered (missing entry/initials), "held per DR/RN orders," on the following

Statement of Deficiencies	License #: 2127	Compliance Determination # 35040
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dates: 11/03/2023, 11/05/2023, 11/11/2023, 11/12/2023, 11/16/2023, and 11/18/2023.

Review of Resident 3's December 2023 MAR showed the resident's 2:00 PM Buspirone was not given as ordered (missing entry/initials) and on the following dates: 12/01/2023, 12/09/2023, 12/16/2023, 12/21/2023, 12/24/2023, 12/28/2023, 12/29/2023, and 12/30/2023.

Review of Resident 3's January 2024 MAR showed the resident's 2:00 PM Buspirone was not given as ordered (missing entry/initials) and on the following dates: 01/05/2024 and 01/07/2024.

In an interview on 01/09/2024 at 1:11 PM, Staff E stated there was no "doctor's order" to hold Resident's 3's medications and that Resident 3 either was out of the facility at the time of the medication administration or refused. Staff E confirmed facility staff were not documenting correctly on Resident 3's MARs.

In an interview on 01/16/2024 at 10:38 AM, Staff A stated the blank documentation and the circles on Resident 3's MAR should state "out of facility."

<Resident 4>

Review of Resident 4's NSP/A, dated 02/27/2023, showed the resident required medication assistance.

Review of Resident 4's December 2023 and January 2024 MARs showed the following medications were prescribed:

-Tamsulosin, -RX # XXXX850 – Take 1 CAP by mouth once daily *30 minutes after the same meal for BPH (Benign prostatic hyperplasia, enlarged prostate).

-Tamsulosin -RX # XXXX163 – Take 1 CAP by mouth once daily *30 after same meal each day.

Review of Resident 4's December 2023 MAR showed the following medications were "withheld per DR/RN orders" on the following dates:

Tamsulosin -RX # XXXX850: 12/01/2023 through 12/11/2023, 12/13/2023 through 12/24/2023, and 12/28/2023 through 12/30/2023.

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Tamsulosin -RX # XXXX163: 12/31/2023.

Review of Resident 4's December 2023 MAR showed the resident did not receive any of their 12/24/2024 8:00 PM medications.

Review of Resident 4's January 2024 MAR showed the following medications were "withheld per DR/RN orders" on the following dates:

Tamsulosin -RX XXXX850: 01/05/2024 through 01/09/2024.

Tamsulosin -RX # XXXX163: 01/01/2024 through 01/04/2024.

Review of Resident 4's undated facility file showed no doctors orders to hold the medication.

In an interview on 01/09/2024 at 1:11 PM, Staff E stated staff documented the Tamsulosin as "held per doctor's orders," and could not state if Resident 4 received their medications on 12/24/2023. Staff E stated staff needed additional training to ensure the residents medications were documented correctly.

In an interview on 01/16/2024 at 10:38 AM, Staff A stated they were unaware of why Resident 4's 12/24/2023 MAR was missing entries at 8:00 PM.

This is a recurring deficiency previously cited on 08/23/2022.

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 BLAIR HOUSE is or will be in compliance with this law and / or regulation on (Date) 3-1-24 .

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

Administrator (or Representative) 2-2-24 Date

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WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were agreed to and signed annually by a representative of the facility for 4 of 4 sampled residents (Resident 1, 2, 3, and 4). This deficient practice placed residents at risk of not receiving care and services as agreed upon.

Findings included...

<Resident 1>

Review of Resident 1's Negotiated Care Plan/Assessment (NCP/A, the facility's titled negotiated service agreement), dated 07/11/2023, showed it did not include a signature by a representative of the facility to show the plan was agreed upon.

<Resident2>

Review of Resident 2's Negotiated Service Plan/Assessment (NSP/A, another name for the facility's titled negotiated service agreement), dated 10/16/2023, showed it did not include a signature by a representative of the facility to show the NSP/A was agreed upon.

<Resident 3>

Review of Resident 3's NSP/A, dated 01/13/2023, did not include a signature by a representative of the facility to show the NSP/A was agreed upon.

<Resident 4>

Resident 4's NSP/A dated 02/27/2023, did not include a signature by a representative of the facility to show the NSP/A was agreed upon.

In an interview and record review on 01/10/2024 at 2:12 PM, Staff A, Administrator, stated they were responsible for the signing of the NSP/As. Staff A stated they developed signature pages. Review of the dated signature pages were not consistent with the date of the plans for the sampled residents.

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

Administrator (or Representative) 2-2-24 Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(ii) Individual preferences to the extent reasonably possible.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to recognize and provide a resident with a requested preferred condiment for 1 of 4 residents (Resident 1). This failure resulted in the resident being denied a reasonable request based on a facility staff's opinion.

Findings included...

Review of Resident 1's Negotiated Care Plan/Assessment (the facility's titled negotiated service agreement), dated 07/11/2023, showed the resident was on a gluten free diet, was required to be cued to eat three meals a day, and had good communication skills.

Review of the facility's menu for 01/05/2024 showed a lunch entrée of hot dogs, bean and bacon soup, saltines, and milk.

Observation on 01/05/2024 at 12:17 PM, showed Resident 1 asked for peanut butter for their hot dog. Staff F, Caregiver, stated, "you are not getting peanut butter [Resident 1]."

Observation on 01/05/2024 at 12:20 PM showed Resident 1 was served their meal and asked again for peanut butter. Staff F stated, "I'm not doing peanut butter, it's not on the

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menu."

In an interview on 01/05/2024 at 12:30 PM, Staff F stated to the department licensor that they would not give Resident 1 peanut butter as that was their personal preference, that peanut butter should not go on a hot dog.

In an interview on 01/05/2024 at 12:31 PM, Resident 1 stated if they were provided peanut butter, they would have put it on their hot dog and that "was why I asked for it."

Plan/Attestation Statement

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

Administrator (or Representative) 2-2-24 Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that Washington state name and date of birth background checks were completed for 2 of 6 sampled staff (Staff A and F). This deficient practice placed residents at risk of receiving care and services by potentially disqualified staff.

Findings included...

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<Staff A>

Review of the facility's undated staff list showed Staff A, Administrator, began their employment at the facility on 09/07/2011.

Review of Staff A's Washington state name and date of birth background check showed a date of 05/18/2021.

Review of Staff A's current Washington state name and date of birth background check showed a date of 01/09/2024.

<Staff F>

Review of the facility's undated staff list showed Staff F, Caregiver, began their employment at the facility on 08/01/2016.

Review of Staff F's Washington state name and date of birth background check showed a date of 08/06/2021.

Review of Staff A's current Washington state name and date of birth background check showed a date of 01/09/2024.

In an interview on 01/09/2024 at 2:00 PM, Staff A stated they submitted the most recent background checks for Staff A and Staff F to the background check unit on that date (after the initiation of the inspection).

Plan/Attestation Statement

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

BCP 2-2-24

Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care

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worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 12 hours of continuing education was complete by 2 of 6 sampled staff (Staff C and Staff D). This failure placed residents at risk of receiving care and services from staff without ongoing professional development.

Findings included...

Per WAC 388-112A-0611, certified home care aides (HCAs) and certified nursing assistants (NACs) employed in an assisted living facility are required to complete 12 hours of continuing education by their birthday each year.

<Staff C>

Review of the facility's undated staff list showed Staff C, Caregiver, was hired on 06/16/2022.

Review of Staff C's personnel file showed Staff C had an HCA credential and no documentation to support that they had completed 12 hours of continuing education (CE) during the required time frame.

<Staff D>

Review of the facility's undated staff list showed Staff D, Caregiver, was hired on 09/12/2016.

Review of Staff D's personnel file showed Staff D had a NAC credential and no documentation to support that they had completed 12 hours of CE during the required time frame.

In an interview on 01/10/2024 at 2:12 PM, Staff A, Administrator, stated Staff C and Staff D did not have CE hours completed over the last year.

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

Administrator (or Representative) 2-2-24 Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(2) The licensee must:

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

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to develop and implement a respiratory protection program as required and failed to post the most recent full inspection conducted by the department in a conspicuous area. This failure placed residents and staff at risk for respiratory infection should an outbreak occur and violated the requirement for residents and visitors to review the facility's last inspection for compliance with the rules and regulations associated with their license.

Findings Included...

<Respiratory Protection>

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (proper seal), and provide effective training before employees are assigned duties that may require the use of respirators (filtered face mask).

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to "follow regulations pertaining to respiratory protection".

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In an interview on 01/09/2024 at 10:25 AM, Staff A, Administrator, stated that staff were not current with their fit testing for respirators. Staff A stated they had a resource for fit testing and was looking for a resource for medical evaluations. Staff A stated they did not have a written program for respiratory protection.

<Posting of full inspection>

Observation on 01/04/2024 at 1:15 PM, upon entrance to the facility and located in the dining room, showed a department letter dated October 1, 2018. The letter documented the department completed a follow-up inspection and found no deficiencies.

In an interview on 01/04/2024 at 2:40 PM, Staff A stated the last full inspection was posted on the wall in dining room. The department licensor informed Staff A that the posted letter was not the department's most recent inspection, which occurred on 08/23/2022.

Observation on 01/10/2024 at 11:59 AM, showed the department letter dated October 1, 2018, was still posted.

In an interview on 01/10/2024 at 2:18 PM, Staff A confirmed they had not posted the most recent full inspection.

Plan/Attestation Statement

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

BCP 2-2-24

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

B.C. PARKER INC
THE BLAIR HOUSE
W 2718 SINTO AVE
SPOKANE, WA 99201

RE: THE BLAIR HOUSE # 2127

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 01/16/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Stephanie Jenks, Field Manager
Residential Care Services
Region 1, Unit B
8517 E Trent Ave, Ste 102

Spokane Valley, WA 99212

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

During a meal service observation on 01/05/2024, a staff person was observed and heard directing residents to wash their hands prior to the meal. The staff stated they did not believe certain residents when the residents stated they had washed their hands and asked one resident to smell their hands to ensure they were clean. The staff denied a beverage to another resident until the resident's hands were washed and served that resident their meal last, as they were the last to wash their hands. The facility administrator was informed of the observation and stated they would provide training on resident rights to that staff person.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration

Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure