STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

08/01/2024

Josephine Caring Community

Josephine Caring Community
9901 272nd Pl NW
Stanwood, WA 98292

RE: Josephine Caring Community License # 569

Dear Administrator:

This letter addresses Compliance Determination(s) 44767 (Completion Date 07/26/2024) and 36603 (Completion Date 02/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/26/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-2665-5, WAC 388-78A-2474-2-c, WAC 388-112A-0400-1, WAC 388-78A-2650-3, WAC 388-78A-2650-2, WAC 388-78A-2371-1, WAC 388-78A-2100-2-a, WAC 388-78A-2270-2, WAC 388-78A-2090-1-b

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor
Allison Nunn, Long Term Care Surveyor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 569	Compliance Determination # 36603
Plan of Correction	Josephine Caring Community	Completion Date
Page 1 of 13	Licensee: Josephine Caring Community	02/27/2024

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

The department completed data collection for the unannounced on-site full inspection on 02/07/2024 and 02/12/2024 of:

Josephine Caring Community
9901 272nd Pl NW
Stanwood, WA 98292

The following sample was selected for review during the unannounced on-site visit: 7 of 51 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Judith Mellon, RN, Licensor
Allison Nunn, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

03/12/2024
Date

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

Administrator (or Representative) 3-18-24 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;

This requirement was not met as evidenced by:

Based on observations and interviews the Assisted Living Facility (ALF) failed to keep the interior and exterior of the ALF structure clean and in good repair. This resulted in an unkept living environment and placed all 51 residents at risk for a decreased quality of life.

On 02/07/2024 at 10:35 AM, an ALF facility tour was completed with Staff H, Director of Facility and Environmental Operations. The ALF was a two-story structure.

Findings included...

At 10:35 AM, on the second-floor the dayroom had surface abrasions on the wall from the wood trim of two chairs. A screen and one slat from a broken window blind were on the floor behind a chest of drawers. An unlocked window was missing a screen.

On 02/07/2024 at 10:37 AM, Staff H stated that there was no reason that the screen should have been out of the window and that someone must have removed it and set it behind the dresser. Staff H stated that he would have the screen placed in the window immediately.

At 10:40 AM, an elevator room had two pairs of dirty gloves and a dirty rag sitting on top of a metal cabinet that covers the elevator electrical panel.

At 10:42 AM, the resident dining room had a cabinet under the kitchenette sink with a dried dark brown substance. A brown liquid substance was on the drainpipe that was coming from the sink.

On 02/07/2024 at 10:47 AM, Staff H stated that it was hard to tell what the stain under the

sink was coming from and that he would figure out where the liquid was coming from.

At 11:01 AM, a resident common entrance area had wall surface abrasions on two walls that were grooved into the plaster on one wall.

At 11:04 AM, a hallway exit area on the first floor had six dirty tissues on the floor under a chair, and dead spiders and debris on the windowsill and ledge. There were spider webs around the framing of the door.

At 11:13 AM, on the first floor near room 111 surface abrasions were observed on a handrail.

At 11:15 AM, the second floor Northeast hallway exit area had spider webs and spider debris on the windowsill and wooden ledge around the wall.

At 11:21 AM, an exterior corner on the Southwest side of the ALF had wood exposed.

On 02/07/2024 at 11:22 AM, Staff H stated that Ivy was removed from growing on the ALF and the exposed corner would be repaired.

At 11:23 AM, the Westside of the ALF's exterior had one piece of siding that was missing that exposed had a black material to inclement weather.

On 02/07/2024 at 11:23 AM, Staff H stated that they were unaware that the piece of siding from the ALF was missing and that the black material was a type of underlayment.

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, Josephine Caring Community is or will be in compliance with this law and / or regulation on (Date) 4-19-24 .

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

Administrator (or Representative) 3-19-24 Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the policy on accepting Medicaid was written in a type of font that was at least size 14 point. This failure resulted in residents signing an agreement that was potentially too small to read and placed all residents at risk of entering an agreement that they did not understand.

Findings included...

Review of the ALF's "Active Medicaid Contract Participation Notice" dated May 2, 2019, showed a type of font that was smaller than 14 point.

In an interview on 02/08/2024 at 10:12 AM, Staff F, Administrator, stated that they were not aware the document needed to be written in at least a size 14 font.

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, Josephine Caring Community is or will be in compliance with this law and / or regulation on (Date) 3-9-24.

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

Administrator (or Representative) 3-19-24 Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities.

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:

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 5 staff (Staff A and B) completed specialized dementia and mental health training. This failure resulted in Staff A and Staff B not being trained to provide care to residents with dementia or mental health and placed all residents with a diagnosis of [redacted] or [redacted] at risk of not receiving proper care.

Findings included...

The ALF's Resident Characteristic Roster dated 02/07/2024, showed 23 residents living in the ALF had a [redacted] diagnosis and 3 residents living in the ALF had a [redacted] diagnosis.

Review of the ALF's employee files showed:

Staff A, Med Tech, was hired on 05/11/2023. No documentation of specialized dementia training was found in Staff A's file.

Staff B, Caregiver, was hired on 09/29/2023. No documentation of specialized dementia or mental health training was found in Staff B's file.

On 02/08/2024 at 12:12 PM, Staff G, Director of Nursing, stated that Staff A did not complete the dementia specialty training and Staff B did not complete either the dementia or mental health specialty training.

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, Josephine Caring Community is or will be in compliance with this law and / or regulation on (Date) 4-22-24 .

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

Administrator (or Representative) 3-19-24 Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on interviews and observations, the Assisted Living Facility (ALF) failed to report to the Complaint Resolution Unit (CRU) a water leak in a resident's room above the dining room which resulted in half of the dining room being closed and a resident being moved to a different apartment. This failure resulted in the Department not being informed that the ALF had an incident that required emergent action and placed all residents at risk of not eating meals in the dining room due to the limited seating.

Findings included...

Resident 3 was admitted to the ALF on [redacted]/2018 with multiple medical diagnoses including [redacted] and [redacted].

On 02/12/2024 at 10:44 AM, Resident 3 stated that their belongings were moved to another room because of the water damage in their previous apartment.

On 02/07/2024 at 1:50 PM, during the group meeting, two residents stated that other residents were eating in their apartments due to the limited seating the in the dining room.

On 02/07/2024 at 10:49 AM, the dining room was observed to have a plastic sheet attached to the ceiling and extended to the floor which closed off one-half of the dining room.

On 02/07/2024 at 9:47 AM, Staff F, Administrator, stated that a toilet in a second-floor resident apartment overflowed and caused water to leak through the floor into the light fixtures below into the dining room. Staff F stated that that the dining room needed repairs due to the water leak. Staff F stated that one resident was moved to another apartment because their room was flooded with water and it wasn't safe for the resident to stay in the apartment.

On 02/12/2024 at 12:22 PM, Staff F stated that they had not reported the water damage

from the floor or the dining room closure to the CRU.

Review of the Department's Secure Tracking and Reporting System on 12/12/2024 showed there was no report made to the Department's CRU hotline related to a toilet that overflowed that caused one-half of the dining room to close and a resident that was moved to another apartment.

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, Josephine Caring Community is or will be in compliance with this law and / or regulation on (Date) 4-25-24 .

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

Administrator (or Representative) 3-19-24 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to thoroughly investigate 1 of 2 residents (Resident 4) when Resident 4 had a laceration to the right upper thigh that required stitches. This failure resulted in the circumstances surrounding the incident not being investigated and placed Resident 4 at risk of not receiving the necessary medical follow-up care and implementation of preventative actions.

Findings included...

Review of the ALF's Policy and Procedure for "Incident and Accident Reporting," undated, showed the Med Tech was to begin the initial investigation by completing the incident and accident report from.

Review of the Assisted Living Facility Guidebook; Partners in Protection, dated 02/2018, page 9 showed the investigation is done to determine what occurred and to make necessary changes to the provision of care and services to prevent reoccurrence.

Resident 4 was admitted into the ALF on [redacted]/2019 with multiple diagnoses including [redacted] and [redacted].

A negotiated service agreement updated on 08/23/2023 showed Resident 4 had a right leg skin laceration in August 2023.

Progress notes labeled "incident note" and dated 08/21/2023 showed an unnamed staff went to change Resident 4's catheter drainage bag. The unnamed staff noticed blood on Resident 4's leg and bed and then alerted Staff A, Med Tech/Caregiver, to help. The progress note showed Staff A asked Resident 4 what had happened and Resident 4 stated that they were trying to cut something with scissors and slipped and cut the right upper leg.

Review of an after-visit summary dated 08/21/2023 showed Resident 4 was seen in the hospital for a laceration to the right thigh and that stitches could be removed in 7-10 days.

On 02/12/2024 at 10:20 AM, Staff A stated that when she went into Resident 4's room to check on Resident 4's catheter she had noticed blood on Resident 4's thigh and bed. Staff A stated that Resident 4 reported that they had used scissors to cut off the adhesive patch that holds the catheter tubing in place.

On 02/12/2024 at 10:17 AM, Staff G, Director of Nursing, stated that she received a call from staff reporting that Resident 4's leg was bleeding and she directed the staff to call 911. Staff G stated that neither an incident report nor an investigation was completed.

On 02/12/2024 at 10:25 AM, Staff A stated that she could not recall if an incident report was completed. Staff A stated that the normal process was for staff to complete an incident report and notify the nurse.

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, Josephine Caring Community is or will be in compliance with this law and / or regulation on (Date) 3-27-24.

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

[signature] 3-19-24

Administrator (or Representative) 3-19-24 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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 7 residents, (Resident 2) was assessed at least annually to be capable of self-administering medication. This failure resulted in Resident 2 self-administering medication without an annual assessment to ensure they were able to follow the directions as prescribed and placed Resident 2 at risk for taking medication incorrectly.

Findings included...

The ALF's undated policy titled, "Self-Medication Services (Store in Apartment and Manages All Aspects), Category A" showed the Registered Nurse will complete an assessment annually (and upon admission) on all residents who are self-medicating.

Resident 2 was admitted to the ALF on [redacted]/2015 with multiple medical diagnoses including [redacted] and [redacted].

Negotiated Service Agreement (NSA) dated 01/22/2024 showed that Resident 2 self-administers eye drops and they will call for assistance if needed due to tremors or weakness in hands. The NSA showed that Resident 2 had an order to keep Melatonin (provides relief from insomnia) at the bedside.

Electronic Medication Administration Record (EMAR) from December 2023 through February 2024 showed that Resident 2 self-administered three medications: Bimatoprost 0.03% Eye Drop one in each eye daily at bedtime, (treats high pressure in the eye and helps with Glaucoma) with a start date of 10/15/2023, Dorzolamide-Timolol Eye Drops, one drop in left eye twice daily (treats increased pressure in the eye caused by open-angle Glaucoma) with a start date of 10/15/2023 and Melatonin Tablet Give 6 mg by mouth at bedtime for insomnia unsupervised self-administration with a start date of 12/22/2020.

A document titled, "Medication Self-Administration Evaluation Form" dated 05/31/2017

showed Resident 2 was assessed by the ALF and deemed able to safely self-administer medications. No other documentation of an annual assessment completed by the ALF was found in Resident 2's record.

On 02/09/2024 at 12:49pm, Staff G, Director of Nursing stated that they complete a self-medication assessment every year on residents who take their own medications. Staff G stated that the last self-medication assessment they could find for Resident 2 was completed in 2017.

On 02/12/2024 at 12:30pm, Resident 2 stated that their eye drops are kept in their apartment and they are able to put the drops in their eye. Resident 2 stated that they will ask for help from the staff if they are having trouble. Resident 2 stated that they have a bottle of Melatonin in their apartment and they take it at night.

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, Josephine Caring Community is or will be in compliance with this law and / or regulation on (Date) 4-26-24.

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

Administrator (or Representative) 3-19-24 Date

WAC 388-78A-2270 Resident controlled medications.

(2) The assisted living facility must allow a resident to control and secure the medications that he or she self-administers or self-administers with assistance if the assisted living facility assesses the resident to be capable of safely and appropriately storing his or her own medications and the resident desires to do so.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 residents (Resident 4) had a completed assessment that addressed if the resident was able to independently self-administer their own medications. This failure resulted in Resident 4 administering their own medications without being determined if they were able to administer their own medications safely and appropriately and placed Resident 4 at risk for unmet care needs.

Findings included...

Review of the ALF's undated policy titled "Medication Services" showed a reference to "Self-Medication Category A" which showed in order for a resident to self-administer their own medications an assessment will be completed annually and upon admission on all residents who are self-medicating. A Medication Self-Administration Evaluation Form was to be completed with a notation citing the accuracy of the resident's knowledge and stated compliance and placed in the resident's chart under the assessment tab.

Resident 4 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including [redacted].

Review of a plan of care that was updated on 08/23/2023 showed Resident 4 was to receive supervision and assistance with medications, and that the ALF was to store and dispense medication as prescribed by the physician.

Review of electronic medication administration records from December 2023 through February 2024 showed Resident 4 self-administered two medications: Flonase in each nostril one time a day with a start date of 09/30/2022 and Saline Nasal Spray Solution to both nostrils one hour before bedtime for sinus irrigation with a start date of 10/04/2022.

On 02/12/2024 at 11:35 AM, Resident 4 stated that the ALF does all medication except for Resident 4's two nasal sprays. Resident 4 stated they take the sprays themselves.

On 02/09/2024 at 2:45 PM, Staff G, Director of Nursing stated that the ALF provided assistance with medications to Resident 4 except for Resident 4's Flonase and Saline Nasal Spray. Staff G stated that Resident 4 kept the Flonase and Saline Nasal Spray at bedside and self-administered both medications.

On 02/09/2024 at 3:02 PM, Staff G stated that Resident 4 should have had a self-med assessment completed and that there was no self-medication assessment completed. No self-medication assessment was available for review on Resident 4's medical record.

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) 3-19-24 Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(b) Chronic, current, and potential skin conditions; or

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to identify a skin wound in an assessment for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 having a right heel blister which was not identified or treated for 22 days and placed Resident 1 at risk for medical complications from an untreated wound.

Findings included...

Resident 1 was admitted to the ALF on [redacted]/2024 with multiple medical diagnoses including [redacted] and [redacted].

An assessment dated 01/03/2024 completed by Staff G, Director of Nursing, showed Resident 1 had a groin and coccyx rash. The assessment did not identify a blister on the right heel.

A negotiated service agreement (NSA) dated 01/08/2024 showed chronic skin condition identified as eczema. The NSA had current skin conditions listed as "good." A diagnosis of [redacted], dated 01/26/2024 was identified and written on the NSA.

A progress note dated 01/05/2024 showed Resident 1 was up during the night walking with a limp, with difficulty bearing weight on the right leg.

A progress note dated 01/25/2024 at 9:39 PM showed Resident 1 had a right heel fluid filled blister.

A progress note dated 01/26/2024 at 10:39 AM by Staff A, Medication Technician, showed Resident 1 had a deep tissue injury to the right bottom of the heel and complained of pain when applying socks or shoes to the right foot.

An after-visit summary dated 01/26/2024 at 1:45 PM showed Resident 1 was seen for a blister on the right heel. A picture on the after-visit summary showed a fluid filled blister

on the back of Resident 1's heel.

On 02/09/2024 at 11:50 AM, Staff G stated that Resident 1 had a blood blister on their right heel on admission and that she had input the blister in the assessment. After reviewing the assessment Staff G stated, "Oh. I only put the coccyx rash on the assessment. I thought I put it on there." Staff G stated the blister was not identified on the assessment.

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) 3-19-24 Date