



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

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

RE: ISLAND HOUSE License # 2375

Dear Administrator:

This letter addresses Compliance Determination(s) 40382 (Completion Date 04/25/2024) and 40275 (Completion Date 03/19/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/25/2024 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-2810, WAC 388-78A-2810-1, WAC 388-78A-2810-2, WAC 388-78A-2810-3, WAC 388-78A-3100-1, WAC 388-78A-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2481-1-a, WAC 388-78A-2481-1-b, WAC 388-78A-2481-1, WAC 388-78A-2481-2, WAC 388-78A-2481, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2

The Department staff who did the on-site verification:

Sunny Kent, Licensor
Scottie Sindora, ALF Licensor

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



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

Statement of Deficiencies	License #: 2375	Compliance Determination # 40275
Plan of Correction	ISLAND HOUSE	Completion Date
Page 1 of 8	Licensee: CRP/CSH Mercer Island LLC	03/19/2024

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 03/11/2024 and 03/13/2024 of:

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

This document references the following SOD dated: 03/19/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 57 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Sunny Kent, Licensors
Scottie Sindora, ALF Licensors

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.

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.

Administrator (or Representative)

Date

WAC 388-78A-2810 Criteria for increasing licensed bed capacity. Before the licensed bed capacity in an assisted living facility may be increased, the assisted living facility must:

- (1) Obtain construction review services' review and approval of the additional rooms or beds, and related auxiliary spaces, if the rooms were not previously reviewed and approved for the physical plant requirements at time of construction; and
- (2) Ensure that each additional licensed bed or "stand-by" bed meets the assisted living licensing requirements under this chapter and chapter 388-110 WAC, when applicable.
- (3) Before approving any increase in licensed bed capacity, the department will determine the facility's maximum facility capacity to ensure that any increase is consistent with this chapter and chapter 388-110 WAC, when applicable.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain department approval to increase bed capacity of 55 residents prior to admitting additional residents that exceeded licensure. This failure placed any Assisted Living (AL) residents, beyond the maximum of 55, at risk of receiving care and services in a facility not licensed for that number of residents.

Findings included...

Record review on 03/11/2024 of the Department's Secure Tracking and Reporting System (STARS) database showed the ALF's license allowed the facility to provide care and services for 55 residents 05/09/2022. STARS showed the Department made an unannounced visit to the ALF on 11/16/2023 and found there were 61 residents on Assisted Living (AL) services. STARS showed the Department conducted a licensing visit on 01/03/2024 and found the ALF had 57 residents on AL services.

Record review of a Care Levels roster, dated 03/11/2024, showed 57 residents with Assisted Living (AL) contracts. These AL contracted residents were categorized on a point system according to their level of care. The levels of care included 16 residents who were on "Base" services from the ALF. Record review showed all 16 of the "Base" level service residents had signed an AL contract with the ALF.

During an interview on 03/13/2024 at 12:55PM, Staff A (Executive Director) stated that the roster was incorrect, and the 16 residents categorized under "Base" services were not actually assisted living but independent living, and therefore should have been removed from the roster.

Record review of an undated letter delivered to community residents showed that the ALF's "Baseline assisted living services level include:

- Access to 24/7 nursing care
- Access to our community nurse
- Monthly vital check clinic: Weight, blood pressure etc. with communication with your personal physician
- Emergency services: This allows our team to provide service to you in the event of an emergency."

Review of Washington Administrative Code 388-78A-2030 - Assisted living facility license required - showed (2) An assisted living facility license is required when any person other than a family member provides housing, one or more basic services, and one or more of the following: (ii) Providing health support services, either directly or indirectly as defined in this chapter and described in WAC 388-78A-2200; or (iii) Providing intermittent nursing services, either directly or indirectly as described in WAC 388-78A-2310. The "Base" services the ALF offered meet these regulations as requiring an AL license.

This is an uncorrected deficiency previously cited on 01/17/2024.

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, ISLAND 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-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure a system was in place to safely store hazardous chemicals away from residents. This placed 17 residents at risk for poisoning and health issues.

Findings included....

Record review of a "Care Levels" roster, dated 03/11/2024, showed 57 residents with Assisted Living contracts. Review of a Resident Character Roster, dated 03/11/2024, showed 16 residents with a diagnosis of [REDACTED]

[REDACTED]. 1 resident showed a diagnosis of [REDACTED].

An observation, on 03/11/2024 at 2:50 PM, showed the 2nd floor tub room was comprised of two rooms, both doors were unlocked. Then first room contained a handwashing sink. Observation of the contents of the unsecured cabinet under the sink showed one 1.17-quart bottle of Clorox bleach, and one 32-ounce spray bottle of Awesome Cleaner with Bleach.

Review of a Safety Data Sheet for Clorox bleach showed the product can cause severe skin burns and eye damage, and to contact Poison Control if swallowed. Review of the label for Totally Awesome cleaner showed, "Keep out of the reach of children".

During an interview, on 03/11/2024 at 2:50 PM, Staff G (Maintenance Director) stated the chemicals should not be in the unlocked cabinet. Staff G removed the chemicals from the room.

This is an uncorrected deficiency previously cited on 01/17/2024.

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, ISLAND 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-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(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:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 3 sampled staff (Staff B) completed in-person CPR training. This placed 57 residents at risk for harm from being in the care of staff who had not completed required training and certifications.

Findings included...

Note: WAC 388-112A-0700 - What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests. WAC 388-112A-0710 What is CPR/first-aid training? CPR/first-aid training is training that meets the guidelines established by the Occupational Safety and Health Administration (OSHA). Under OSHA guidelines, training must include hands on skills development through the use of mannequins or trainee partners.

A review of staff records during the full inspection, on 01/03/2024, showed Staff B (Director of Health) completed online CPR training through the "National CPR Foundation".

Review of staff records, on 03/11/2024, showed that Staff B did not complete CPR with a hands-on skill component by the ALF's back-in-compliance date of 03/02/2024.

During an interview, on 03/11/2024 at 12:30 PM, Staff H (Business Office Manager) stated that in a conversation with Staff B, Staff B stated they did not need to update their CPR training.

During an interview, on 03/11/2024 at 12:45 PM, Staff A (Executive Director) stated that they understood Staff B did not need to update their CPR training because Staff B was a nurse.

This is an uncorrected deficiency previously cited on 01/17/2024.

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)

Date

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

(b) By a trained professional; or

(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 4 sampled staff (Staff A and C) received tuberculosis (TB) screening in the form of blood or skin testing or provided proof of a previous positive blood or skin test. This placed 57 residents at risk for receiving care from a staff person whose TB history was incomplete.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2481 -Tuberculosis - Testing method—Required. The assisted living facility must ensure that all tuberculosis testing is done through either: (1) Intradermal (Mantoux) administration with test results read: (a) Within forty-eight to seventy-two hours of the test; and (b) By a trained professional; or (2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

NOTE: WAC 388-78A-2482 - Tuberculosis—No testing. The assisted living facility is not required to have a staff person tested for tuberculosis if the staff person has: (1) A documented history of a previous positive skin test, with ten or more millimeters induration; (2) A documented history of a previous positive blood test; or (3) Documented evidence of: (a) Adequate therapy for active disease; or (b) Completion of treatment for latent tuberculosis infection preventive therapy.

Record review of an undated Staff Roster showed the ALF hired Staff A on 06/07/2021 as

an Executive Director. During the full inspection on 01/03/2024, review of employee files showed no evidence of TB screening for Staff A. Record review on 03/11/2024 showed Staff A did not obtain new TB testing results to rule out active TB by the ALF's back-in-compliance date of 03/02/2024. Record review showed Staff A did not have a documented positive skin or blood test that would qualify for no TB testing (see WAC 388-78A-2482 above).

During an interview on 03/11/2024 at 12:30 PM, Staff H (Business Office Manager) stated that Staff A obtained a chest x-ray (CXR) on 03/08/2024. Staff A did not request a skin or blood test because they have a history of positive TB test results.

During an interview on 03/12/2024 at 12:15 PM, Staff A stated that since every TB test is positive, they have always presented a CXR as a TB testing record.

Record review of an undated Staff Roster showed the ALF hired Staff C as a Caregiver on 07/05/2023. Review of employee files showed Staff C completed a chest x-ray on 07/11/2023. The employee file showed no evidence that Staff C received positive results from a blood or skin test that would require a chest x-ray (CXR) to rule out active TB. Record review on 03/11/2024 showed no evidence Staff C obtained a skin or blood test for TB by the ALF's back-in-compliance date of 03/02/2024.

During an interview, on 03/11/2024 at 12:30 PM, Staff H (Business Office Manager) stated that there were no new testing records to show Staff C obtained a blood or skin test.

This is an uncorrected deficiency previously cited on 01/17/2024.

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, ISLAND 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-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 sampled staff (Staff D) received a second-step tuberculosis (TB) screening test one to three weeks after the first-step. This placed 57 residents at risk for receiving care from a staff person whose TB history was incomplete.

Findings included...

Record review of an undated Staff Roster, on 01/03/2024, showed the ALF hired Staff D on 08/01/2022 as a Caregiver/Medication Technician. Review of employee files showed Staff D received two TB skin tests. The first test was placed 08/03/2022 and read 08/05/2022. The second test was placed 08/28/2023 and read 08/31/2023.

Record review on 03/11/2024 showed a two-step skin test for Staff D was never completed with a second test done one to three weeks after the first test. to rule out active TB by the back in compliance date of 03/02/2024.

During an interview, on 03/11/2024 at 12:30 PM, Staff H (Business Office Manager) acknowledged Staff D did not update their TB records and still required a two-step skin test.

This is an uncorrected deficiency previously cited on 01/17/2024.

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, ISLAND 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



Residential Care Services Investigation Summary Report

Provider/Facility: ISLAND HOUSE

Provider Type: Assisted Living Facility

License/Cert.#: 2375

Compliance Determination #: 34476

Intake ID: 106641

Investigator: Sunny Kent

Region/Unit #: RCS Region 2 / Unit J

Investigation Date(s): 01/03/2024 through 01/17/2024

Complainant Contact Date(s):

Allegation(s):

The facility housed more residents than allowed with current licensure.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 7 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Kitchen
Interviews:	Residents Nursing staff Business office manager Administrator
Record Reviews:	State reporting log Facility policies

Investigation Summary:

Investigation showed the facility was housing 57 residents while their maximum capacity for residents with care and services was 55.

Conclusion / Action:

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



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

01/22/2024

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

RE: ISLAND HOUSE License # 2375

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 01/17/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

CRP/CSH Mercer Island LLC

ISLAND HOUSE # 2375

01/17/2024

Page 2 of 19

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

- 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.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

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 (425)670-6070.

Sincerely,


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

Enclosure



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

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 3 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

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 and complaint investigation on 01/03/2024 and 01/05/2024 of:

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

This document references the following complaint numbers: 111136, 106641.

The following sample was selected for review during the unannounced on-site visit: 7 of 57 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Sunny Kent, Licensor
Scottie Sindora, ALF Licensor

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.

Residential Care Services

1/22/2024
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.

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 4 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

ENC UDUMA
Administrator (or Representative)

01-25-2024
Date

WAC 388-78A-2810 Criteria for increasing licensed bed capacity. Before the licensed bed capacity in an assisted living facility may be increased, the assisted living facility must:

- (1) Obtain construction review services' review and approval of the additional rooms or beds, and related auxiliary spaces, if the rooms were not previously reviewed and approved for the physical plant requirements at time of construction; and
- (2) Ensure that each additional licensed bed or "stand-by" bed meets the assisted living licensing requirements under this chapter and chapter 388-110 WAC, when applicable.
- (3) Before approving any increase in licensed bed capacity, the department will determine the facility's maximum facility capacity to ensure that any increase is consistent with this chapter and chapter 388-110 WAC, when applicable.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to obtain department approval to increase bed capacity prior to admitting additional residents that exceeded licensure. This failure placed 57 residents at risk for decreased quality of life and being placed in unapproved rooms.

Findings included...

Record review of the Department's Facilities Management System database, on 01/03/2024, showed the ALF was licensed to provide care and services for 55 residents.

Review of a Resident Characteristic Roster showed the ALF was providing care and services to 57 residents, two residents beyond licensed capacity.

In an interview, on 01/03/2024 at 9:40 AM, Staff A (Executive Director) confirmed the current census exceeded the number of residents the Department had approved and licensed. Staff A stated that he had submitted a bed capacity/licensed resident increase, "Way back last year." Staff A confirmed he moved residents into the ALF without having the increased licensed bed capacity.

Record review of an email received from the Department's Business Operations and Application Unit (BOAU) confirmed that an application for an increase in bed/resident capacity had been submitted by the ALF and signed by Staff A on 12/07/2023. The BOAU confirmed no earlier application had been submitted and no approval for an increase had

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 5 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

been provided by the Department. The BOAU stated, "the capacity increase is not effective until approved." As of 1/16/2024 no bed/resident capacity increase had been approved.

In interview, on 01/16/2023 at 2:21 PM, a Department Representative stated they had made an unannounced visit to the ALF, on 11/16/2023, and found there were 61 residents there receiving care and services. Six residents beyond licensed capacity, 21 days before a capacity/bed increase was submitted by the ALF.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ISLAND HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~05/07/2024~~ 3/2/2024

SB confirmed ammended POC date with provider on 2/6/2024.

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

[Signature]

Administrator (or Representative)

01-25-2024

Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure there was sufficient staffing scheduled and available for residents to provide the care outlined in Negotiated Service Agreements (NSA) or answer and respond to call lights in a timely manner. This failure placed all 57 residents at risk for not receiving care, increased health issues, and decreased quality of life and harm.

Findings included...

Record review of the Resident Characteristic Roster (RCR), updated on 01/01/2024, showed the ALF had 57 residents receiving care and services. The RCR showed four residents required maximum care, multiple times daily, with all Activities of Daily Living

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 6 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

(ADL's – dressing, grooming and toileting), 17 residents required moderate assistance with ADLs, and 9 residents required the presence of a caregiver with minimum assistance. RCR showed nine residents required assistance with urinary incontinence, and/or catheter care, 19 residents had a diagnosis of [REDACTED] and four residents were considered high fall risks.

In an interview, on 01/03/2024 at 9:45 AM, Staff A (Executive Director) stated that the staffing pattern for the ALF was: three caregivers and one medication technician during day shift, two caregivers and one medication technician during evening shift, and one caregiver with one medication technician on night shift. Staff A stated that he felt it was an adequate pattern for the residents.

During the Resident Group Meeting, on 01/03/2024 at 3:00 PM, the following statements were made by sample, and non-sample residents:

"Are there any rules about how long a caregiver can spend with a resident?" "Are there any guidelines for nighttime caregiver coverage?" "What is a standard call light response time?" "I've waited 30 minutes for a response to my call pendant." "I think there are problems with the pagers not working." "Everyone who need a caregiver needs one right now, but there's not a lot to go around." "One night I waited 2 ½ hours after pressing the call pendant, I finally fell back asleep and then they woke me up 2 ½ hours later."

In an interview, on 01/04/2024 at 1:10 PM, Resident 2 stated that she usually waited a very long time for help.

In an interview, on 01/05/2023 at 10:00 AM, Resident 3 stated that the wait time for assistance after pulling the call light seemed to be very long. Resident 3 stated that the afternoons were the worst times.

In an interview, on 01/04/2024 at 11:00 AM, Resident 8 (non-sampled resident) stated that she had waited up to 90 minutes after pushing her call light. Resident 8 stated that consistent poor response to receiving help was one of the reasons she had given a 30-day notice and was moving to another location.

In an interview, on 10/04/2024 at 11:20 AM, Resident 4 stated, "I have waited a long time, I missed dinner one time. That has been an issue." Resident 4 stated that she usually laid down in the afternoons before dinner and trying to get help to get up afterwards was a "big problem."

Observation, on 01/05/2024 at 9:15 AM, that showed their system was computerized, automated and a report should be able to be obtained.

In an interview, on 01/05/2024 at 10:10 AM, Staff A stated that he was having trouble with

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 7 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

producing a "Call Light Time Response Report," and he was unable to print it out or download to email. In a follow up interview, on 01/08/2024 at 1:00 PM, Staff A stated that he was not able to gain any information regarding the report. Staff A had data on his computer that could have been sent with a screen shot but Department Representative never received any requested information to show the facility answered lights in a timely manner.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 2/6/2024.

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

En Udmo
Administrator (or Representative)

01/25/24
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) included necessary information to provide care and services for 1 of 7 sampled residents (Resident 4). This failure placed Resident 4 at risk for increased health issues.

Findings included...

Resident 4

Record review of a Face Sheet, dated 06/26/2022, showed the ALF admitted Resident 4 on

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 8 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

██████/2022 with medical conditions to include type 2 diabetes (a disorder in which the body has high sugar levels for prolonged periods of time) and urinary retention. Record review of the Resident Characteristic Roster (RCR), updated on 01/01/2024, confirmed Resident 4 had diabetes and had a long-term Foley urinary catheter (an indwelling tube that drain urine). Record review of Resident 4's Assessment, dated 04/25/2023, showed the resident had a diagnosis of ██████, ██████, and had a Foley catheter.

In interview, on 01/04/2024 at 11:10 AM, Resident 4 confirmed she had diabetes and knew the warning signs for hyperglycemia (too much sugar in the blood) and hypoglycemia (not enough sugar in the blood) and monitored herself closely. Resident 4 stated she did not know if the caregivers knew the signs and symptoms of hyperglycemia, or hypoglycemia, but that it should be stated on her Negotiated Service Plan (NSP – equivalent to an NSA) that she signed. Resident 4 also confirmed that she had a Foley catheter leg-bag on, and caregivers changed the bag every night.

In an interview, on 01/05/2023 at 08:28 AM, Staff J (Medication Technician) stated that all information regarding residents' care needs could be found in their NSP. Staff J stated that NSP's were updated regularly to inform staff on the care needs of each resident.

Record review of Resident 4's NSP, updated on 02/02/2023, gave no indication regarding what to observe and report if Resident 4 had signs and symptoms of hyper/hypoglycemia. There was no information regarding what to observe and report regarding care of Resident 4's catheter bag, or urine collection regarding abnormal output, displacement of catheter or unusual characteristics of the contents.

Bonnie to update SP by 02/02/24

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ISLAND HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~05/07/2024~~ 3/2/2024

SB confirmed ammended POC date with provider on 2/6/2024.

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

EM UDUMBS

Administrator (or Representative)

01/25/24

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:

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 9 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure all food was properly stored off the floor and protected from contamination. This failure placed all 57 of 57 residents at risk for food-borne illness and increased health issues.

Findings included...

Reference to: Federal Food Code, updated 01/18/2023, Washington Administrative Code 246-215-03351 -Preventing contamination from the premises—Food storage (Food and Drug Administration Food Code 3-305.11). (1) Except as specified in subsections (2) and (3) of this section, FOOD must be protected from contamination by storing the FOOD: (a) In a clean, dry location; (b) Where it is not exposed to splash, dust, or other contamination; and (c) At least six inches (15 cm) above the floor.

An observation and interview, on 01/03/2024 at 12:58 PM, the walk-in freezer in the kitchen showed 12 boxes stacked on the floor. Staff I (Cook) stated that the boxes contained food that were delivered two days ago.

An observation and interview, on 01/04/2024 at 12:54 PM, the walk-in freezer in the kitchen showed 17 boxes stacked on the floor. Staff I stated additional boxes had been delivered and they contained food.

An observation, on 01/05/2024 at 10:05 AM, the walk-in freezer in the kitchen showed three boxes, containing food, were stacked on the floor.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ISLAND HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~02/03/24~~ **3/2/2024**

SB confirmed ammended POC date with provider on 2/6/2024.

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

Ja. Neume
Administrator (or Representative)

01-25/24
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 10 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure a system was in place to safely store hazardous chemicals away from residents. This failure placed 20 of 20 residents, with cognitive loss and [REDACTED] diagnoses, at risk for poisoning and health issues.

Findings included...

Record review of the Resident Characteristic Roster, dated 01/01/2023, showed 19 residents had a diagnosis of [REDACTED] and one resident was indicated as having [REDACTED].

Observations, on 01/03/2024 at 10:58 AM on the 3rd floor of the ALF adjacent to Apartment 307, showed a housekeeping cart sitting in the hallway. The housekeeping cart was unattended and unlocked. The interior of the cart showed three cleaning chemicals – Method All-Purpose Cleaner, Comet cleanser, and a canister of insect spray.

Review of the manufacturer website For Method All-Purpose Cleaner showed the statement, "KEEP OUT OF THE REACH OF CHILDREN". Review of Material Safety Data for Comet cleanser showed the statement, "Keep out of the reach of children". The United States Environmental Agency recommends always storing pesticides out of children's reach.

Observations, on 01/03/2024 at 11:05 AM, showed the 2nd floor tub room was comprised of two rooms, both with lockable doors. Then first room contained a handwashing sink. Observation of the contents of the unsecured cabinet under the sink showed one 55 fluid ounce bottle of Clorox bleach, one 144-ounce bottle of Lysol Clean & Fresh cleaner, and one spray bottle of "Awesome" cleaner. The spa room contained a tub and toilet. The door to the spa room was unlocked and labeled, "Keep jacuzzi door locked at all times." Observation showed one 144-ounce bottle of Lysol Clean & Fresh and one Zep brand spray bottle stored on shelving inside the spa room.

Review of a Safety Data Sheet for Clorox bleach showed the product can cause severe skin burns and eye damage, and contact Poison Control if swallowed. Review of the Safety Data Sheet for Lysol Clean & Fresh showed it can cause serious eye damage and eye irritation, and "Keep out of the reach of children". Totally Awesome Cleaner Safety Data Sheet showed the statement, "Keep away from children".

An observation and interview, on 01/03/2024 at 11:06 AM on the 2nd floor of the ALF, showed a housekeeping cart sitting the hallway. The housekeeping cart was unattended

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 11 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

and unlocked. Inside the cart were three different cleanser bottles, two bottles had a warning to keep out of eyes and away from children. Staff G (Maintenance Director) stated that housekeeping carts should always be locked.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 2/6/2024.

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

Eve Udum

Administrator (or Representative)

01/25/24

Date

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

- (1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.
- (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:
 - (c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;
 - (d) Cardiopulmonary resuscitation and first aid; and
 - (e) Continuing education.

This requirement was not met as evidenced by: *CPR training in place on 02/01*

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 6 sampled staff (Staff B, Staff C and Staff F) completed in-person CPR training, 2 of 6 sampled staff (Staff C and Staff F) maintained current first-aid training, 1 of 3 sampled staff (Staff C) completed 12 hours of continuing education (CE), and 1 of 6 sampled staff (Staff A) completed specialized training for dementia and mental health. This left the ALF's 57 residents at risk for harm in the care of staff who had not completed required training and certifications.

Findings included...

Done
Dementia 02/21

CPR/First Aid

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 12 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

Note: WAC 388-112A-0700 - What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests. WAC 388-112A-0710 What is CPR/first-aid training? CPR/first-aid training is training that meets the guidelines established by the Occupational Safety and Health Administration (OSHA). Under OSHA guidelines, training must include hands on skills development through the use of mannequins or trainee partners.

A review of staff records showed Staff B (Director of Health), Staff C (Caregiver) and Staff F (Caregiver) completed online CPR training through the "National CPR Foundation". The National CPR Foundation is an online-only training entity. It does not offer a hands-on component for staff to demonstrate competence with chest compressions and other skills necessary for CPR, as required by OSHA.

The ALF hired Staff B on 05/01/2023. Staff B completed online CPR training, without the hand-on skills component, on 05/01/2023.

The ALF hired Staff C on 07/05/2023. Staff C completed on-line CPR training, without the hand-on skills component, on 07/28/2023. There was no record of current first-aid training for Staff C.

The ALF hired Staff F on 01/09/2019. Staff F completed on-line CPR training on 01/09/2019. There was no record of current first-aid training for Staff F.

During an interview, on 12/03/2024 at 4:35 PM, Staff H (Business Office Manager) stated that they directed staff to use National CPR Foundation to renew CPR certificates. The Department Representative explained the regulation required in-person training for CPR and first-aid to Staff H.

Continuing Education

Note: Washington Administrative Code (WAC) 388-112A regulates training and continuing education for long-term care workers. WAC 388-112A-0611 (1)(a)(iii) shows Nursing Assistants must complete 12 hours of continuing education annually by their birthday.

Record review of Staff C's employee file showed they only completed one hour of CE for the 2023 renewal cycle.

Specialized Training

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 13 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

Note: WAC 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. WAC 388-78A-2510 -Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

Record review of the ALF's Disclosure of Services, updated on 03/2017, showed the ALF accepted residents with [REDACTED] and [REDACTED] diagnosis. Record review of the ALF's Resident Characteristic Roster, updated on 01/01/2024, indicated 19 residents had a diagnosis of [REDACTED], and one resident with [REDACTED].

- The ALF hired Staff A as the Executive Director on 06/07/2021. Review of Staff A's personnel file showed no evidence of their having taken specialty training for dementia or mental health.

In an interview, on 01/05/2024, Staff A stated that he had taken both the specialty dementia and mental health courses, and the certificates of completion was probably at his home. Staff A stated that he would look at home and bring the certificates. In a follow up interview, on 01/08/2024 at 1:00 PM, Staff A stated that he was not able to find the certificates of completion for specialty training in dementia and mental health.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 2/6/2024.

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

Julianne

Administrator (or Representative)

01/25/24

Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility,

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 14 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 sampled staff (Staff A and Staff B) initiated tuberculosis (TB) screening within three days of hire. This placed 57 residents at risk for contact with a staff person whose TB status was unknown to the ALF.

Findings included...

Record review of an undated Staff Roster showed the ALF hired Staff A on 06/07/2021 as an Executive Director. Review of employee files showed no evidence of TB screening for Staff A.

In an exit interview, on 01/08/2024 at 1:00 PM, The Department Representatives asked Staff A if there were any TB records they could furnish for review. The deadline for receiving additional records was 5:00 PM on 01/08/2024. The Department received no TB records for Staff A by the deadline.

Record review of an undated Staff Roster showed the ALF hired Staff B on 05/01/2023 as a Director of Health. Review of employee files showed Staff B received a QuantiFERON blood test before their hire date on 06/22/2022. The results from the blood test showed Staff B did not have active TB. The employee file also showed Staff B received the required one-step TB skin test on 09/01/2023, over 3 months after hire, and 15 months after the QuantiFERON blood test.

On interview, on 01/04/2023, Staff H (Business Office Manager) stated that she did not know why the tests were so far apart.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 2/6/2024.

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

BK Waine

Administrator (or Representative)

01/25/24

Date

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 15 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

- (1) Intradermal (Mantoux) administration with test results read:
 - (a) Within forty-eight to seventy-two hours of the test; and
 - (b) By a trained professional; or
- (2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 sampled staff (Staff C) received tuberculosis (TB) screening in the form of blood or skin testing, or provided proof of a previous positive blood or skin test. This placed 57 residents at risk for receiving care from a staff person whose TB history was incomplete.

Findings included...

Record review of an undated Staff Roster showed the ALF hired Staff C as a Caregiver on 07/05/2023. Review of employee files showed Staff C completed a chest x-ray on 07/11/2023. The employee file showed no evidence that Staff C received positive results from a blood or skin test that would require a chest x-ray (CXRs) to rule out active TB.

During an interview, on 01/04/2024 at 9:55 AM, Staff H (Business Office Manager) stated that they sent Staff C for a screening chest x-ray because Staff C reported to Staff H they had a history of positive TB skin test results. Staff C did not furnish Staff H with any documentation showing a history of positive TB skin tests.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 2/6/2024.

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

Eric Williams
Administrator (or Representative)

02/06/24
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 16 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

following two-step skin testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 sampled staff (Staff D) received the second-step tuberculosis (TB) screening test one to three weeks after the first-step. This placed 57 residents at risk for receiving care from two staff persons whose TB histories were incomplete.

Findings included...

Record review of an undated Staff Roster showed the ALF hired Staff D on 08/01/2022 as a Caregiver/Medication Technician. Review of employee files showed Staff D received two TB skin tests. The first test was placed 08/03/2022 and read 08/05/2022. The second test was placed 08/28/2023 and read 08/31/2023. Over a year elapsed since the first and second TB skin tests were placed and read.

During an interview on 01/04/2024 at 9:55 AM, Staff H stated that they were unsure as to why the tests were completed outside of the required time frame.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ISLAND HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~02/09/24~~ **3/2/2024**

SB confirmed ammended POC date with provider on 2/6/2024.

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

Erik Uduma

Administrator (or Representative)

01/25/24

Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

- (2) Ensure animals living on the assisted living facility premises:
 - (a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;
 - (b) Are certified by a veterinarian to be free of diseases transmittable to humans;

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 17 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 3 pets (Pet 3) had up-to-date vaccinations and 3 of 3 pets (Pet 1, Pet 2 and Pet 3) failed to obtain certification from a veterinarian to ensure they did not carry diseases that could infect the residents. This placed 57 residents at risk for exposure to pets whose vaccination and health status was incomplete or unknown.

Findings included...

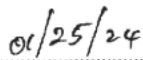
A review of the ALF's Pet Ownership Policy, dated 07/12/2016, showed that, "pets must be inoculated...in accordance with state and local laws."

A review of the ALF's pet records binder and a Resident Characteristic Roster, dated 01/01/2024, showed three ALF residents owned either a cat or a dog. Pet 1 resided with Resident 8, Pet 2 resided with Resident 9, and Pet 3 resided with Resident 10.

Record review showed Pet 1, Pet 2, and Pet 3 had no documentation to show the pets were free of disease and Pet 3 had no record of up-to-date vaccinations.

During an interview, on 01/11/2024 at 9:40 AM, Staff A (Executive Director) confirmed the pet records were not complete per regulation.

This is a repeated deficiency previously cited on 06/13/2022.

Plan/Attestation Statement	
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SB confirmed ammended POC date with provider on 2/6/2024.	
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:

- (a) The operation of the assisted living facility;
- (b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 18 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on observation, record review and interview, the Assisted Living Facility (ALF) failed to obtain a Medical Testing Site Waiver/Clinical Laboratory Improvement Amendments (MTSW/CLIA) waiver certificate by the deadline of June 30, 2023. The ALF also failed to implement their written Respiratory Protection Program (RPP) when 6 of 6 sampled staff (Staff A, Staff B, Staff C, Staff D, Staff E and Staff F) did not have medical clearance and respiratory mask fit-testing. This placed the staff and 57 of 57 residents at risk for contacting respiratory illnesses.

Findings included...

Medical Testing Site Waiver/Clinical Laboratory Improvement Amendments (MTSW/CLIA)

Note: A "Dear Assisted Facility Administrator" letter, issued by the Department on 08/03/2022, showed that ALFs were informed about state and federal regulations related to COVID-19 (an infectious disease which can result in illness with symptoms including cough, fever, malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) and other medical tests done on site. A MTSW certificate is required in Washington state to conduct these tests. The MTSW meets both federal and state requirements, and includes a federally- issued CLIA number. ALFs were also made aware of the deadline of 06/30/2023 for submitting the certificate application.

Observation during the environmental tour, on 01/03/2024 at 10:30 AM, did not show a MTSW/CLIA certificate posted anywhere in the ALF.

Record review showed the ALF had no documentation of MTSW/CLIA certification.

During the exit interview, on 01/08/2024 at 1:00 PM, Staff A (Executive Director) confirmed that the ALF did not have the MTSW/CLIA waiver.

Implementation of the Respiratory Protection Program (RPP)

Note: Review of a "Dear Administrator" letter, dated 04/30/2021, showed the Department informed ALFs of their responsibility to develop and maintain an RPP. An RPP is defined by the Washington State Department of Health (DOH) as a "federal and state OSHA (Occupational Safety and Health Administration) requirement to protect workers from exposure to respiratory hazards." The ALFs were required to provide initial and annual fit-tests for each Health Care Worker (HCW) with the same model, style, and size respirator that the HCW would be required to wear for protection against COVID-19 and airborne

Statement of Deficiencies	License #: 2375	Compliance Determination # 34476
Plan of Correction	ISLAND HOUSE	Completion Date
Page 19 of 19	Licensee: CRP/CSH Mercer Island LLC	01/17/2024

hazards. The ALF were required to provide fit-tested respirators, such as the N95, to all HCWs with the potential to have contact with residents with known or suspected COVID-19. The ALFs were required to provide gowns, gloves, and eye protection to staff who were providing care to residents.

Note: Washington Administrative Code 296-842-12005 is a Washington State Department of Labor and Industries (L&I) rule that requires employers to develop a written RPP to safeguard employees from airborne hazards.

Review of RPP records showed the ALF had no documentation of medical evaluations or respiratory mask fit-testing for sampled Staff A (Executive Director), Staff B (Director of Health), Staff C (Caregiver), Staff D (Caregiver/Medication Technician), Staff E (Server) and Staff F (Caregiver).

During an interview, on 01/03/2024 at 12:35 PM, Staff A (Executive Director) stated that medical evaluations and respiratory mask fit-testing were not completed for Staff A, Staff B, Staff C, Staff D, Staff E and Staff F.

Plan/Attestation Statement

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SB confirmed ammended POC date with provider on 2/6/2024.

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

Julie Adams
Administrator (or Representative)

2/25/24
Date