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

SHI-III First Hill LLC
Truewood by Merrill, First Hill
1421 MINOR AVE
SEATTLE, WA 98101

RE: Truewood by Merrill, First Hill License # 2420

Dear Administrator:

This letter addresses Compliance Determination(s) 48688 (Completion Date 10/14/2024) and 43746 (Completion Date 08/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/14/2024 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-2660-1

The Department staff who did the on-site verification:
Cathy Prentice, Complaint Investigator

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

Sincerely,

Jamie Singer

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Truewood by Merrill, First Hill
Provider Type: Assisted Living Facility
License/Cert.#: 2420
Intake ID: 133915
Compliance Determination #: 43746
Region/Unit #: RCS Region 2 / Unit J
Investigator: Cathy Prentice
Investigation Date(s): 07/08/2024 through 08/22/2024
Complainant Contact Date(s): 06/25/2024, 08/22/2024

Allegation(s):

1. The named resident went to the hospital and was clear for discharge for over 2 months but the facility refused to readmit. 2. The facility requested the named resident pay rent due although refusing to readmit. 3. No 30 day notice of discharge given to the named resident. 4. The named resident was discharged from the hospital to a hotel. 5. The facility is keeping the named resident's belongings.

Investigation Methods:

Sample:	Total residents: 34 Resident sample size: 2 Closed records sample size: 1
Observations:	Named resident no longer at facility; other residents; delivery of care and services; staff interactions with residents; residents' appearance; environment
Interviews:	Other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), grievances, facility policies, other pertinent records.

Investigation Summary:

1. Interview and record review, showed the facility completed an assessment and negotiated service agreement as required for the named resident that was being implemented at the time of the transfer to the hospital as the named resident who made his own decisions would allow. Although the hospital notified the facility that the named resident was ready to be discharged, the facility refused to re-admit the name resident. The facility failed to allow the named resident to return home to the ALF although his level of care was within the services the facility provided and was similar to the assessment and plan of care in place before the named resident went to the hospital. The named resident did not meet the requirements for an appropriate discharge. Failed practice identified see Statement of Deficiencies dated 08/22/2024. 2. The facility stated the named resident had been paying rent for the apartment he had been renting since [redacted] 2023 where his belongings stayed while he was in the hospital and the facility would not be charging rent past

the date of the facility refusal to re-admit ([redacted]/3024) No failed practice identified. 3. Record review and interview showed the discharge did not meet regulation. See Statement of Deficiencies dated 08/22/2024. 4. Since the ALF refused to allow the named resident to return home to the ALF, the hospital discharged the named resident to a hotel because he no longer met criteria to stay in the hospital and had no home to go to. See Statement of Deficiencies dated 08/22/2024. 5. The facility stated they kept the named resident's belongings until he could pick them up. No failed practice identified.

Conclusion / Action:

- [x] 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

Statement of Deficiencies	License #: 2420	Compliance Determination # 43746
Plan of Correction	Truewood by Merrill, First Hill	Completion Date
Page 1 of 5	Licensee: SHI-III First Hill LLC	08/22/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 07/08/2024 and 07/08/2024 of:

Truewood by Merrill, First Hill
1421 MINOR AVE
SEATTLE, WA 98101

This document references the following complaint number(s): 133915, 137297

The following sample was selected for review during the unannounced on-site visit: 2 of 34 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

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

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

Jamie Singer
Residential Care Services

8/26/2024
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.

Patrick Conner
Administrator (or Representative)

09/05/2024
Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed honor resident rights by discharging 1 of 1 resident (Resident 1) when the residents level of care did not exceed the ALFs services. This failure resulted in Resident 1, who required care and services, being discharged from the hospital to a hotel without care.

Findings included...

NOTE: Revised Code of Washington 70.129.110 - (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (3) Before a long-term care facility transfers or discharges a resident, the facility must: (a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident; (c) Record the reasons in the resident's record; (7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility.

NOTE: Revised Code of Washington 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. (2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to: (a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (c) Make choices about aspects of his or her life in the facility that are significant to the resident; (f) Unless adjudged incompetent or otherwise found to be legally incapacitated, to direct his or her own service plan and changes in the service plan, and to refuse any particular service so long as such refusal is documented in the record of the resident. (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

Record review showed the ALF admitted Resident 1 on [redacted] 2024 with a diagnosis of [redacted]. Resident 1's Negotiated Service Agreement (NSA), dated 01/04/2024, showed Resident 1 was alert and oriented, had no hallucinations or delusions, was pleasant, and had behaviors of

Administrator (or Representative) Date

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Record review showed the ALF admitted Resident 1 on [redacted]/2024 with a diagnosis of [redacted] ([redacted]). Resident 1's Negotiated Service Agreement (NSA), dated 01/04/2024, showed Resident 1 was alert and oriented, had no hallucinations or delusions, was pleasant, and had behaviors of

refusing medications due to believing they did not help. The NSA showed Resident 1 had paranoia about food prepared by others. The NSA showed Resident 1 had no history of harming self or others. The NSA showed Resident 1 had a history of smoking and was at moderate risk for falls. The NSA showed interventions in place to provide reminders and cues for meals and activities and Resident 1 was independent with transfers but needed minimal assist with mobility. The NSA showed Resident 1 was able to determine their own preferences for dining.

Review of ALF Progress Notes (PN), showed during January of 2024 Resident 1 frequently refused to eat in the dining room and preferred to eat own food in the apartment. A PN, dated 01/11/2024, showed Resident 1 was found on the ground of the garage after a non-injury fall when he was going outside to smoke. Review of PNs showed Resident 1 had three other non-injury falls in his apartment during January. A PN, dated 01/19/2024, showed Resident 1 had multiple non-injury falls that week and refused meals in the dining room preferring to eat his own snacks. The PN showed Resident 1 was alert and responsive, drinking protein drinks and eating mostly peanut butter sandwiches in the apartment. A PN, dated 01/23/2024 showed Resident 1 was taken to the hospital, after consulting with the physician, after he showed a pattern of refusing care.

Review of hospital records (HR), dated 05/15/2024, showed the hospital social worker contacted the ALF about Resident 1 returning. The HR showed that Resident 1 was medically stable and had no changes in his care needs. The HR showed the ALF required their corporate office to decide on whether they would accept Resident 1 back. A HR, dated 05/24/2024, showed Resident 1 had a "strong will" to go back to the ALF. A HR, dated 05/29/2024, showed the hospital social worker again contacted the ALF to find that the corporate office had still not made a decision on whether Resident 1 could return home. A HR, dated 05/30/2024, showed Resident 1's physician was concerned about why the ALF was not accepting him back as he was at baseline and medically stable with no new behavior issues or diagnoses. A HR, dated 05/30/2024, showed the ALF Administrator notified the hospital they were declining the re-admission of Resident 1.

An additional HR note by the Social
Worker (SW) dated 05/30/2024, showed the SW spoke with Staff A who requested an explanation of the ITA (Involuntary Treatment Act) statement in the resident's hospital notes. The SW explained to Staff A this is a standard statement on all patients and the ITA hold will be dropped once the patient leaves the hospital and Resident 1 did not meet any clinical criteria to be in the hospital any longer and he has the right to make his own choices and he is decisional. Staff A requested to speak with the psychiatrist. The SW told Staff A Resident 1 has to return to his apartment.

The HRs showed Resident 1 was required to stay in the hospital, after being medically cleared for 15 days before the ALF made the decision to deny his return to his home. A HR, dated 06/10/2024, showed Resident 1 had to be discharged from the hospital to a hotel when he was declined re-admission to the ALF.

In interview, on 07/08/2024 at 11:10 AM, Staff A (Administrator) stated the reason the ALF did not re-admit Resident 1 from the hospital was because he refused care, wandered around and had falls, and was refusing to eat. Staff A stated he was informed by the hospital psychiatric physician that there was no reason why Resident 1 should not be safe in the ALF, however the ALF still refused to accept him based on refusing care and not eating. Staff A stated the hospital psychiatrist assured him the hospital notes that stated Resident 1 needed around the clock psych care was just for billing at the hospital and that Resident 1 could return home to the ALF. When Staff A was informed by the Department Representative during the interview that Resident 1 had a right to refuse care and fall, and the ALF was required to honor his rights and preferences, Staff A did not respond. Staff A then stated the decision was made to deny re-admission of Resident 1 based on Staff B (Wellness Director) updated Assessment.

In an interview, on 07/08/2024 at 10:25 AM, Staff B stated she went to the hospital sometime in May of 2024 to conduct an Assessment.

Review of an undated Assessment, created by Staff B in May of 2024 at the hospital, showed Resident 1 was alert and oriented with mild memory loss, liked to go outside and smoke, had a history of refusing care, no hallucinations or delusions, no harm to self or others, had three or more falls in 90 days, used an assistive device for walking (walker), occasionally incontinent of urine, minimal assist with mobility, minimal assist with transfers, assist with medications, moderate assist with bathing, moderate assist with grooming and dressing, independent toileting usually continent, uses pendant to call staff.

Review of the ALF Disclosure of Services (DOS), undated, showed the facility provided one person assist with mobility and transfers, care for residents with Mental Health diagnoses unless a safety risk to self or others, and cueing for meals as well as assist with bathing, toileting, hygiene, dressing, and medications. Review of the HR and the ALF's hospital Assessment showed Resident 1 did not exceed the ALF's DOS and level of care they provide.

In an interview, on 07/08/2024 at 10:25 AM, Staff B stated the ALF thought it may be unsafe for Resident 1 to return because he would end up the same, not eating and falling when he went out to smoke.

Statement of Deficiencies	License #: 2420	Compliance Determination # 43746
Plan of Correction	Truewood by Merrill, First Hill	Completion Date
Page 5 of 5	Licensee: SHI-III First Hill LLC	08/22/2024

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, Truewood by Merrill, First Hill is or will be in compliance with this law and / or regulation on (Date) 10/06/2024

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

Patrick Conner — 09/05/2024

~~Administrator (or Representative)~~ ~~Date~~