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) 43321 (Completion Date 06/27/2024) and 38221 (Completion Date 03/21/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/27/2024 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, WAC 388-78A-2660-1

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, 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 #: 38221
Intake ID: 119438
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/13/2024 through 03/21/2024
Complainant Contact Date(s):

Allegation(s):

Admission, Transfer & Discharge Rights: Public report of facility refusing to re-admit resident after being sent to hospital for evaluation.

Investigation Methods:

Sample:	Total residents: 62 Resident sample size: 5 Closed records sample size: 3
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Management
Record Reviews:	Incident investigation Facility policies Staff training records Personnel files Medication Administration Records Progress Notes Disclosure of Services Admission Agreements Negotiated Service Agreements Progress Notes

Investigation Summary:

Admission, Transfer & Discharge Rights: After review of resident records, facility failed to provide a Discharge Notice/Letter to the resident or their representative after they determined the resident exceeded the level of care they could safely provide. Resident was not given notice, and was forced to find alternate placement. Failed practice identified.

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

Statement of Deficiencies	License #: 2542	Compliance Determination # 38221
Plan of Correction	Artesian Place	Completion Date
Page 1 of 4	Licensee: Caring Places Management, LLC	03/21/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 03/13/2024 and 03/21/2024 of:

Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

This document references the following complaint number(s): 119438, 120515, 123333

The following sample was selected for review during the unannounced on-site visit: 5 of 62 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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.

Cory Cisneros
Residential Care Services

03/26/2024
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.

Administrator (or Representative)

4.3.2024
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 facility failed to provide residents or their representatives a thirty-day written notice to notify them for the reason for discharge from the facility when the residents care exceeded the facility's level of care for 1 of 4 residents reviewed, [Resident 1 (R1)]. This failure resulted in the resident being discharged from the facility and forced the resident and their representatives to look for alternate placement without required notice.

5.3.24

Findings included...

"RCW 70.129.110 Disclosure, transfer, and discharge requirements... (4)(a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged. (b) Notice may be made as soon as practicable before transfer or discharge when: (iii) An immediate transfer or discharge is required by the resident's urgent medical needs; (5) The written notice specified in subsection (3) of this section must include the following: (a) The reason for transfer or discharge; (b) The effective date of transfer or discharge; (c) The location to which the resident is transferred or discharged; (d) The name, address, and telephone number of the state long-term care ombuds."

5.3.24

During an interview on 03/13/2024 at 12:13PM, Staff B, the Resident Care Coordinator, was asked to explain the process on what the facility would do when they felt a resident had exceeded the level of care and initiated a discharge of that resident. Staff B stated, "We keep in touch with family or the POA [Power of Attorney]. We keep in touch with the case manager and case worker that oversees that resident in the hospital. We also send notes over to our Regional Nurse, and [they are] one of the final decision makers for if they exceeded level of care." Staff B was asked if a letter was sent to the resident or representative of the notice of discharge. Staff B stated that they were notified usually "via Phone call, or email." Staff B was asked if they were aware that per the Admission Agreement, it stated that the facility would provide written notice. Staff B stated that they were not aware of this and stated that they had never done this. Regarding discharge letters or notices, Staff B stated, "I have not personally ever seen one."

Review of the R1's Face sheet showed that R1 was admitted to the facility on [redacted]/2022.

Review of R1's Admission Agreement, signed by the resident on 07/06/2022 and a facility

representative on 07/10/2022, under the section titled, "TERMINATION BY FACILITY AND DISCHARGE OR TRANSFER REQUIREMENTS", stated, "The facility will permit the resident to remain in the facility, and will not transfer or discharge the resident against the resident's will unless:
1. The resident has failed to make the required payment for his or her stay.
2. Transfer or discharge is necessary for the resident's welfare and the resident needs cannot be met by the facility.
3. The safety of individuals in the facility is endangered.
4. The health off individuals in the facility would otherwise be endangered.
5. The Facility ceases to operate.
If the facility transfers or discharges the resident for one or more of the above reasons, the facility shall provide written notice of the discharge to the resident and his or her representative at least 30 days in advance. However, written notices may be made on less than 30 days, and as soon as practicable before discharge or transfer if:
1. The health or safety of individuals in the Facility would be endangered.
2. An immediate transfer or discharge is required by the resident's urgent medical needs; or
3. The resident has not resided at the facility for 30 days."
Under the section titled, "WRITTEN NOTICE OF TERMINATION" it stated, "The facility agrees to give a copy of the written notification to vacate the facility to the resident and/or the resident's representative. The notice will include the reasons that the resident is required to vacate the facility."

Review of Facility Discharge List, from 01/20/2024-03/20/2024 showed that R1 was discharged to the hospital on [redacted]/2024 for Urgent Medical Needs.

Review of an untimed Progress Note for R1, dated, [redacted]/2024, stated that the facility received paperwork on R1's condition from hospital. After review, the facility determined R1's needs could no longer be met by the facility. "Currently not swallowing requires suctioning and tube feeding. [R1] also experiencing right upper extremity weakness and poor hand coordination. [R1] is reluctant to attempt swallowing or advancing diet with speech therapy. Resident is extremely weak and lethargic. Requires 2-person total assist or mechanical lift to get out of bed. Has Foley catheter [a thin flexible device used to drain urine from the bladder] inserted." "[R1] Using PICC [Peripheral Intravenous Central Catheter] line for IV [Intra-Venous] antibiotics for MRSA [Methicillin Resistant Staphylococcus Aureus-any of several strains of bacterium (Staphylococcus aureus) that are resistant to methicillin and related antibiotics (such as penicillin) and that may cause mild infections of the skin or sometimes more severe (as of the blood, lungs, or bones) especially in hospitalized or immunocompromised individuals]." After making this determination, the facility discharged R1 from the facility.

During an interview on 03/13/2024 at 4:05PM, Staff A, the Assistant Administrator, was asked why the facility discharged R1 to the hospital. Staff A stated that after reviewing R1's hospital records and current condition, that the facility determined that they were no longer able to accommodate R1's medical needs and stated that R1 exceeded the facility's level of care. Staff A stated that R1 was not happy to hear this but understood the reasoning. Staff A was asked if a move-out/discharge letter was provided to R1 or their representative after the facility made this determination explaining the reasoning for discharge in writing, in language the resident could understand. Staff A stated that R1 was

their own responsible party. Staff A stated, "No move out letter was provided as this was discussed with resident, DSHS case manager and emergency contact and agreed upon for resident to move to a higher level of care due to the changes in [R1's] condition with no anticipated [discharge] date [from the hospital] for [their existing medical conditions]."

During an interview on 03/21/2024 at 12:37PM, Staff A was asked on what circumstances a Discharge Notice/Letter would be provided to a resident, or their representative as per the signed Resident Admission Agreement. Staff A stated, "What I had been told by home office is that if the resident does not agree to the discharge, then we will meet with them, and they can plead their case. If after this meeting we wanted to continue with the discharge we would issue a letter, or if there was any pushback from the resident or family, we would give them a 30-day notice." Staff A was asked to review the facility Admission Agreement. After their review, Staff A was asked why a Discharge Notice/Letter was not provided to R1. Staff A stated, "After reading that, there should have been a letter sent out."

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) May 3rd 2024.

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

Angela Pitts
Administrator (or Representative)

4.3.2024
Date