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

Caring Places Management, LLC
Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

RE: Artesian Place License # 2542

Dear Administrator:

This letter addresses Compliance Determination(s) 29047 (Completion Date 09/06/2023) and 22956 (Completion Date 05/24/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/06/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

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

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Maria Salas, ALF Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Artesian Place
Provider Type: Assisted Living Facility
License/Cert.#: 2542
Compliance Determination #: 22956
Intake ID: 75666
Investigator: Maria Salas
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 04/25/2023 through 05/24/2023
Complainant Contact Date(s):

Allegation(s):

1.Concern for multiple falls- resident allegedly had multiple falls prior to hospitalization.
2.Not following medical provider orders- facility was not notifying medical provider when blood pressures were outside of parameters.
3.Notification- case manager was not notified of alleged falls.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies Staff training records

Investigation Summary:

1. Based on record review and interview facility conducted an incident investigation, resident was placed on alert and resident concerns were monitored. No failed practice identified.

2. Based on record review and interview no change in condition was identified, it was acceptable for the facility not to notify the case manager. No failed practice identified.

3.Based on record review and interview the facility failed to administer medications as prescribed. Failed practice identified.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

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

The department completed data collection for an unannounced on-site complaint investigation on 04/25/2023 and 05/24/2023 of:

Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

This document references the following complaint number(s): 77157, 77098, 75666

The following sample was selected for review during the unannounced on-site visit: 3 of 81 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator

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

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

Jody Just
Residential Care Services

05/31/2023
Date

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

Angela Pitts
Administrator (or Representative)

6.15.2023
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 :

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to administer medications as prescribed for two of three sampled residents (Resident 2, Resident 3). This failure placed both residents at risk for side effects of low blood pressure.

Findings include...

Review of the American Heart Association website page, titled, "Facts About High Blood Pressure", dated 12/30/2017, showed "Normal blood pressure- Systolic (SBP, top number of a blood pressure reading) less than 120mm Hg and Diastolic (DBP, lower number of a blood pressure reading) less than 80mm Hg,
Elevated- SBP 120-129mm Hg and DBP less than 80mm Hg, High Blood pressure- SBP 130-139mm Hg or DBP 80-89mm Hg."

Review of the American Heart Association website, titled, "Low Blood Pressure- When Blood Pressure Is Too Low" dated 10/31/2016, showed "Most doctors will only consider chronically low blood pressure as dangerous if it causes noticeable signs and symptoms, such as: Dizziness or lightheadedness, Nausea, Fainting, Dehydration and unusual thirst, Lack of concentration, Blurred vision, Cold, clammy, pale skin, Rapid, shallow breathing, Fatigue, Depression. A number of drugs can cause low blood pressure, including drugs that treat hypertension (blood pressure that is higher than normal)."

Record review of the facility's "Abnormal Vital Signs To Report To MD/RN Policy", undated, showed that staff were guided to notify the Registered Nurse (RN) of resident's vital sign outside of ordered parameter. Staff were instructed to observe resident for shortness of breath, swelling, dizziness, chest pain, headache, or any other complaint made by resident. Staff were then supposed to fax the medical doctor (MD) with a full set of vital reading and any abnormal observation finding.

Record review of Resident 1's (R1), face sheet, unknown date, showed R1 was admitted to the facility on [redacted]/2018 with a diagnosis history of [redacted] and [redacted]. R1 independently ambulated with a four wheeled walker.

Record review of Resident 2's (R2), Face Sheet, unknown date, showed R2 was admitted to the facility on [redacted]/2020 with a diagnosis history of [redacted], and [redacted]. R2 walked with a four wheeled walker, had poor safety awareness and required stand-by-assist for safety while ambulating.

Record review of R1's Medication Administration Record (MAR), dated February 1, 2023 through February 28,2023 showed R1 had a physicians order for lisinopril (lowers blood pressure) 5 mg tablet, was to take one tablet by mouth daily and the lisinopril was to be held for SBP (systolic blood pressure) less than 110millimeters of mercury (mmHg, the units that blood pressure is measured in) and to notify RN or MD. Documentation showed lisinopril was administered to R1 5 of 28 days when SBP was less than 110mmHg. Documentation showed that the same 5 of 28 SBP readings that were less than 110mmHg had been documented as not outside of parameters and the lisinopril had been administered. No documented notification to RN or MD were found in MAR.

Record review of R1's MAR, dated March 1,2023 through March 31,2023, showed R1 had an order for lisinopril 5 mg tablet, was to take one tablet by mouth daily and the lisinopril was to be held for SBP less than 110mmHg and notify RN or MD. Documentation showed lisinopril was administered to R1 2 of 31 days when SBP was less than 110mmHg. Documentation showed that the same 2 of 31 SBP readings that were less than 110mmHg had been documented as not outside of parameters and the lisinopril had been administered. No documentation of notification to RN or MD were found in MAR.

Record review of R2's MAR, dated February 1, 2023 through February 28,2023, showed R2 had an order for metoprolol succinate (lowers blood pressure) 50 mg tablet extended release, take one tablet by mouth two times a day and was to be held for SBP less than 100mmHg or heart rate less than 40 beats per minute. Documentation showed metoprolol succinate was administered to R2 3 of 28 days when SBP was less than 100mmHg. Documentation showed that the same 3 of 28 SBP readings that were less than 100mmHg had been documented as not outside of parameters and the metoprolol succinate had been administered. No documented notification to RN or MD were found in MAR.

Record review of R2's MAR, dated March 1, 2023 through March 31,2023, showed R2 had an order for metoprolol succinate 50 mg tablet extended release, take one tablet by mouth two times a day and was to be held for SBP less than 100mmHg or heart rate less than 40 beats per minute. Documentation showed metoprolol succinate was administered to R2 3 of 31 days when SBP was less than 100mmHg. Documentation showed that the same 3 of 31 SBP readings that were less than 100mmHg had been documented as not outside of parameters and the metoprolol succinate had been administered. No documented

notification to RN or MD were found in MAR.

Record review of R1's Progress Notes, dated February 2023, no documented communication to RN and MD, alert charting, or MD instructions found related to low blood pressures or medication not administered due to blood pressure outside of parameter.

Record review of R1's Progress Notes, dated March 2023, no documented communication to RN and MD, alert charting, or MD instructions found related to low blood pressures or medication not administered due to blood pressure outside of parameter.

Record review of R2's Progress Notes, dated February 2023, no documented communication to RN and MD, alert charting, or MD instructions found related to low blood pressures or medication not administered due to blood pressure outside of parameter.

Record review of R2's Progress Notes, dated March 2023, no documented communication to RN and MD, alert charting, or MD instructions found related to low blood pressures or medication not administered due to blood pressure outside of parameter.

In an interview Staff A, Medication Technician, stated that when a resident's blood pressure was outside of parameter she would notify the Assistant Executive Director, Assistant Residential Care Coordinator, RN, and send a fax to the MD for notification of the abnormal blood pressure. While waiting for a reply from the MD, the RN would guide Staff A on resident care if needed. Staff A stated the original fax sheet to the MD would be placed in the "Follow-Up" fax file, once the response was received instructions would be documented in the electronic medical records, then the fax sheet with the MD response on it would be placed in the paper holder awaiting to be filed in the resident's hard chart. Staff A was unable to find communication to RN and MD related to February and March dates when R1 and R2 had blood pressures outside of parameters.

In an interview Staff B, Medication Technician, stated when a resident's blood pressure was outside of parameters she would notify the Assistant Executive Director, RN, and would send a fax to the MD notifying them of the abnormal vital sign. Staff B stated she then would have made an alert note entry in the MAR for the medication entry. Staff B stated she would not have administered the medication associated with the blood pressure parameter and would observe the resident for any signs and symptoms of low blood pressure.

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, Artesian Place is or will be in compliance with this law and / or regulation on (Date) 7.8.2023 .

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

Administrator (or Representative) — Date: 6.15.2023

Artesian Place

Artesian Place
Plan of Correction

Statement of Deficiencies Report Dated June 1, 2023

Deficiency	Actions	Responsible Person(s)	Due Date	Completed Date
WAC 388-78A-2210 Medication Services	Quick MAR set up to email Admin when vital signs documented are outside of parameters.	Angie-Admin	6-5-2023	Angela Pitts 6.5.23
	RCC will review all vital signs documented in QuickMar twice weekly Checking for appropriate, accurate documentation and Alerting Nurse/PCP of vitals outside of parameters. Vital signs include: Blood Pressures, Weights, Pulse, Temperature or Oxygen Saturation.	[redacted] RCC	6-5-2023	Angela Pitts 6.5.23
	PCP will be notified of any Vital Sign monitored that is outside of house or PCP set parameters. House Parameters Posted in Med Room and In Med Aide Communication Binder.	Med Aide	6-5-2023	Angela Pitts 6.5.23
	Nurse will be notified of any Vital Sign outside of House or PCP set parameters.	Med Aide	6-5-2023	Angela Pitts 6.5.23

Artesian Place

	Staff to be retrained on abnormal vital signs. Who to notify, when to notify and what to include in notification. How to properly document about notifications.	Angie-Admin [redacted]-RCC	7-5-2023	Angie RHS 7.5.23