Residential Care Services
Investigation Summary Report

Provider/Facility: Artesian Place
Provider Type: Assisted Living Facility
License/Cert.#: 2542
Compliance Determination #: 58045
Intake ID: 159584
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 04/15/2025 through 04/29/2025
Complainant Contact Date(s):

Allegation(s):
1) Concern related to discharge.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident
Interviews:	Nursing staff Residents Identified resident Family members
Record Reviews:	State reporting log Facility policies Staff patterns

Investigation Summary:
1) Based on observation, interview, and record review the resident still resides in the facility and the concern is unable to be substantiated.

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

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 04/15/2025 and 04/18/2025 of:

Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

This document references the following complaint numbers: 159584.

The following sample was selected for review during the unannounced on-site visit: 7 of 54 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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.

Staci Dilg , IDR PM for Reg 3E
Residential Care Services

July 1, 2025
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-2305 Food sanitation. The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow and implement safe food handling and storing practices for 2 of 2 areas (dining room and kitchen) reviewed. These failures placed 54 of 54 residents at risk for food-borne illnesses from receiving improperly handled food.

Findings included...

Washington Administrative Code (WAC) 246-215-02310 "When to wash (FDA Food Code 2-301.14). FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) After handling soiled EQUIPMENT or UTENSILS; (6) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (7) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (8) Before donning gloves for working with READY-TO-EAT FOOD unless a glove change is not the result of contamination; and (9) After engaging in other activities that contaminate the hands or gloves."

WAC 246-215-03342 "Preventing contamination from equipment, utensils, and linens—Gloves, use limitation (FDA Food Code 3-304.15). (1) If used, SINGLE-USE gloves must be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when

interruptions occur in the operation."

WAC 246-215-03351 "Preventing contamination from the premises—Food storage (FDA 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 …"

Record review of the facility policy, "Infection Control Policy & Procedures", dated 04/18/2025, showed hands should be washed before and after touching the resident and immediately if hands were soiled. Hands should be washed after glove removal. Hand washing was the single most important measure to prevent the spread of infection and disease. All staff were responsible to carry out the hand washing policy. Staff would wash hands before and after they helped residents with personal care tasks, before they handled food, whenever they changed from doing a dirty task to a clean task, and dietary employees would wash hands at the kitchen sink upon reentry in the kitchen. The use of gloves did not replace hand washing.

Record review of the facility policy, "Sanitation and Food Storage", dated 04/18/2025, showed proper hand washing would be practiced. Food supplies would be wholesome and not adulterated. Food would be protected from contamination during storage. Record review of the facility policy, "Food Storage and Handling", dated 04/18/2025, showed food should be protected at all times from potential or real contamination. If food had been opened and remained in the original container it should be covered.

Dining Room

In an observation on 04/16/2025 at 12:14 PM, Staff K, Life Enrichment Coordinator, had been observed to pat Resident 7 [R7]'s back inside of the dining room. R7 had been observed to say they felt as if something had been stuck in the back of their throat. Staff K had been observed to touch R7's wheelchair. At 12:16 PM, Staff K left the area. At 12:18 PM, Staff K did not perform hand hygiene before they went to the mobile drink cart, poured drinks, and served them to other residents inside of the dining room. At 12:21 PM, Staff K had been observed to touch the back of a resident chair. At 12:24 PM, Staff K had been observed to touch a table as they talked to residents. At 12:30 PM, without performing hand hygiene they retrieved a knife and delivered it to a resident to use.

In an observation on 04/16/2025 at 12:24 PM, Staff M, Caregiver, had been observed to touch a resident's walker as they talked to residents inside of the dining room. Staff M went to another table with residents and touched the back of a chair with their hands. Without performing hand hygiene Staff M went to the mobile drink cart, poured drinks, and served them to residents.

Kitchen

In an observation on 04/16/2025 at 1:45 PM, the kitchen walk in freezer showed there was an opened to air package of over ten unknown light brown rectangular patties. There was an opened to air package of breaded chicken.

In an interview on 04/16/2025 at 4:15 PM, Staff I, Dietary Manager said it was not standard practice to have items opened to air inside of the kitchens walk in freezer.

In an observation on 04/17/2025 at 11:37 AM, Staff M, Caregiver had been observed to enter the kitchen, they were observed to perform hand hygiene and then donned (put on) a pair of gloves. Staff M said out loud that they forgot to put their hair net on. Staff M had been observed to retrieve a hair net from the wall's dispenser and with their gloved hands touched their hair and head to put on the hair net. Staff M acknowledged they were supposed to put the hair net on first before they performed hand hygiene. Staff M was not observed to doff (take off their gloves) and re-perform hand hygiene.

In an interview on 04/17/2025 at 11:38 AM, Staff I said the two items that were in the freezer that were open to air the day prior, were meat and chicken tenders. Staff I said that they had to throw away some of the contents in the packages because they got freezer burnt (discoloration or other damage caused to frozen food due to inadequate packing or storing conditions). Staff I reiterated that food items were not supposed to be opened to air and they were supposed to be properly sealed with the date of when the item had been opened. Staff I said the facility staff wore hair nets when they were in the kitchen. Staff I said staff were to put the hair net on and then wash their hands. Staff I said facility staff were supposed to wash their hands when they changed tasks or if they touched something that would cause cross contamination.

In an interview on 04/18/2025 at 1:03 PM, Staff G, Medication Aide, stated they were to wash their hands before and after resident care, before they put on gloves, and after they took off gloves.

This is a recurring deficiency previously cited on 05/13/2024, 09/06/2023, and 05/19/2023.

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)_____ .

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

Administrator (or Representative) _____ Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 1 of 1 areas within the building (Mechanical Storage Room). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean for 1 of 1 facility reviewed. These failures placed 54 of 54 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility, "Disclosure of Services Required by RCW [Revised Code of Washington] 18.20.300" dated, "03/2017", showed all assisted living facilities must maintain resident areas they may use in a safe, clean and comfortable condition.

Record review of the facility, "Infection Control Policy & Procedures", dated 04/18/2025, showed syringes and needles were sharp objects that posed the greatest risk to exposure. Immediately after use put them in a puncture resistant container. Do not bend, break, recap or remove the needle from the syringe. Containers should be sealed and discarded as directed when two-thirds to three-quarters full.

Record review of Stericycle's document titled, "Packaging Procedures for Reusable Containers and Corrugated Boxes", undated, showed generators (the facility staff) were responsible for packaging waste. Sharps materials must be placed in a puncture-resistant container designed for sharps waste. Sharps include needles, syringes, broken glass, scalpels, culture slides, culture dishes, broken capillary tubes, broken ridged plastic, and exposed ends of dental wires. All sharps containers should be properly closed before being placed into secondary containers.

In an observation on 04/15/2025 at 12:51 PM, on the wall under the stack of full red sharp containers that was on the ground was a poster that was titled, "packaging procedures for medical waste disposal", undated, showed the document was directions on how to use Stericycle's corrugated containers. The document showed the facility was to set up the box by turning it over and seal the bottom flaps with tape, then they were to line the inside of the box with red biohazard bag. Once the biohazard bag was full, the bag was to be tied and the box was to be closed and sealed shut with tape. The box would then be ready for the company to come and pick it up to dispose.

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 04/15/2025, showed 20 of 54 residents were labeled to have dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making). The roster showed Resident 9 [R9] moved into the facility on 01/30/2023.

Mechanical Storage Room

In an interview and observation on 04/15/2025 at 12:50 PM, on the second floor, Staff J, Maintenance Supervisor, approached the mechanical storage room door and stated

they hoped the door was unlocked as Staff J did not have a key to open the door. Staff J had been observed to turn the doorknob without a key and entered the room. Inside the room there were no staff members present. Across the room by the back door, there were five large full red sharp containers and one small square red sharp container that were stored on the ground. On top of the five sharp containers were four large full red sharp containers. There was a sign posted up on the wall three quarter up above the full sharps containers that were on the ground that showed, “please place full sharps containers in in this box, gently, thank you”. There was no box that was set up near the full sharp containers. Behind the full sharps containers on the ground were five boxes that were folded flat up against the wall with five large red biohazard bags that were draped over the flat boxes. Staff J stated when the company came to collect the sharps containers often times they had to wait on them to package the sharps containers.

In an observation on 04/17/2025 at 3:07 PM, on the second floor the mechanical room door was unlocked and opened without the use of a key. There were no staff members in the room. Across the room by the back door, there were five large full red sharp containers and one small square red sharp container that were stored on the ground. On top of the five sharp containers were four large full red sharp containers, a box with five new empty sharp containers, and a teal plastic bin full of new wrapped Band-Aids. The sign remained posted up on the wall that showed, “please place full sharps containers in in this box, gently, thank you”. There was no box that was set up near the full sharp containers. Behind the sharps containers were five boxes that were folded flat up against the wall with five large red biohazard bags that were draped over the flat boxes.

In an interview on 04/17/2025 at 1:35 PM, Staff F, Medication Aide, stated when the red sharps container on the medication cart was full, they were to close the container shut and dispose into a large red biohazard bag in a box that was in a locked room on the second floor.

In an interview on 04/17/2025 at 1:30 PM, Staff H, Resident Care Coordinator, stated the company that picked up the full sharp containers provided the boxes and the large red biohazard bags that go into the boxes to place the full sharp containers in. Staff H stated the facility was to ensure that the boxes were made and available for the staff to put the full sharps containers inside. Staff H stated the box was locked on the second floor in the mechanical storage closet that was to be locked at all times.

Exterior of the Facility

In an interview and observation on 04/15/2025 at 1:12 PM, the outside courtyard attached to the dining area had flower boxes attached to the wooden fence panels. One of the wooden flower boxes had the wood separating that caused seven nails to protrude out of the wood with the pointed part exposed. Multiple flower boxes did not have secure bottoms which left gaps in the wood and exposed nails. The two panels of the wooden fence by the east hallway exit door, the wooden flower boxes were missing. One of the panels had three rusty nails that were protruding from the frame of the fence. The other panel that had the flower box missing had ten rusty screws protruding from the bottom fence board. Staff J said they had approximately six flower boxes they needed to fix. Staff J said R9 and Resident 10 loved to garden and they were surprised they had not complained to them about the broken flower boxes.

In an observation on 04/18/2025 at 2:22 PM, outside in the courtyard that was outside

of the dining room, the fence had missing wooden flower boxes on the fence panels. The wooden flower box still had the wood separating that caused seven nails to protrude out of the wood with the pointed part exposed. The flower box did not have a secure bottom that left gaps in the wood. The two panels of the wooden fence by the east hallway exit door, the wooden flower boxes were missing. One of the panels had three rusty nails that were protruding from the frame of the fence. The other panel that had the flower box missing had ten rusty screws protruding from the bottom fence board.

In an interview on 04/18/2025 at 1:25 PM, R9 said the raised flower beds attached to the fence in the outside courtyard had been broken since before their time. R9 said they wanted to use the garden beds despite the safety concern of nails protruding out of them. R9 said they thought they could put cardboard on the bottom of the broken flower beds and plant around the nails. R9 said they liked gardening and wanted to make the space more beautiful.

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-2300 Food and nutrition services.

(1) The assisted living facility must:

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to record and retain documentation when a change to the original food menu occurred for 1 of 1 facility dining room. This failure placed all 54 of 54 residents at risk of not having their nutritional needs met.

Findings included...

Record review of “Assisted Living Facility Request for Documentation [Attachment B]”, dated “08/2024”, showed Attachment B requested that the administrator provided four

weeks of menus as served.

Record review of the facility, “Weekly Menu”, dated 03/23/2025 – 04/13/2025, showed no changes to the menu to review. On 04/16/2025 lunch showed there would be pineapple cheesecake for dessert.

In an interview on 04/15/2025 at 2:08 PM, Staff A, Administrator, said to their knowledge there had been no changes to the menu that they provided to review. Staff A said if a change to the menu occurred it would be documented on the daily whiteboard. Staff A said Staff I, Dietary Manager, would retain documentation to the menu if it was changed.

In an observation and interview on 04/16/2025 at 11:57 AM, the whiteboard outside of the dining room showed there had been nothing written on it. Staff L, Caregiver said normally the facility staff wrote what was going to be served on the whiteboard. Staff L wrote for lunch dessert would be a chocolate chip cookie.

In an observation and record review on 04/18/2024 at 12:18 PM, showed on the facility menu that was posted up on the wall showed lunch that was to be served was green salad, Greek lemon chicken, seasoned brown rice, spinach and tomatoes, baked roll, and fruit pizza. On the white board that was written by the facility kitchen staff showed the dessert for lunch was pudding and not the fruit pizza. When observed on the table that the residents were served showed they got a small bowl of creamy brown substance that residents stated was chocolate pudding. The menu that was posted showed the residents were to be served vegetable rice soup, chicken herb potato casserole, chefs steamed vegetables, baked cheddar roll, and select apple salad. On the white board that was written by the facility staff showed the resident would be served borscht soup, grilled steak salad, pears, French bread, and chocolate chip cookie. The menus that were provided did not reflect these changes.

In an interview on 04/16/2025 at 3:01 PM, Resident 11 [R11] confirmed that the dessert for lunch was a chocolate chip cookie. R11 said changes to the menu happened often.

In an interview on 04/17/2025 at 11:40 AM, Staff I confirmed there had been a change to the menu on 04/16/2025 and noted that instead of cheesecake for dessert residents were served a chocolate chip cookie. Staff I could not speak to how often changes in the menu occurred. Staff I said that desserts and side dishes were the main items on the menu that were changed. Staff I stated they did not have documentation to provide to show when changes to the menu occurred.

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-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 1 sampled staff (Staff A) had completed character, competence, and suitability (CCS) forms to review. Failure to ensure all CCS's were completed placed all 54 of 54 residents as risk of being cared for by a staff member with a potentially disqualifying history.

Findings included...

Washington Administrative Code (WAC) 388-113-0060 "(1) The department or an authorized entity must conduct a character, competence, and suitability determination of an employee, prospective employee, or other individual who is required to undergo a background check when the applicant has received a "review required" result as defined in WAC 388-113-0101(b).
(2) If the department or an authorized entity is required to conduct a character, competence, and suitability determination under this section, the person or entity responsible must document in writing the following information:
(a) Reason for the decision;
(b) Whether or not the applicant may have unsupervised access to minors and vulnerable adults;
(c) The date the character, competence, and suitability determination was completed; and
(d) The name and signature of the person or persons who performed the determination.
(3) If an applicant is required to have a character, competence, and suitability determination under this section, the applicant may not have unsupervised access to minors or vulnerable adults unless the character, competence, and suitability determination has:

(a) Been completed and documented in writing.
(b) Concluded the applicant may have unsupervised access to minors or vulnerable adults.
(4) A character, competence, and suitability determination may not be conducted if an applicant has an automatically disqualifying conviction or pending charge under WAC 388-113-0020 or has an automatically disqualifying negative action under WAC 388-113-0030."

Record review of the facility, "Employee HR (Human Resources) List", undated, showed Staff A, Administrator, was hired at the facility on 06/12/2020.

Record review of Staff A's, Notification of Background Check Result, dated 06/11/2021, showed Staff A's interim fingerprint required a CCS.

Record review of Staff A's, RCS Character, Competence, and Suitability Determination for Unsupervised Access to Minors and Vulnerable Adults, dated 06/22/2021, showed it was completed eleven days after Staff A's interim fingerprint was completed.

Record review of Staff A's, Notification of Background Check Result, dated 06/08/2023, showed Staff A's Washington state name and date of birth background check required a CCS.

Record review of Staff A's, RCS Character, Competence, and Suitability Determination for Unsupervised Access to Minors and Vulnerable Adults, dated 06/15/2023, showed it was completed by Staff N, Office Manager, 7 days after Staff A's Washington state name and date of birth background check result was completed.

Record review of Staff A's, Final Fingerprint Notification of Background Check Result, dated 07/09/2021, showed Staff A required a CCS.

Record review on 04/16/2025 at 10:00 AM, showed there was no CCS to review for Staff A's final fingerprint notification of background check dated 07/09/2021.

In an interview on 04/16/2025 at 10:19 AM, Staff A said Staff N was the facility staff member responsible for completed CCS.

In an observation and interview on 04/16/2025 at 10:29 AM, Staff N said if an interim background check needed a CCS then it would be completed immediately. Staff N observed Staff A's Washington state name and date of birth background check dated 06/08/2023 and Staff A's CCS they completed on 06/15/2023. Staff N said they could not speak to why there was a seven day delay in the CCS being completed.

In an interview on 04/16/2025 at 11:39 AM, Staff N said Staff A did not have a CCS to provide for review after Staff A's final fingerprint background check dated 07/09/2021 was completed. Staff N said they were trained that if the information from the interim fingerprint to the final fingerprint had not changed then a CCS was not required to be completed.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 6 of 6 sampled Staff (Staff C, Staff F, Staff D, Staff E, Staff G, and Staff L) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) by a qualified person. The facility failed to ensure that 1 of 5 sampled staff (Staff E) received their tuberculosis test within the required time frames. These failures placed 58 of 58 residents and staff at risk for exposure to TB.

Findings included…

Record review of the Washington State Department of Health document 343-243 titled, “who may administer, read and interpret a tuberculin [liquid used to test for TB] skin test (TST) in Washington State”, dated “April 2025”, showed certified and registered nursing assistants and health care aides were not allowed to administer TST, interpret the TST, and were not allowed to read a TST result unless they were delegated by Registered nurse or medical provider that was not a licensed practical nurse.

Record review of the facility policy titled, “Tuberculosis Testing policy and procedure [Washington]”, dated 04/18/2025, showed the facility was committed to ensuring the health and safety of all residents and staff. To comply with state regulations, each staff person must be screened for TB within three days of employment.

Record review of Staff A’s, Administrator, Washington Department of Health credential verification, dated 07/02/2024, showed Staff A had credentials as a nursing assistance certification.

Record review of the facility's document, "employee HR [human resources] list", undated, showed Staff E, Medication Aide, started employment at the facility on 10/24/2024.

Record review of Staff E's "TB test by mantaux (also known as a skin test for TB) Method", undated, showed Staff E's step one TB test was given on 10/24/2024 and was read on 10/28/2024, that was past the 48-to-72-hour requirement. Review of the document showed there was no documentation to show who gave Staff E their step one and step two TB skin test. The document showed Staff E's step one and step two skin test was read by Staff A.

Record review of Staff C's "TB test by mantaux method", undated, showed Staff C's step one was administered on 01/16/2025 and step two was administered on 01/28/2024. There was no name or signature that showed who had administered the TB skin test. Staff C's step one test was read on 01/19/2025 and step two test was read on 01/31/2025. Staff C's step one and step two were read by the same person that was unable to be read, as the signature that was on the document was illegible.

Record review of Staff F's "TB test by mantaux method", undated, showed Staff F's step one was administered on 06/15/2022 and step two was administered on 06/29/2022. There was no name or signature that showed who had administered the TB skin test. Staff F's step one test was read on 06/17/2022 and step two test was read on 07/01/2022. Staff F's step one and step two were both read by the same person that was unable to be read as the signature that was on the document was illegible.

Record review of Staff G's "TB test by mantaux method", undated, showed Staff G's step one was administered on 06/03/2022 and step two was administered on 06/24/2022. There was no name or signature that showed who had administered the TB skin test. Staff G's step one test was read on 06/07/2022 and step two test was read on 06/27/2022. Staff G's step one and step two were both read by the same person that was unable to be read, as the signature that was on the document was illegible.

Record review of Staff D's "TB test by mantaux method", undated, showed Staff D's step one was administered on 10/07/2024 and step two was administered on 10/21/2024. There was no name or signature that showed who had administered the TB skin test. Staff D's step one test was read on 10/10/2024 and step two test was read on 10/24/2024. Staff F's step one and step two were both read by Staff A.

Record review of Staff L's "TB test by mantaux method", undated, showed Staff L's step one was administered on 03/18/2024 and step two was administered on 03/25/2024. There was no name or signature that showed who had administered the TB skin test. Staff L's step one test was read on 03/18/2024 and step two test was read on 03/28/2024. Staff L's step one and step two were both read by Staff A.

In an interview and record review on 04/14/2025 at 2:57 PM, Staff A stated the facility registered nurse administered the staffs TB skin tests. Staff A stated the residents nurse would have a zoom computer video call with the staff member that would show the registered nurse their arm to read the TB skin test. Staff A stated the would sign off on the TB test the results after the zoom call with the registered nurse. Staff A stated the signature by TB skin test read was their own signature for Staff C, Staff F, Staff D, Staff G, and Staff E's TB test documents.

In an interview on 04/18/2025 at 11:52 AM, Anonymous 2 (A2), facility staff member, stated Staff A and Staff H, Resident Care Coordinator, had looked at their arm where the TB skin test was administered for any bump. A2 stated they did not have a computer video call with the registered nurse to have their TB skin test read.

In an interview on 04/18/2025 at 1:32 PM, Anonymous 1 (A1), facility staff member, stated Staff A and Staff H had looked at their arm together to read their TB skin test. A1 stated they did not have a computer screen video call with any nurse to show them their arm to read the TB skin test.

In an interview on 04/18/2025 at 3:30 PM, Staff A acknowledged that the employee TB's skin test showed Staff A read the TB skin tests and no documentation who administered the employees TB skin test.

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-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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 3 of 3 sampled pets (Resident 12 [R12]'s pet, Resident 13 [R13]'s pet, and Resident 14's [R14] pet) had regular examinations and were certified by a veterinarian to be free of diseases transmittable to humans. This failure placed 54 of 54 residents and 35 staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility policy, "Resident Pets", dated 05/05/2024, showed a signed copy of the pet agreement would become an attachment to the resident agreement.

Record review of the facility, “Pet Agreement”, undated, showed the following pet agreement and statement of policy had been established for the protection and benefit of all residents of the community. Resident responsibilities included care and well being of the pet which entailed medical care such as vaccinations and routine veterinary visits.

Record review of R13’s pet document titled, “[pets name] vaccine history”, undated, showed R13’s pet received vaccinations on 02/25/2025. The document did not show how long the vaccination was good for and when R13’s pets last vet examination was completed that showed the pet was free of diseases transmittable to humans.

Record review of R12’s pet document titled, “vaccination certificate”, undated, showed R12’s pet last vaccinations were completed on 04/16/2025. There was no documentation for R12’’s pet that showed the pet was free of disease transmittable to humans.

Record review of R14’s pet document titled, “preventative care history report”, dated 08/28/2024, showed R14’s pet had vaccinations that were due on 03/13/2025. There was no documentation on the record that showed when R14’s last pet vet examination was completed to show that R14’s pet was free of diseases transmittable to humans.

In an observation and interview on 04/15/2025 at 12:44 PM, Resident 12’s apartment door had a sign that said there was a kitten in their room. Staff J, Maintenance Supervisor, said that pets resided in the community.

In an interview on 04/17/2025 at 12:48 PM, Staff N, Office Manager, said they were not responsible for the upkeep of resident pet records. Staff N said if a resident’s pet’s record were about to expire Staff A, Administrator, was the person who followed up with the resident.

In an interview on 04/17/2025 at 1:48 PM, Staff A, said Staff N had a tracker system and they were the person responsible to ensure resident pets had yearly wellness examinations and updated vaccinations.

As of 04/21/2025 at 6:00 PM, the facility did not provide any further documentation that showed R12, R13, and R14’s pet’s were up to date with current vaccinations and when their last vet examinations were completed for review.

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)_____ .

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.

(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:

(a) Orientation and safety;

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review the facility to ensure 1 of 4 staff (Staff A) completed their facility orientation training and 1 of 2 staff (Staff F) completed their continued education. These failures placed all 54 of 54 residents at risk for being improperly cared for by untrained staff.

Findings included...

Washington Administrative Code (WAC) 388-112A-0200 “What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.”

WAC 388-112A-0210 “What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use

of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor.”

WAC 388-112A-0611 “Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are

required, and when must they be completed? (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (i) A certified home care aide; (iii) A certified nursing assistant; (b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC."

WAC 246-980-110 Continuing education. "(1) A home care aide must demonstrate completion of twelve hours of continuing education per year as required by RCW 74.39A.341. The required continuing education must be obtained during the period between renewals. Continuing education is subject to the provisions of chapter 246-12 WAC, Part 7. (2) Verification of completion of the continuing education requirement is due upon renewal. If the first renewal period is less than a full year from the date of certification, no continuing education will be due for the first renewal period." Record review of the facility, "Employee HR (Human Resources) List", undated, showed Staff A, Administrator, was hired on 06/12/2020 and Staff F, Medication Aide, was hired on 05/24/2022 and their birthday was on March 14th.

Facility Orientation

Staff A

Record request on 04/16/2025 at 12:50 PM, showed Staff A's facility orientation had been requested for review.

Record review of an email on 04/16/2025 at 2:52 PM, showed Staff N, Office Manager, said they attached the requested documents that they had to review. Staff A's facility orientation had not been attached to review.

Continued Education

Staff F

Record request on 04/15/2025 at 2:26 PM, Staff F's continued education from 03/14/2024 – 03/14/2025 were requested for review.

Record review of Staff F's continued education showed they had 11 of 12 hours completed within the time period of 03/14/2024 – 03/14/2025.

In an interview on 04/17/2025 at 12:48 PM, Staff N said they were the person responsible for the upkeep of facility staff records.

In an interview on 04/18/2025 at 3:00 PM, Staff A, said Staff N had been the facility staff member who tracked staff members' continued education. Staff A said Staff N would send out trainings and reminders to the staff. Staff A expressed understanding they had until 04/21/2025 to submit Staff F's continued education credits for review.

As of 04/21/2025 at 5:00 PM, the Department had not received any more continued education credits for Staff F to review.

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)_____ .

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

Administrator (or Representative) Date

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

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the resident's service agreements (facility's version of the negotiated service agreement) was signed for 3 of 7 sampled residents (Resident 5 [R5], Resident 6 [R6], and Resident 7 [R7]). This failure placed R5, R6, and R7 at risk for unmet care and service needs.

Findings included...

Record review of the facility policy, "Service Agreement Policy", dated 04/18/2025, showed service agreements would include the date, services needed and to be provided, resident requests and preferences. Participants would sign the agreement, and it would be kept in the resident's record. Service agreements would be completed quarterly. If a resident service agreement was revised and updated at the quarterly review, changes must be dated and initialed and prior historical information must be maintained. The service agreement would be signed by the resident or resident representative, administrator, director of nursing services, and if appropriate case manager.

R5

Record review of R5's untitled and undated document that was R5's face sheet showed R5 moved into the facility on [redacted]/2023.

Record review of R5's, "Service Agreement", dated 03/13/2024, showed the document was not signed by R5, the Nurse/Resident Care Coordinator, the Case manager, or the

Administrator.

Record review of R5's, "Service Agreement", dated 12/13/2024, showed it was signed by R5, Staff A, Administrator, and Staff H, Resident Care Coordinator.

R6

Record review of R6's untitled and undated document that was R6's face sheet, showed R6 moved into the facility on [redacted]/2024.

Record review of R6's "Service Agreement", dated 01/10/2025, titled, "initial evaluation", showed it was not signed or dated by the resident or the resident representative.

Record review of R6's "Service Agreement", dated 01/24/2025, titled, "14 day eval", showed it was not signed or dated by the resident or the resident representative.

Record review of R6's "Service Agreement", dated 02/07/2025, titled, "30 day eval", showed it was not signed or dated by the resident or the resident representative.

Record review of R6's "Service Agreement", dated 01/10/2025, titled, "initial evaluation", showed it was not signed or dated by the resident or the resident representative.

R7

Record review of R7's untitled and undated document that was R7's face sheet showed R7 moved into the facility on [redacted]/2024.

Record review of R7's, "Service Agreement", dated 05/20/2024, showed the document was not signed by R7, the Nurse/Resident Care Coordinator, the Case manager, or the Administrator.

Record review of R7's, "Service Agreement", dated 03/09/2025, showed it was signed by R7, Staff A, and Staff H.

In an interview on 04/18/2025 at 2:45 PM, Staff A and Staff N said service agreements were signed at the time they were updated, which was on a quarterly basis. Staff N said the signature on the service agreement represented everyone's agreement to the reflected changes.

In an interview on 04/18/2025 at 3:30 PM, Staff H, Resident Care Coordinator, stated resident service agreements were signed by the facility and the resident or the resident representative every time they were completed. Staff H stated it the residents service plans were completed upon admission as the initial, then 14 days, then 30 days, and then quarterly.

As of 04/21/2025 at 6:00 PM, the facility did not provide any further documentation for R5, R6, and R7 for review.

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)_____ .

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

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

(c) Ensure the staff person performing the ongoing assessments is qualified to perform them.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure that clinical assessments for assistive devices and medication assessments were completed by a qualified assessor for 5 of 7 sampled residents (Resident 3 [R3], Resident 5 [R5], Resident 4 [R4], Resident 7 [R7], and Resident 2 [R2]) annually. This failure placed the residents at risk of unmet care needs and staff not having the most updated and accurate care and services the resident required.

Findings included...

Washington Administrative Code (WAC) 388-78A-2080 “Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident: (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied

field and three years social service experience working with adults who have functional or cognitive disabilities; or (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or (4) Is a physician with a valid state license to practice medicine; or (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living".

"WAC 246-980-140 Scope of practice for long-term care workers. (1) A long-term care worker performs activities of daily living or activities of daily living and instrumental activities of daily living. A person performing only instrumental activities of daily living is not acting under the long-term care worker scope of practice. (a) "Activities of daily living" means self-care abilities related to personal care such as bathing, eating, medication assistance, using the toilet, dressing, and transfer. This may include fall prevention, skin and body care. (b) "Instrumental activities of daily living" means activities in the home and community including cooking, shopping, house cleaning, doing laundry, working, and managing personal finances. (2) A long-term care worker documents observations and tasks completed, as well as communicates observations. (3) A long-term care worker may perform medication assistance as described in chapter 246-888 WAC. (4) A long-term care worker may perform nurse delegated tasks, to include medication administration, if he or she meets and follows the requirements in WAC 246-980-130. (5) A long-term care worker may provide skills acquisition training on instrumental activities of daily living and the following activities of daily living tasks: Dressing, application of deodorant, washing hands and face, hair washing, hair combing and styling, application of makeup, menses care, shaving with an electric razor, tooth brushing or denture care, and bathing tasks excluding any transfers in or out of the bathing area. (6) This section applies to all long-term care workers, whether required to be certified or exempt."

"WAC 246-840-700 Standards of nursing conduct or practice.
(2) The nursing process is defined as a systematic problem solving approach to nursing care which has the goal of facilitating an optimal level of functioning and health for the client, recognizing diversity. It consists of a series of phases: Assessment and planning, intervention and evaluation with each phase building upon the preceding phases. (a) Registered Nurse: (b) Licensed Practical Nurse: Minimum standards for registered nurses include the following: Minimum standards for licensed practical nurses include the following: (i) Standard I Initiating the Nursing Process: (i) Standard I - Implementing the Nursing Process: The practical nurse assists in implementing the nursing process; (A) Assessment and Analysis: The registered nurse initiates data collection and analysis that includes pertinent objective and subjective data regarding the health status of the clients. The registered nurse is responsible for ongoing client assessment, including assimilation of data gathered from licensed practical nurses and other members of the health care team; (A) Assessment: The licensed practical nurse makes basic observations, gathers data and assists in identification of needs and problems relevant to the clients, collects specific data as directed, and, communicates outcomes of the data collection process in a timely fashion to the appropriate supervising person; (B) Nursing Diagnosis/ Problem Identification: The registered nurse uses client data and nursing scientific principles to develop nursing diagnosis and to identify client problems in order to deliver effective nursing care; (B) Nursing Diagnosis/ Problem Identification: The licensed practical nurse provides data to assist in the development of nursing

diagnoses which are central to the plan of care"

Record review of the Washington Health Care Association article titled, "Who Can Conduct Resident Assessments in Assisted Living?", dated 05/23/2023, showed topics that would warrant a Registered Nurses assessment included diabetic management that may include enhanced oversight of the condition. Residents who need nursing services would need a nursing assessment that focused on the residents conditions that warrant nursing care and could only be conducted by the registered nurse (RN). The Washington state nurse practice act outlines the differing roles and responsibilities of the RN and the licensed practical nurse (LPN). The LPN could make observations, gather data, and provide relevant information as part of a nursing assessment while the RN is responsible to conduct the nursing assessment. Topics that warrant a RN's assessment include medication administration to ensure the resident can perform the final step of medication self-administration or not, administration of health treatments that requires consideration of tasks that a licensed nurse to complete, and diabetic management.

Record review of the facility policy, "Service Agreement Policy", dated 04/18/2025, showed service agreements would include the date, services needed and be provided, resident requests and preferences. Service agreements would be completed quarterly. If a resident service agreement was revised and updated at the quarterly review, changes must be dated and initialed and prior historical information must be maintained. The service agreement would be signed by the resident or resident representative, administrator, director of nursing services, and if appropriate case manager. Quarterly review of service agreements would include the administrator, RN (registered nurse), care staff members, resident, resident family and case worker.

Record review of an email sent to the Department on 04/16/2025 at 2:19 PM, showed Staff A, Administrator, said they did initial full assessments prior to admission, at 14 and 30 days, and then when it was time to update the assessments the service agreements were one in the same.

Record review of State of Washington Department of Health credential verification, dated 04/18/2025, showed Staff H, Resident Care Coordinator, had credentials as Nursing Assistant Certification since 07/15/2015.

In an interview on 04/16/2025 at 4:30 PM, Staff A stated the facility assessments were the same document as the resident's service agreements that were titled, service agreements.

R3

Record review of R3's untitled and undated document that was R3's face sheet showed R3 moved into the facility on [redacted]/2023. R3 had a diagnosis of being a [redacted].

Record review of R3's, "Service Agreement", dated 02/19/2025, showed R3 was an insulin dependent diabetic. R3 was now self medicating, and they poked their own finger and injected their own insulin. The document was signed by R3, Staff H, Resident Care Coordinator, and Staff A, Administrator. The document was not signed by the facility nurse.

Record review of "Medication Self-Administration Evaluation", dated 01/27/2025, showed under prospective resident there had been a name blacked out. There was not another resident name written to review. The resident had been determined cable to safely self-administer their medications. The document was signed by Staff H.

In an interview on 04/18/2025 at 1:13 PM, Staff G said when R3 first admitted into the facility the facility provided them with all their medications. Staff G said R3 did not like the facility staff providing them their medications, a self-medication assessment had been completed, and R3 had been assessed to be able to self-administer their own medication. Staff G said Staff H was the person who completed R3's self-administration medication assessment. Staff G said to their knowledge Staff P, Registered Nurse, would be involved and Staff P usually participated via zoom (videoconferencing application).

R5

Record review of R5's untitled and undated document that was R5's face sheet showed R5 moved into the facility on [redacted]/2023. R5's medical history showed 5 had a diagnosis of [redacted].

Record review of R5's, "Service Agreement", dated 12/13/2024, showed R5's short term memory had been fair and their long-term memory had been good. The medical care management section showed on all shifts the facility staff assisted R5 with their medications as ordered. The facility staff stored, ordered, and reordered R5's medication. The document was signed by R5, Staff A, and Staff H. The document was not signed by the facility nurse.

Record review of R5's, "Assessment Details", dated 06/21/2024, showed it was the current annual assessment from Department of Social and Health Services, and under the medication management section it showed R5 was supposed to be administered their medication. The facility was to document medication taken, hand R5 their medication, put medication in a lockbox, and remind R5 to take their medications. R5's limitations included they forgot to take their medications, did not follow frequency or dosage, unaware of dosages, they had a complex regimen.

Record review of R5's MAR (Medication Administration Record), dated 04/01/2025 – 04/16/2025, showed R5 had a PRN (as needed) order to inhale one vial by nebulizer (a machine that converted liquid medication into mist which made it easy to inhale) every four hours as needed.

In an interview and observation on 04/18/2025 at 12:38 PM, R5 said the facility provided them with their medications. On R5's bedside table was a nebulizer, R5 said they thought they used the nebulizer four times a day. R5 said they independently completed their nebulizer treatments but the facility staff helped them add the vial when needed.

In an interview on 04/18/2025 at 12:21 PM, Staff O, Lead Medication Aide, said R5 had been more forgetful recently. Staff O said R5 had an appointment the day prior and R5 did not remember they had their appointment.

In an interview on 04/18/2025 at 1:13 PM, Staff G, Medication Aide, confirmed the facility provided R5 their medications. Staff G said R5 had a nebulizer on their bedside

table. Staff G said the facility staff added the vials because of R5's poor eyesight. Staff G pulled up R5's MAR and confirmed R5 used their nebulizer four times a day.

In an interview on 04/18/2025 at 2:54 PM, Staff A, Administrator, said R5 had been forgetful lately. Staff H said R5 had been a poor historian.

R4

Record review of R4's untitled and undated document that was R4's face sheet, showed R4 moved into the facility on [redacted]/2025.

Record review of R4's service agreement, dated 04/08/2025, showed R4 took too many medication to remember them all and when to take the medications. Staff were to assist R4 with administering their medications per physician orders. Staff were to assist R4 with the prescribed inhalers and nebulizers as needed. There was no documentation that R4 was allowed to have medications in their room.

Record review of R4's medication evaluation, dated 04/08/2025, showed R4 was assessed needing staff to assist with administering all medications. The medication evaluation was signed and dated by Staff H on the line that was labeled "admin/nurse signature".

Record review of R4's pharmacy prescription label, dated 04/16/2025, showed R4 got a new medication SSD (silver sulfadiazine- prescribed medicated cream to prevent and treat bacterial or fungal infections) to apply externally to the affected area daily.

Record review of R4's "medication self-administration evaluation", dated 04/18/2025, showed R4 was assessed, observed, and documented that R4 was safe to self-administer the medication. The document was signed and dated by Staff H on 04/18/2025.

In an interview on 04/18/2025 at 11:52 AM, Staff G, Medication Aide, stated R4 had just gotten a new prescribed medicated cream for their vaginal area today 04/18/2025. Staff G stated Staff H observed and assessed R4 putting on the medicated cream and cleared R4 to apply the medicated cream independently.

In an interview on 04/18/2025 at 3:03 PM, Staff H stated they had just received the new medicated cream from R4 that morning. Staff H stated they completed the medication assessment on R4 applying the cream that morning 04/18/2025.

R7

Record review of R7's untitled and undated document that was R7's face sheet showed R7 moved into the facility on [redacted]/2024. R7 had a diagnosis of [redacted].

Record review of R7's, "Service Agreement", dated 03/09/2025, showed R7 preferred to have staff help with their medication due to their eyesight. Medication would be ordered through the house pharmacy and stored on medication carts. The facility staff administered all medications per the medical doctors orders. The service agreement was signed by R7, Staff A, and Staff H. The document was not signed by the facility nurse.

Record review of "Medication Self-Administration Evaluation", dated 03/09/2025, showed under prospective resident there had been a name blacked out. There was not another resident name written to review. The resident had been determined cable to safely self-administer their medications. The document was signed by Staff H.

In an interview on 04/18/2025 at 12:21 PM, Staff O said the facility staff provided R7 their medication. Staff O said the facility staff ordered and stored R7's medication for them.

In an interview on 04/18/2025 at 1:13 PM, Staff G said the facility staff ordered and provided some of R7 their medication and R7 stored and administered some of their medications themselves. Staff G said R7's family helped them obtain their over-the-counter medications that they took.

R2

Record review of R2's untitled and undated document that was R2's face sheet, showed R2 moved into the facility on [redacted]/2023 and showed R2 currently used oxygen, gets easily tired, frequently falls, and requires staff assistance.

Record review of R2's equipment evaluation, dated 02/12/2025, showed R2 had a bed cane on the left side of their bed. Under the section titled, "support for safety", there was only documentation about the bed cane being secured to the bed and condition. There was no documentation on how the resident used the bed cane and if they used it in a safe manor. The evaluation was completed, signed, and dated by Staff H.

In an interview on 04/17/2025 at 2:57 PM, Staff A and Staff H confirmed that they signed R2's resident service agreement dated 02/19/2025. Staff A and Staff H confirmed that they signed R3's resident service agreement dated 12/13/2024. Staff A and Staff H confirmed that they signed R7's resident service agreement dated 03/09/2025. Staff H said the master copy of the medication self-administration evaluation had a resident's name on it, which is why the document has a name blacked out. Staff H said they should have written R7's name on the document but they confirmed that they signed R7's medication self-administration evaluation dated 03/09/2025.

In an interview on 04/18/2025 at 2:46 PM, Staff H stated they completed medication evaluation assessment, self-medication evaluation, fall, elopement, dementia, if they smoked, if they used any specialty adaptive equipment, general risk agreement, motorized electric wheelchairs, and health assessment for the residents. Staff H stated they had their nursing assistant certification. Staff H stated the signatures on the resident's service agreements were the signatures of the staff members that completed the assessment/service plan.

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)_____ .

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

Administrator (or Representative) 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:

(ii) The resident's full assessments;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to have the Resident Service Plans (facility's version of the Negotiated Service Agreements) show the care and services necessary to meet the residents needs for 5 of 7 sampled residents (Resident 2 [R2], Resident 6 [R6], Resident 3 [R3], Resident 5 [R5], and Resident 7 [R7]). This failure placed the residents at risk for unmet care needs and care and services not being provided per the negotiated service agreements.

Findings included...

Record review of the facility policy, "Service Agreement Policy", dated 04/18/2025, showed service agreements would include the date, services needed and be provided, resident requests and preferences. If a resident service agreement was revised and updated the changes must be dated and initialed and prior historical information must be maintained. The assistance required section showed the area would include assistance that contractually would be performed by the family to ensure it was understood who was responsible. There must include a written description of who would provide the services, what, when, how, and how often services would be provided. A quarterly review of service agreements would include the administrator, RN (registered nurse), care staff members, resident, resident family and case worker and the document would be signed.

R2

Record review of R2's untitled and undated document that was R2's face sheet, showed R2 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of an investigation for R2, dated 03/08/2025 at 5:57 AM, showed R2 was found on the ground in their room. R2 told the medication aide that they were trying to change their clothes and was unable to get back to their bed before they fell. Under the section titled, "what action will be taken to reduce the possibility of incident recurring?", showed staff were to encourage R2 to be seated while dressing themselves.

Record review of an investigation for R2, dated 04/04/2025 at 3:13 AM, showed R2 was found on the ground by the doorway in their bedroom. R2 told the medication aide that they their feet got tangled in their blankets. Under the section titled, "what action will be taken to reduce the possibility of incident recurring?", showed staff were to encourage R2 to remove blankets from their feet and legs before they got out of bed.

Record review of an investigation for R2, dated 04/05/2025 at 10:16 PM, showed R2 was found on the ground in front of the toilet in their bathroom. R2 told the medication aide that they missed the toilet when they were sitting down and fell on their buttocks. Under the section titled, "what action will be taken to reduce the possibility of incident recurring?", showed R2 had a toilet seat riser with handles was ordered and when it arrived at the facility it was to be placed on R2's toilet to help minimize R2's risk of falls.

Record review of an investigation for R2, dated 04/13/2025 at 11:10 PM, showed R2 was found on the ground on their left side with their walker on its side in front of them. R2 told the caregiver that that were walking to the bathroom when they tripped over their robe and fell on their back on the ground. Under the section titled, "what action will be taken to reduce the possibility of incident recurring?", showed staff were to encourage R2 to secure loose clothing when they transferred.

Record review of R2's Service Agreement, dated 02/12/2025, showed that it was a quarterly update and was provided as the working care plan. Under the section titled, "dressing", showed R2 was able to dress themselves for the day. R2 picked out their clothing appropriate for the season and comfort. R2 would call staff for assistance as

needed. R2 had a fall when they stepped backwards and tripped on their long night gown. There was nothing in this section about the staff needing to encourage R2 to remain seated while dressing themselves per the incident that occurred on 03/08/2025. There was nothing documented about staff to encourage R2 to secure loose clothing when they transfer. Under the section titled, “toileting”, showed R2 was continent of bowel and bladder. Staff needed to provide standby assistance with transfers. R2 was able to perform proper peri care. Grippy material was added onto the grab bars in the bathroom to assist R2’s hands from slipping off when they used the grab bar to get on and off the toilet. Staff were to encourage R2 to call for assistance when needed to use the bathroom, encourage R2 to wipe toilet seat dry after using the bathroom, and encourage R2 to have staff assist with adjusting R2’s brief. There was nothing in this section or the service plan about staff to encourage R2 to secure loose clothing when R2 transferred or that there was a toilet seat riser that was ordered and to be placed on the toilet to help minimize the risk of falls for R2. Under the section titled, “transfers”, showed R2 was able to stand, bear weight, and complete a pivot transfer with their walker. R2 used a bed cane on their bed to help get in and out of their bed safely. Staff were to encourage R2 to place their feet underneath them before transferring, ensure brakes were on, before they transferred with their walker, and encouraged R2 to call staff for assistance with transfers. There was nothing in the section or the service agreement about staff to encourage R2 to remove blankets from feet and legs before they got out of bed.

R6

Record review of R6’s untitled and undated document that was R6’s face sheet, showed R6 moved into the facility on [redacted]/2024.

Record review of R6’s Service Agreement, dated 02/07/2025, showed under the section titled “housekeeping and laundry”, showed R6 was not able to make their bed, but their spouse was able and willing to make the bed.

In an interview on 04/16/2025 at 2:18 PM, R6 stated their spouse passed away ten days prior and it was just them selves living in the apartment.

R3

Record review of R3’s untitled and undated document that was R3’s face sheet showed R3 moved into the facility on [redacted]/2023. R3 had a diagnosis of being a [redacted].

Record review of R3’s, “Service Agreement”, dated 02/19/2025, that was the working care plan labeled, “30 Day Eval (evaluation)”, showed changes to the service agreement included that R3’s family no longer provided R3 transportation to and from appointments and the facility staff assisted to make and coordinate transportation to R3’s appointments. The appointments and transportation section showed R3 could get in and out of a vehicle with set up or standby assistance. The medical care section showed R3 had home health.

Record review of R3’s, “Investigation”, dated 03/30/2025, showed R3 was found on the floor next to their driver’s side car door with their walker in front of them.

In an interview on 04/18/2025 at 12:21 PM, Staff O, Lead Medication Aide, said they were unsure if R3 was on home health services. Staff O said to their knowledge R3 left the facility to attend their appointments.

In an interview on 04/18/2025 at 1:13 PM, Staff G, Medication Aide, said they were unsure if R3 was on home health services.

In an interview on 04/18/2025 at 2:39 PM, Staff A, Administrator, said R3 used to be on home health services until R3's medical provider allowed R3 to drive again. Staff A said R3 had been discharged from home health because they were able to drive themselves to outpatient physical therapy. Staff A said R3 kept their car at the facility and drove.

Record review of R3's, "Service Agreement", dated 02/19/2025, that was the working care plan labeled, "30 Day Eval", showed no updated information that R3 had been approved to drive their car, their car resided at the facility, and information about R3's outpatient physical therapy.

R5

Record review of R5's untitled and undated document that was R5's face sheet showed R5 moved into the facility on [redacted]/2023. R5's medical history showed R5 had a diagnosis of [redacted].

Record review of R5's, "Service Agreement", dated 12/13/2024, that was the working care plan labeled, "Quarterly Update", showed R5's vison was adequate with correction, R5 used glasses, and read better with larger sized font. R5's short term memory had been fair, and their long-term memory had been good. The medical care management section showed on all shifts the facility staff assisted R5 with their medications as ordered. The facility staff stored, ordered, and reordered R5's medication.

Record review of R5's, "Assessment Details", dated 06/21/2024, showed it was the current annual assessment from Department of Social and Health Services, and under the medication management section it showed R5 was supposed to be administered their medication. The facility was to document medication taken, hand R5 their medication, put medication in a lockbox, and remind R5 to take their medications. R5's limitations included they forgot to take their medications, did not follow frequency or dosage, unaware of dosages, they had a complex regimen.

Record review of R5's MAR (Medication Administration Record), dated 04/01/2025 – 04/16/2025, showed R5 had a PRN (as needed) order to inhale one vial by nebulizer (a machine that converted liquid medication into mist which made it easy to inhale) every four hours as needed.

In an interview and observation on 04/18/2025 at 12:38 PM, R5 said the facility provided them with their medications. On R5's bedside table was a nebulizer, R5 said they thought they used the nebulizer four times a day. R4 said they independently completed their nebulizer treatments but the facility staff helped them add the vial when needed.

In an interview on 04/18/2025 at 12:21 PM, Staff O, Lead Medication Aide, said R5 had been more forgetful recently. Staff O said R5 had an appointment the day prior and R5

did not remember they had their appointment.

In an interview on 04/18/2025 at 1:13 PM, Staff G, Medication Aide, confirmed the facility provided R5 their medications. Staff G said R5 had a nebulizer on their bedside table. Staff G said the vials for the nebulizer were kept inside the medication cart and when R5 asked for them they would add the vials to the machine because R5's had poor eyesight. Staff G pulled up R5's MAR and confirmed R5 used their nebulizer four times a day.

In an interview on 04/18/2025 at 2:54 PM, Staff A, Administrator, said R5 had been forgetful lately. Staff H, resident Care Coordinator, said R5 had been a poor historian.

Record review of R5's, "Service Agreement", dated 12/13/2024, that was the working care plan labeled, "Quarterly Update", showed no information about R5's increased confusion, or R5's ability to self administer their as needed nebulizer treatments. The working care plan did not include details for the facility staff to reference related to how often they needed to change the vial in R5's nebulizer.

R7

Record review of R7's untitled and undated document that was R7's face sheet showed R7 moved into the facility on [redacted]/2024. R7 had a diagnosis of [redacted].

Record review of R7's, "Service Agreement", dated 03/09/2025, that was the working care plan labeled, "Quarterly Update", showed R7 had poor vision in both of their eyes due to macular degeneration (an eye condition that effected the retina which was responsible for sharp central vision). R7 preferred to have staff help with their medication due to their eyesight. Medication would be ordered through the house pharmacy and stored on medication carts. The facility staff administered all medications per the medical doctors orders.

Record review of "Medication Self-Administration Evaluation", dated 03/09/2025, showed R7 had been determined cable to safely self-administer their medications.

In an interview on 04/18/2025 at 12:21 PM, Staff O said the facility staff provided R7 their medication. Staff O said the facility staff ordered and stored R7's medication for them.

In an interview on 04/18/2025 at 1:13 PM, Staff G said the facility staff ordered and provided some of R7's medication and R7 stored and administered some of their medications themselves. Staff G said R7's family helped them obtain their over-the-counter medications that they took.

In an interview on 04/18/2025 at 2:39 PM, Staff A said the facility staff provided R7 some of their medication and R7 self-administered some of their medications to themselves. Staff A said R7 had been capable to take their medication on their own but did not trust their memory in regard to their scheduled medications and if R7 took them or not. Staff A said R7 picked up some of their medications themselves and R7's friends brought R7 their medication. Staff A said if R7 could not obtain their medication then the facility would be the back up plan.

Record review of R7's, "Service Agreement", dated 03/09/2025, that was the working care plan labeled, "Quarterly Update", did not reflect the change that R7 started to self-administer some of their own medications. The service agreement did not indicate that R7's family or friends supplied them their medications and the alternative plan if R7, R7's family, and R7's friends were unable to provide R7 their medications.

In an interview on 04/18/2025 at 1:03 PM, Staff G, Medication Aide, stated if there was information that was handwritten or typed in red ink on the residents working care plan, it meant that information was new and recently updated. Staff G stated staff were to read the updates and then initial to show that they read the updates to the residents working care plan.

In an interview on 04/18/2025 at 2:54 PM, Staff A confirmed they provided the residents most updated working service agreements to review. Staff A said if a residents family member provided them their medications, the facility would be the back up plan if they were unable to do so.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician after residents refused their medications for 4 of 4 sampled resident (Resident 6 [R6], Resident 4 [R4], Resident 5 [R5], and Resident 1 [R1]). This failure placed the residents at risk for medical complications.

Findings included...

Record review of the "Medication Aide Handbook", updated "07/2024", showed the "Fax Follow Up Procedure" was to fax the medical doctor (MD) in accordance with "When to fax MD" procedure. Facility staff placed faxes and confirmation of faxes on a clipboard in the fax box. Each medication aide checked faxes daily. Staff were to refax the MD if no response was provided after two days. If staff received a response, each medication aide must remove the fax from the fax box. Staff did not need to keep original fax or confirmation once they received a response from the MD. Once a confirmation page had been faxed it needed to be placed into the box to be filed into the residents chart.

Record review of the "Medication Aide Handbook", updated "07/2024", showed "When faxing the doctor always include the following information", the name of the resident, their date of birth, the date of the fax, and the person who sent the fax. The doctor could be faxed 24 hours a day. The doctor should be notified when there was a refusal of medication.

Record review of an email dated 04/22/2025 at 2:54 PM, showed Staff A, Administrator, stated the facility did not keep residents fax notifications that were sent to their medical providers. Staff A stated once a fax confirmation went through the facility, staff would shred them. Staff A stated the medications aides said the facility nurse would follow up with a phone call about a sent fax. The email showed the facility did not have any fax responses from R1, R4, and R6's medical providers to provide that showed they acknowledged the fax or that the fax was actually sent to the medical provider for review.

R6

Record review of R6's untitled and undated document that was R6's face sheet, showed R6 moved into the facility on [redacted]/2024.

Record review of R6's service Agreement, dated 02/07/2025, that was the working care plan labeled, "30 day eval", showed R6 was aware that they took medications, but was not always able to remember to take them and when they were supposed to take medications. Staff would store R6's medication on the locked medication cart, would assist and administer R6'smedications per physician orders.

Record review of R6's Medication Administration Record (MAR), dated 04/01/2025 through 04/16/2025, showed R6 had an order for Ketoconazole (a prescribed medication to help treat infections caused by fungus) apply to affected area of perianal two times daily. Review of administrations showed on 04/11/2025 at 8:00 PM, R6 refused to take the medication. Under the section titled, "exceptions for R6", showed R6 was sleeping and reason why R6 refused the medication.

Record review of R6's "fax", dated 04/11/2025, showed R6 was asleep and missed their dose of ketoconazole. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

R4

Record review of R4's untitled and undated document that was R4's face sheet, showed R4 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R4's service agreement, dated 04/08/2025, that was provided as the working care plan titled, "30-day eval", showed R4 took too many medications to remember them all and when to take the medications. Staff were to assist R4 with administering their medications per physician orders. Staff were to assist R4 with the prescribed inhalers and nebulizers as needed. Staff were to communicate with R4's primary care physician and health care providers.

Record review of R4's MAR, dated 03/11/2025 through 03/31/2025, showed R4 had an order for constulose (prescribed medication to help with difficulties having bowel movements and liver disease) for constipation, take two times a day. Review of the administrations showed on 03/16/2025 at 7:06 PM, 03/29/2025 at 4:54 PM, and 03/30/2025 at 4:56 PM, R4 had refused to take their dose of constulose.

Record review of R4's MAR, dated 04/01/2025 through 04/16/2025, showed R4 had an order for constulose for constipation, take two times a day. Review of the administrations showed on 04/05/2025 at 4:48 PM and 04/11/2025 at 12:02 PM, R4 refused to take their dose of constulose.

Record review of R4's "fax", dated 03/16/2025, showed R4 refused their evening dose of constulose. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

Record review of R4's "fax", dated 03/29/2025, showed R4 refused their evening dose of constulose medication. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

Record review of R4's "fax", dated 03/30/2025, showed R4 refused their evening dose of constulose. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

Record review of R4's "fax", dated 04/05/2025, showed R4 refused their evening dose of constulose. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

Record review of R4's "fax", dated 04/11/2025, showed R4 refused their morning dose of constulose. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

R5

Record review of R5's untitled and undated document that was R5's face sheet, showed R5 moved into the facility on [redacted]/2023. R5's medical history showed R5 had a diagnosis of [redacted]

[redacted] .

Record review of R5's Service Agreement, dated 12/13/2024, under the section titled, "medication administration", showed R5 administered their medications themself with assistance. On all shifts the facility staff assisted R5 with their medications as ordered. The facility staff stored, ordered, and reordered R5's medication. The document was signed by R5, Staff A, Administrator, and Staff H, Resident Care Coordinator.

Record review of R5's, MAR, dated 04/01/2025 through 04/16/2025, showed R5 had an order for polyethylene glycol (medication used to treat constipation). Review of the notes section showed R5 refused their medication on 04/11/2025.

Record review of R5's "fax", dated 04/11/2025, showed R5 refused their morning dose of polyethylene glycol medication. The fax did not show any proof that the physician was faxed, or a response from the physician that showed they reviewed the refusal.

R1

Record review of R1's untitled and undated document that was R1's face sheet, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R1's Service Agreement, dated 11/10/2024, that was a quarterly update and was provided as R1's working care plan. Under the section titled, "medical care management", showed R1 was able to inject their own insulin. Staff would assist R1 with their medications as R1 often didn't recall if they had taken them or not. Staff were to communicate with primary care provider and other health care provides as needed.

Record review of R1's MAR, dated 02/01/2025 through 02/28/2025, showed R1 had an order for insulin lispro kwikpen (medicated injection to help lower high blood sugar levels quickly) injection five units into the skin three times daily with meals. Review of the administrations showed on 02/15/2025 at 2:07 PM, R1 refused their lispro insulin injection as "R1 felt it was too low to take insulin". On 02/21/2025 at 1:01 PM, R1 refused their lispro insulin injection as R1 blood sugar level was 99 after they ate lunch. R1 did not want to have their blood sugar level drop too low, and it was already low that morning. On 02/22/2025 at 4:49 PM, R1 refused their lispro insulin injection as R1 felt "it was too low".

Record review of R1's MAR, dated 03/01/2025 through 03/31/2025, showed R1 had an order for insulin lispro kwikpen injection five units into the skin three times daily with meals. Review of R1's administrations showed on 03/06/2025 at 1:17 PM, R1 refused their lispro insulin injection. R1 did not want to take their insulin injection as they took their morning medication late after their medical appointment.

Record review of an email sent on 04/24/2025 at 1:40PM, of R1's physician notifications, showed there was a "fax", dated 02/10/2025 that showed R1 missed their lispro insulin dose due to being out of facility, a "fax" dated 02/15/2025, that showed R1 refused their lispro insulin dose due to feeling their blood sugar was low with no blood sugar reading listed, a "fax" dated 02/21/2025, that showed R1 refused their lunch scheduled lispro insulin as R1's blood sugar was 99, a "fax" dated 02/22/2025, that showed R1

refused their dose of lispro insulin as R1 felt low blood sugar symptoms without the blood sugar or the symptoms listed, a "fax" dated 03/04/2025, that showed R1 did not take their evening dose of lispro insulin due to being out of the facility, and a "fax" dated 03/06/2025, that showed R1 refused their lunch lispro injection. All of the faxes did not show confirmation that the physician was faxed, or the physician followed up and acknowledged the fax about R1.

In an interview on 04/17/2025 at 12:41 PM, Staff Q, Medication Aide, stated they were to document on the residents MAR if they had refused a medication. Staff Q stated the medication aide on shift was then to fax the resident's physician to notify them of the refusal and let the nurse, Staff P, Registered Nurse, know either by cellular phone text message, phone call, or an electronic mail.

In an interview on 04/17/2025 at 12:58 PM, Staff F, Medication Aide, stated they were to mark the resident MAR under exceptions "refused" and fax the resident's physician every time the resident refused to take their medications.

In an interview on 04/18/2025 at 12:21 PM, Staff O, Lead Medication Aide, said if a resident refused a medication, then the facility staff would contact their medical provider.

In an interview on 04/18/2025 at 1:13 PM, Staff G, Medication Aide, said if a resident refused their medication the MAR would reflect that they refused the medication and the reason why. Staff G said facility staff faxed the resident's medical provider every time a resident refused their medication.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 6 sampled residents (Resident 4 [R4], Resident 5 [R5], and Resident 6 [R6]) medications were

available to be administered. This failure resulted in the residents not receiving their medications as ordered and placed the residents at risk for unmet care needs and medical complications associated with not receiving medications as ordered.

Findings included...

Record review of the "Medication Aide Handbook", updated "07/2024", showed the "Missing or unavailable medication procedure" was that no resident should ever miss a dose of medication. It was the facility responsibility to obtain medications. All medication aides were to follow medication refill procedures and re-order all medications seven to ten days before the medication ran out. If a medication had not been delivered from the pharmacy or the family did not bring in the medication the facility staff should notify the nurse and resident care coordinator before the first dosage was missed. Staff were to contact the pharmacy about an emergency supply, notify the medical doctor the medication was unavailable and why, and request a hold order from the medical doctor until the medication arrived. The facility staff placed the resident on alert charting to monitor for side effects of not receiving the medication, notify the residents family or power of attorney of the medication issue, and request the family follow up with the medical doctor if a refill order was needed. The facility staff filled out an incident report if a medication dosage was missed, documented in the MAR (medication administration record) and wrote a story about why the medication was not available, and if resident missed a dosage of medication facility staff were to write a progress note on side effects of missed medication and what steps were being done to obtain the medication.

R4

Record review of R4's untitled and undated document that was R4's face sheet, showed R4 moved into the facility on [redacted] 2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R4's service agreement, dated 04/08/2025, that was provided as the working care plan titled, "30-day eval", showed R4 took too many medications to remember them all and when to take the medications. Staff were to assist R4 with administering their medications per physician orders. Staff were to communicate with primary care physicians and health care providers. R4's medications were to be ordered through the facility's house pharmacy.

Record review of R4's Medication Administration Record (MAR), dated 03/10/2025 through 03/31/2025, showed R4 had an order for vitamin B-1, take every day in the morning. Review of the administrations showed that on 03/14/2025, 03/15/2025, 03/18/2025, and 03/19/2025 the vitamin B-1 was not available at the facility to be administered. Under the section titled, "exceptions for [R4's name]", showed "on order from pharmacy", for the vitamin B-1 for dates 03/14/2025, 03/15/2025, 03/18/2025, and 03/19/2025. There was no other documentation as to why R4 missed their medication and the steps taken by the facility to obtain R4's medication.

Record review of R4's progress notes dated 03/10/2025 through 04/15/2025, showed there was no documentation that R4 was out of their vitamin B-1, if R4 was having any side effects from missing the medication, and what was being done to get R4 their

vitamin B-1 at the facility for administration.

Record review of R4's alert notes, dated 03/10/2025 through 04/15/2025, showed that R4 was not put on alert charting for missing the vitamin B-1 medication documented.

R5

Record review of R5's untitled and undated document that was R5's face sheet, showed R5 moved into the facility on [redacted]/2023. R5's medical history showed R5 had a diagnosis of [redacted]

Record review of R5's Service Agreement dated 12/13/2024, under the section titled, "medication administration", showed R5 administered their medications themself with assistance. On all shifts the facility staff assisted R5 with their medications as ordered. The facility staff stored, ordered, and reordered R5's medication. The document was signed by R5, Staff A, Administrator, and Staff H, Resident Care Coordinator.

Record review of R5's MAR, dated 03/01/2025 through 03/31/2025, showed R5 had an order trelegy ellipta (medication used to treat COPD). Review of the notes section showed on 03/09/2025 and on 03/13/2025 R5 did not receive their medication because it was on order from the pharmacy.

Record review of R5's, "Resident Progress Note", dated 03/01/2025 through 03/31/2025, showed no progress notes to review related to R5's missed trelegy ellipta medication on 03/09/2025 and 03/13/2025 that indicated side effects to look out for and what had been done to obtain the medication.

R6

Record review of R6's untitled and undated document that was R6's face sheet, showed R6 moved into the facility on [redacted]/2024.

Record review of R6's service Agreement, dated 02/07/2025, that was the working care plan labeled, "30-day eval", under the section titled, "medical care management", showed R6 was aware that they took medications, but was not always able to remember to take them and when they were supposed to take medications. Staff would store R6's medication on the locked medication cart, would assist and administer R6 their medications per physician orders. Staff were to notify the resident care coordinator, power of attorney/son when R6's medication had seven to ten days left until they were out. Medications were ordered through non-house pharmacy.

Record review of R6's MAR, dated 04/01/2025 through 04/16/2025, showed R6 had an order for carvedilol (prescribed medication to help lower high blood pressure) take one tablet two times a day with meals. Review of the administrations showed on 04/05/2025, 04/06/2025, 04/07/2025, 04/08/2025, and 04/09/2025, R6 was not administered their carvedilol. Under the section titled, "exceptions for [R6's name]", showed on 04/05/2025 at 7:01 PM, "no medication in house, called POA [power of attorney] and left voicemail." For dates 04/06/2025, 04/07/2025, 04/08/2025, and 04/09/2025, there was no documentation other than waiting on family to bring in and on order from pharmacy.

Record review of R6's progress notes, dated 02/01/2025 through 04/16/2025, showed there was no documentation that R6 was out of their carvedilol and was not administered it on 04/05/2025, 04/06/2025, 04/07/2025, 04/08/2025, and 04/09/2025.

Record review of R6's alert notes, dated 02/01/2025 through 04/16/2025, showed there was no documentation that R6 was out of their carvedilol and was not administered it on 04/05/2025, 04/06/2025, 04/07/2025, 04/08/2025, and 04/09/2025. There was no documentation that showed why R6 missed their medication, the steps taken by the facility to obtain R6's medication, and placed R6 on alert charting to monitor for any negative or side effects from not getting their medication.

In an interview on 04/17/2025 at 12:41 PM, Staff Q, Medication Aide, stated if a resident's medication was not available for administration the medication aide on shift was to find out why. Staff Q stated they were to contact the resident's physician and notify the facility nurse. Staff Q stated they were to contact the resident's physician every time the resident missed a day of their medication until the medication was at that facility and available to administer.

In an interview on 04/17/2025 at 12:58 PM, Staff F, Medication Aide, stated if a resident's medication was not in the medication cart available for administration, they were to fax the resident's physician, call the pharmacy, and then call the family for assistance. Staff F was unsure what the time frame was to ensure and get the residents medication at the facility for administration.

In an interview on 04/18/2025 at 1:03 PM, Staff G, Medication Aide, said if a resident missed their medication the MAR would reflect that the medication was missed and the reason why. Staff G said facility staff faxed the resident's medical provider every time a resident missed their medication. Staff G stated they were to contact the residents representative seven days before the resident's medication was out to get refilled. Staff G stated if the residents representative was unable to get the medication, the facility would have the medication filled from the facility's house pharmacy.

In an interview on 04/18/2025 at 2:54 PM, Staff A, Administrator, said if residents had family members who were responsible to provide the resident's medication, and they did not do so then the facility would order the residents medication from the facility house pharmacy. Staff A said the facility would notify the residents representative seven to ten days prior to the medication being out. Staff A said the facility would wait until the day prior to the medication running out to order it from their house pharmacy. Staff A stated resident family members or representatives were notified and were aware that if the resident ran out of medication and they had not brought in the prescription the facility would order the medications to ensure the resident got their medication. Staff A stated R6's power of attorney was out of town and unable to get the medication at the pharmacy and did not have a back up plan with a designated person to get R6's medication to the facility for R6 to take. Staff A stated if the resident was out of their supplements or over the counter medications they could always order them and have them shipped to the facility.

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)_____ .

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

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that there was a safe system in place to ensure 3 of 7 sampled residents (Resident 4 [R4], Resident 6 [R6], and Resident 1 [R1]) were administered their medication as the resident's physician ordered. This failure placed all three residents at risk of medical complications and the residents physician being unable to provide medical guidance.

Findings included...

Record review of the facility's document titled, "medication administration", undated, showed staff would assist residents who were on medication services by obtaining medications, reminding, coaching, or helping to prepare their medications for administration. Staff were responsible for supervision of the medication service must always sign a medication log indicating that mediation was taken appropriately. If the medication was refused the medication log must show the refusal.

Record review of the Washington State Department of Social and Health Services document titled, "Fundamentals of Caregiving 3rd edition", dated "2011", under the

section titled, “medication assistance and medication administration”, showed medications were substances that change a chemical activity in the human body. Medication could have a positive effect or negative side effects. Home care aides must learn how to sagely assist residents with their medications. The responsibilities for the home care aide while providing medication assistance included preparing the dose of medication, assisting the client with taking the medication, observing and documenting. There were five “rights” of medication that guides the home care aide’s actions anytime they were to help a resident with their medications that included checking the five rights three times. The three checks help to minimize medication errors. The five rights included right medication, right resident, right dose, right route, and right time. Under the section right medication, the home care aide every time they were assisting or administering a residents medications they were to check the label of the medication to make sure, the residents name was on their for prescription medication only and to verify the correct time , dosage, route, and that they were aware of any special instruction for the medications were followed. Under the section “right time”, showed the regular schedule for medication would be determined by the resident, the doctor, a nurse, or the facility/agency’s policy. The schedule should be clear, so the residents were assisted with their medications at the right time. Check the medication record or the medication container for the correct time. Under the section titled, “documentation and reporting”, showed the rule for documenting medication assistance and medication administration have been set in law for assisted livings. The home care aid must document every medication taken and refused. It was considered an error when the medication was not given according to the directions. That would include any of the five rights of medication. Home care aides were to follow medication labels to administer or assist a resident with their medications appropriately.

Record review of an email sent on 04/22/2025 at 2:54 PM, showed Staff A, Administrator, stated when they faxed a resident’s physician, the facility did not keep the fax confirmation sheet. When the fax confirmation sheet was printed after the fax went through, the facility staff would shred the confirmations. Staff A stated at times the medication aides would received a call from the physician nurse or medical assistant with majority of the faxes.

Record review of an email sent on 04/22/2025 at 3:15 PM, showed the facility medication aides would not chart in the resident’s progress or alert notes if they took a call from the physician nurse or medical assistant in regard to the faxes that were sent to them for review about the resident.

R4

Record review of R4’s untitled and undated document that was R4’s face sheet, showed R4 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R4’s service agreement, dated 04/08/2025, that was provided as the working care plan titled, “30-day eval”, under the section titled, “medical care management”, showed R4 took too many medications to remember them all and when to take the medications. Staff were to assist R4 with administering their medications per physician orders. Staff were to communicate with primary care physicians and health care providers. R4’s medications were to be ordered through the facility’s house

pharmacy. R4 had blood pressure parameters for their spironolactone (prescribed medication to help treat fluid retention in the body and high blood pressure). R4 was currently participating in radiation therapy for uterine cancer (a cancer that starts in the uterine tissue that can cause abnormal bleeding).

Record review of R4's vitals report, dated 03/10/2025 through 04/16/2025, showed there was a blood pressure reading that was completed on 03/19/2025 and 03/10/2025 that was 103/71 for both readings. There were no other blood pressure readings documented for R4 for review.

Record review of R4's Medication Administration Record (MAR), dated 03/11/2025 through 03/31/2025, showed R4 had an order for spironolactone take half a tablet ever morning. Hold the medication for systolic blood pressure (SBP- top number of a blood pressure reading) was less than 100. Review of 20 of 20 administrations showed there was no blood pressure readings documented for the order. There was no documentation on the MAR that showed R4's blood pressure readings for the medication order.

Record review of R4's MAR, dated 04/01/2025 through 04/16/2025, showed R4 had an order for spironolactone take half a tablet every morning. Hold the medication if SBP was less than 100. Review of 16 of 16 administrations showed there was no blood pressure readings documented for the order. There was no documentation on the MAR that showed R4's blood pressure readings for the medication order.

In an interview and observation on 04/17/2025 at 12:50 PM, Staff Q, Medication Aide, looked up in the electronic record and showed that R4 was not having their blood pressure taken daily. Staff Q stated the high blood pressure medication that R4 was ordered did not have blood pressure ordered to be taken. Staff Q was unaware that R4's spironolactone required a blood pressure to be a specific parameter to be administered.

In an interview on 04/17/2025 at 12:58 PM, Staff F, Medication Aide, stated the did not check R4's blood pressure that morning prior to administering their spironolactone medication. Staff F reviewed R4's MAR on the electronic record and stated they were to be checking R4's blood pressure to ensure that it was above the physician order parameters. Staff F stated they were unaware that there were parameters for the spironolactone order.

R6

Record review of R6's untitled and undated document that was R6's face sheet, showed R6 moved into the facility on [redacted]/2024.

Record review of R6's service Agreement, dated 02/07/2025, that was the working care plan labeled, "30-day eval", showed R6 was aware that they took medications, but was not always able to remember to take them and when they were supposed to take medications. Staff would store R6's medication on the locked medication cart, would assist and administer R6 their medications per physician orders. R6 had a history of myocardial infarction (medical condition when blood flow to the heart muscle was blocked, causing tissue damage and death, also known as heart attack), and NSTEMI (non-ST segment elevation myocardial infection also known as a heart attack that occurs when blood supply to the heart is reduced and causing damage).

Record review of R6's MAR, dated 02/01/2025 through 02/28/2025, showed R6 had an order for carvedilol (prescribed medication to help lower high blood pressure) take one tablet two times daily with meals. R6's physician was to be notified if SBP was less than 100 or if pulse was less than 60 and the medication was to be held. Review of the administrations showed five administrations at 5:00 PM had pulse below 60 and was administered to R6. At 8:00 AM, six administrations had a pulse below 60 and R6 was administered their carvedilol. On 02/21/2025 R6's SBP was 97 and pulse was 58 and were administered their medications. Five of eleven administrations showed the medication aide acknowledged R6's vital signs were out of parameter per the physician order, but the medication aide's initials were not circled that indicated R6's medication dose was held. Under the section titled, "exceptions for [R6's name]" showed the administration on 02/05/2025 at 8:00 AM, 02/11/2025 at 8:00 AM and 5:00 PM, 02/14/2025 at 5:00 PM, 02/17/2025 at 8:00 AM and 5:00 PM, 02/20/2025 at 5:00 PM, 02/21/2025 at 8:00 AM, 02/22/2025 at 8:00 AM. 02/24/2025 at 8:00 AM, and 02/25/2025 at 5:00 PM were not listed as being withheld per physician orders.

Record review of R6's MAR, dated 03/01/2025 through 03/31/2025, showed R6 had an order for carvedilol take one tablet two times daily with meals. R6's physician was to be notified if SBP was less than 100 or if pulse was less than 60 and the medication as to be held. Review of R6's administrations showed six 8:00 AM administrations had a pulse below 60 and one with SBP below 100 and four 5:00 PM administrations that had pulses below 60. One of ten administrations showed the medication aide acknowledged R6's vital signs were out of parameter per the physician order, but the medication aide's initials were not circled that indicated R6's medication dose was held. All ten of R6's carvedilol administrations with R6's pulse and SBP's readings were out of parameters, showed the medication aide's initials were not circled that indicated R6's medication dose was held. Under the section titled, "exceptions for [R6's name]" showed the administration on 03/02/2025 at 8:00 AM, 03/05/2025 at 5:00 PM, 03/09/2025 at 5:00 PM, 03/15/2025 at 8:00 AM, 03/17/2025 at 8:00 AM and 5:00 PM, 03/22/2025 at 5:00 PM, 03/24/2025 at 8:00 AM, 03/28/2025 at 8:00 AM, and 03/29/2025 at 8:00 AM were not listed as being withheld per physician orders.

Record review of R6's MAR, dated 04/01/2025 through 04/16/2025, showed R6 had an order for carvedilol take one tablet two times daily with meals. R6's physician was to be notified if SBP was less than 100 or if pulse was less than 60 and the medication was to be held. Review of R6's administrations showed four 8:00 AM administrations and one 5:00 PM administrations, R6 had a pulse less than 60. One of five administrations showed the medication aide acknowledged R6's vital signs were out of parameter per the physician order, but the medication aide's initials were not circled that indicated R6's medication dose was held. Under the section titled, "exceptions for [R6's name]" showed the administration on 04/01/2025 at 5:00 PM, 04/04/2025 at 8:00 AM, 04/12/2025 at 8:00 AM, 04/14/2025 at 8:00 AM, and 04/16/2025 at 8:00 AM, were not listed as being within held per physician orders.

In an interview and observation on 04/17/2025 at 12:50 PM, Staff Q stated they gave R6's carvedilol dose on 04/16/2025 at 8:00 AM. Staff Q reviewed the pulse that they had documented and showed R6's pulse was 55. Staff Q stated R6 should have not been given their carvedilol dose as R6's pulse needs to be 60 or above to be administered. Staff Q stated it must have been an input error. Staff Q reviewed the administration dose of R6's carvedilol on 04/14/2025 at 8:00 AM, that showed they had administered R6's carvedilol dose with R6's pulse at 56. Staff Q stated it must not have been an error. Staff Q stated when if they had held a resident's medication because of vital signs

parameters were out of range, the medication aide's initials would be circled on the MAR and then under the exceptions area on the back of the MAR, it would state why the resident didn't receive the medication.

In an interview on 04/17/2025 at 12:58 PM, Staff F stated if a medication was not given, the medication aides initials on the date and time the medication was due would be circled and then there would be a reason as to why it was not given documented on the back of the MAR under the section titled, "exceptions for [residents name]".

R1

Record review of R1's untitled and undated document that was R1's face sheet, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R1's Service Agreement, dated 11/10/2024, that was a quarterly update and was provided as R1's working care plan. Under the section titled, "medical care management", showed staff would assist R1 with their medications as R1 often didn't recall if they had taken them or not. Staff were to communicate with R1's primary care provider and other health care providers as needed. Staff were to assist with administering R1's medications per physician orders. R1 was an insulin dependent diabetic. R1 was able to inject their own insulin after the facility staff dialed up the insulin pen.

Record review of R1's MAR, dated 02/01/2025 through 02/28/2025, showed R1 had an order for blood pressure to take a R1's blood pressure daily if above 140 or above fax R1's primary care provider. Review of the R1's blood pressures showed seven of 28 blood pressure readings were above 140.

Record review of R1's MAR, dated 03/01/2025 through 03/31/2025, showed R1 had an order for blood pressure to take a R1's blood pressure daily if above 140 or above fax R1's primary care provider. Review of the R1's blood pressures showed eight of 30 record blood pressure readings were above 140.

Record review of R1's MAR, dated 04/01/2025 through 04/16/2025, showed R1 had an order for blood pressure to take a R1's blood pressure daily if above 140 or above fax R1's primary care provider. Review of R1's blood pressures showed seven of nine blood pressure readings were above 140. R1 had an order for alcohol prep pads to use prior to testing blood sugar and injecting insulin four times daily. Review of R1's alcohol prep pads administrations, showed R1 used an alcohol prep pad at every administration except on 04/10/2025 at 12:00 PM, as R1 was out of the facility. R1 had an order for lispro insulin (injected prescribed medication to help lower high blood sugar levels quickly) kwikpen to inject under the skin three times daily with meals.

Record review of an email sent on 04/18/2025 at 1:10 PM, showed there were multiple "fax" pages that showed R1's physician was notified that R1's blood pressure reading was out of the prescribed parameter. All of the faxes did not show any confirmation that the fax was sent, that R1's physician's office received the fax, or that R1's physician acknowledged the fax notification for review.

In an observation on 04/16/2025 at 1:41 PM, Staff Q, Medication Aide, knocked on R1's apartment door. R1 stated it was ok for Staff Q to come in. Staff Q brought in R1's insulin. Staff Q checked R1's blood sugar that was 105. Staff Q handed R1 their lispro insulin pen without any alcohol pads. R1 injected their insulin pen into their upper stomach areas. R1 did not use an alcohol wipe before they injected their stomach with their insulin nor was an alcohol wipe provided.

In an interview on 04/17/1025 at 12:11 PM, Staff Q stated they checked R1's blood sugar reading after R1 ate their lunch. Staff Q stated they tried to check it before lunch but R1 refused and had the medication aides check the blood sugar after lunch and then provide R1 with their insulin to administer.

In an interview on 04/17/2025 at 12:58 PM, Staff F, Medication Aide, stated they were to fax and notify the residents physician anytime there was a change in the resident, that included if any of their MAR orders had parameters to notify the physician. Staff F stated the medication aide were to follow the orders that were written on the residents MAR.

In an observation on 04/17/2025 at 1:13 PM, Staff F, Medication Aide, brought R1 their insulin pen to their room for administration. Staff F was observed to only grab R1's lispro insulin kwikpen out of the medication cart. Staff F brought R1's lispro insulin pen to R1's room. Staff F handed R1 their lispro insulin pen and no alcohol prep pad. R1 injected the lispro insulin pen into their upper stomach areas. R1 did not use an alcohol prep pad to cleanse their skin prior to injecting their insulin or was provided an alcohol prep pad from Staff F. R1 stated they had already eaten their lunch.

In an interview on 04/17/2025 at 1:22 PM, Staff A, Administrator, stated Staff H, Resident Care Coordinator, and Staff O, Lead Medication Aide, completed MAR audits every week on opposite days. Staff A stated Staff P, Oversight Register Nurse, completed resident MAR audits every two weeks. At 1:26 PM, Staff H stated when they completed the MAR audits they would look at the residents orders for accuracy, if they had blood pressure taken and were within the physician prescribed parameters, ensure medications were administered. Staff H stated if a resident's medication was not given for any reason, the medications aides initials would be circled on the MAR for that day, and the MAR would show why the medication was not given on the exceptions area of the MAR. Staff H reviewed R4's order for spironolactone order and acknowledged that the medication aides were to check R4's blood pressure prior to administering the medication and hold if R4's blood pressure was out of the physician prescribed parameters.

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)_____ .

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

Administrator (or Representative) Date