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

International Community Health Services
Legacy House
803 South Lane Street
SEATTLE, WA 98104

RE: Legacy House License # 2493

Dear Administrator:

This letter addresses Compliance Determination(s) 54483 (Completion Date 02/07/2025) and 50703 (Completion Date 12/10/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/07/2025 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-2170-1, WAC 388-78A-2240, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-2-a, WAC 388-78A-2230-2-b, WAC 388-78A-2350-7-b, WAC 388-78A-2483-1

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, Licensor

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

Sincerely,

Jamie Singer

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 11/21/2024 and 11/25/2024 of:

Legacy House
803 South Lane Street
SEATTLE, WA 98104

The following sample was selected for review during the unannounced on-site visit: 10 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

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

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

Jamie Singer
Residential Care Services

12/11/2024
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.

Statement of Deficiencies	License #: 2493	Compliance Determination # 50703
Plan of Correction	Legacy House	Completion Date
Page 2 of 12	Licensee: International Community Health Services	12/10/2024

Administrator (or Representative) 12/20/2024 Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure proper and safe installation of side bed rails (SBR) for 4 of 5 sampled residents (Residents 3, 5, 8, and 9). This failure placed Residents 3, 5, 8, and 9 at risk for serious bodily harm, including death from entrapment from a bed mobility device.

Findings included...

Review of the United States Food and Drug Administration (FDA) website, on 05/30/2023, showed the FDA developed a document regarding side bed rail use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessment to monitor a resident's physical and mental status, monitoring high risk residents, and ensuring safe installation of side bed rails. The document outlined risks of using side rails including strangling, suffocating, bodily injury, or death when a person could get caught, and the increased fall risk if not used properly, feelings of isolation and unnecessary restriction and being prevented from completing activities of daily living.

Review of the FDA website, on 05/30/2023, showed specific measurements for side bed rail safety in a posting titled, "Overview of the U.S. food and drug administration's potential zones of bed entrapment." The overview specified the following information:

ZONE 1: Within the Rail - any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space: less than 4 34 inches (").

Review of an undated ALF policy titled ENABLER/SIDE RAIL USAGE, under the section on Procedure, showed, "the ALF Supervisor or his/her designee must complete the Enabler/Side Rail Assessment form for each resident who is requesting the use of an enabler/side rail.

RESIDENT 3
Record review showed that the ALF admitted Resident 3 on [redacted]2024 with multiple

Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure proper and safe installation of side bed rails (SBR) for 4 of 5 sampled residents (Residents 3, 5, 8, and 9). This failure placed Residents 3, 5, 8, and 9 at risk for serious bodily harm, including death from entrapment from a bed mobility device.

Findings included...

Review of the United States Food and Drug Administration (FDA) website, on 05/30/2023, showed the FDA developed a document regarding side bed rail use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessment to monitor a resident's physical and mental status, monitoring high risk residents, and ensuring safe installation of side bed rails. The document outlined risks of using side rails including strangling, suffocating, bodily injury, or death when a person could get caught, and the increased fall risk if not used properly, feelings of isolation and unnecessary restriction and being prevented from completing activities of daily living.

Review of the FDA website, on 05/30/2023, showed specific measurements for side bed rail safety in a posting titled, "Overview of the U.S. food and drug administration's potential zones of bed entrapment." The overview specified the following information:

ZONE 1: Within the Rail - any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space: less than 4 34 inches (").

Review of an undated ALF policy titled ENABLER/SIDE RAIL USAGE, under the section on Procedure, showed, "the ALF Supervisor or his/her designee must complete the Enabler/Side Rail Assessment form for each resident who is requesting the use of an enabler/side rail.

RESIDENT 3
Record review showed that the ALF admitted Resident 3 on [redacted]/2024 with multiple

diagnoses. Review of Resident 3's Service Plan (SP, equivalent to a Negotiated Service Agreement), dated 10/28/2024, showed that Resident 3 had been using an SBR.

Observation and interview, on 11/25/2024 at 11:25 AM, showed an SBR attached on the left side of the bed in Resident 3's apartment. An open space/gap inside of the SBR measured 17" in length and 7" high. There was a metal bar in the middle of the SBR, and a gap from the top bar to the middle bar measured 4.5". Observation showed no protection from the gap of the SBR.

Review of an Enabler/Side Rail (ESR) Assessment, dated 05/28/2024, showed that the ALF marked, "Y" (Yes), to the question "Is there a gap within the side rail?" However, the gap measurement provided on the ESR Assessment was recorded as being 3 ¾", and safely within the assessment minimum measurement of 4 ¾". There was no indication of where in the 3 ¾" measurement was taken inside the gap.

RESIDENT 5
Record review showed that the ALF admitted Resident 5 on [redacted]/2006 with multiple diagnoses. Review of a SP, dated 09/14/2024, showed that Resident 5 had been using an SBR.

Observation, on 11/25/2024 at 1:22 PM, showed an SBR attached to the left side of the bed in Resident 5's apartment. A gap within the SBR measured 14" in length and 4.5" high. Observation showed no protection from the gap of the SBR.

RESIDENT 8
Records review showed that the ALF admitted Resident 8 on [redacted]2023 with multiple diagnoses. Review of Resident 8's SP, dated 09/20/2024, showed that Resident 8 was identified as having an SBR.

Observation, on 11/25/2024 at 1:36 PM, showed an up-side-down U-shaped SBR attached to the left side of the bed in Resident 8's apartment. Observation showed an open space/gap inside of the u-shaped device (the hand grip area) measuring 12" in length and 8" high. Observation also showed an SBR attached to the right side of the bed, and an open space/gap inside the SBR measuring 14" in length and two inches high. Observation showed no protection from the gaps of the SBRs.

Review of an ESR Assessment, dated 08/07/2023 and reviewed on 09/13/2024, showed that the ALF marked, "NO", to the question "Is there a gap within the side rail?" The ESR Assessment showed no gap measurement.

RESIDENT 9
Record review showed that the ALF admitted Resident 9 on [redacted]/2023 with multiple diagnoses, including [redacted] and a history of [redacted].

[redacted]. Review of the Residents Characteristics Roster, date 11/18/2024, showed that Resident 9 was identified as having an SBR.

Observation and interview, on 11/25/2024 at 10:23 AM, showed a SBR attached to the left side of the bed in Resident 9's apartment. Observation showed an open space/gap inside of the SBR measuring 11 inches (") in length and 9" high. Resident 9 stated that they had been using the SBR for getting in and out of the bed for a long time.

Review of an Enabler/Side Rail (ESR) Assessment, dated and reviewed on 11/18/2024, under the section of Risk of Side Rail Entrapment, showed that a gap within the side rail should be less than 4 ¾ inches. But the ALF marked, "NO", to the question of "Is there a gap within the side rail?" The ESR Assessment showed no gap measurement.

In an interview, on 11/25/2024 at 2:15 PM, Staff G (Administrator) stated that she misunderstood about the gap of the SBR. Staff G stated that if the gap was large enough, a resident's head would not become entrapped. Staff G confirmed that she did not measure the gap within the SBR and acknowledged there was no protection from the gap of the SBR.

In an interview, on 11/25/2024 at 4:20 PM, Staff G acknowledged that the gaps of these residents' SBRs needed some protection.

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, Legacy House is or will be in compliance with this law and / or regulation on (Date) 01/08/2025 .

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

Administrator (or Representative) — Date: 10/20/2024

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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to obtain

[redacted] Review of the Residents Characteristics Roster, date 11/18/2024, showed that Resident 9 was identified as having an SBR.

Observation and interview, on 11/25/2024 at 10:23 AM, showed a SBR attached to the left side of the bed in Resident 9's apartment. Observation showed an open space/gap inside of the SBR measuring 11 inches (") in length and 9" high. Resident 9 stated that they had been using the SBR for getting in and out of the bed for a long time.

Review of an Enabler/Side Rail (ESR) Assessment, dated and reviewed on 11/18/2024, under the section of Risk of Side Rail Entrapment, showed that a gap within the side rail should be less than 4 ¾ inches. But the ALF marked, "NO", to the question of "Is there a gap within the side rail?" The ESR Assessment showed no gap measurement.

In an interview, on 11/25/2024 at 2:15 PM, Staff G (Administrator) stated that she misunderstood about the gap of the SBR. Staff G stated that if the gap was large enough, a resident's head would not become entrapped. Staff G confirmed that she did not measure the gap within the SBR and acknowledged there was no protection from the gap of the SBR.

In an interview, on 11/25/2024 at 4:20 PM, Staff G acknowledged that the gaps of these residents' SBRs needed some protection.

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, Legacy House 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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to obtain physician's prescribed medications in a timely manner for 1 of 10

sampled residents (Resident 1) who required staff assistance with medications. This resulted in Resident 1 not receiving an eye medication for over one week and placed Resident 1 at risk for a compromised health condition.

Findings included...

Records review showed that the ALF admitted Resident 1 on [redacted]/2017 with multiple disabling diagnoses including [redacted] and [redacted].

Review of Resident 1's Assessment and Service Agreement Results (ASAR, equivalent to a Full Assessment and a Negotiated Service Agreement), dated 07/16/2024, showed that Resident 1 required staff assistance with medication services.

Review of a physician's order, dated 10/16/2024, showed that Resident 1 was prescribed to use an eye lubricant drop (artificial tears, used for dry eyes) twice a day. Review of the November 2024 electronic Medication Administration Records (eMARs) showed that Resident Assistants (RAs - caregivers who assist residents with medications) had been applying the eye drops for Resident 1 at 8:00 AM and 8:00 PM. Review of the November eMARs showed that RAs had been noting "DNA "(Drug Not Available) in a column for the eye lubricant drops, from the 8:00 PM dose of 11/17/2024 until the 8:00 PM dose of 11/20/2024.

Observation and interview, on 11/22/2024 at 8:40 AM, showed an empty box for Resident 1's eye lubricant drops in a medication cart. Staff J (RA) stated that there were no eye drops. Staff J stated that RAs were responsible for sending a refill order to the pharmacy when the eye drops supply became low, like when there were three or four doses left. Staff J stated that they were unable to tell when the eye drops would run out.

Review of a fax form to the pharmacy, dated 11/17/2024, showed the ALF requested the pharmacy to refill Resident 1's eye drops after it had already completely run out. On 11/18/2024, the ALF received a fax from the pharmacy stating that the eye lubricant was out of stock. Record review showed no documentation as to whether the ALF had contacted the pharmacy to determine how soon they would be able to deliver the eye lubricant. There was no documentation as to whether the ALF had contacted Resident 1's physician about the unavailability of the eye lubricant.

In an interview, on 11/25/2024 at 2:20 PM, Staff H (Registered Nurse) confirmed that Resident 1 had not received the prescribed lubricant drops for about eight days.

Statement of Deficiencies	License #: 2493	Compliance Determination # 50703
Plan of Correction	Legacy House	Completion Date
Page 6 of 12	Licensee: International Community Health Services	12/10/2024

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, Legacy House is or will be in compliance with this law and / or regulation on (Date) 12/10/2024 .

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

Administrator (or Representative) — Date: 12/20/2024

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:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and document a plan in the Negotiated Service Agreement (NSA), for 3 of 6 sampled residents (Resident 2, 4, and 10), a plan to monitor and address potential side effects for aspirin therapy. This placed the Resident 2, 4, and 10 at risk for compromised health.

Findings included...

Note: According to the Davis Drug Guide for Nurses, January 2023, aspirin (also known as Acetylsalicylic Acid or ASA), may be prescribed to reduce the risk of heart attacks in people with a history of heart attacks, ischemic strokes (when a blood clot blocks the flow of blood to the brain). Aspirin decreases platelet aggregation (causes red blood cells to be less sticky so they do not form blood clots). Adverse reactions include ringing in the ears, bloody vomit, unusual bleeding of the gums, bruising, and bright red or black, tarry stools.

Resident 2
Record review showed the ALF admitted Resident 2 on [redacted]/2019 with disabling diagnoses to include a history of [redacted]. Record review showed Resident 2 took prescription medications including aspirin (a medication with blood thinning properties) prescribed on 03/31/2023. Record review of a Service Plan (equivalent to an NSA),

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, Legacy House 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:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and document a plan in the Negotiated Service Agreement (NSA), for 3 of 6 sampled residents (Resident 2, 4, and 10), a plan to monitor and address potential side effects for aspirin therapy. This placed the Resident 2, 4, and 10 at risk for compromised health.

Findings included...

Note: According to the Davis Drug Guide for Nurses, January 2023, aspirin (also known as Acetylsalicylic Acid or ASA), may be prescribed to reduce the risk of heart attacks in people with a history of heart attacks, ischemic strokes (when a blood clot blocks the flow of blood to the brain). Aspirin decreases platelet aggregation (causes red blood cells to be less sticky so they do not form blood clots). Adverse reactions include ringing in the ears, bloody vomit, unusual bleeding of the gums, bruising, and bright red or black, tarry stools.

Resident 2
Record review showed the ALF admitted Resident 2 on [redacted]/2019 with disabling diagnoses to include a history of [redacted]. Record review showed Resident 2 took prescription medications including aspirin (a medication with blood thinning properties) prescribed on 03/31/2023. Record review of a Service Plan (equivalent to an NSA),

dated 09/03/2024, showed Resident 2 required assistance with medication administration.

Record review of the electronic Medication Administration Records (eMARs) for September, October, and November 2024 showed Resident 2 took aspirin 81 milligrams (mg) daily at 8:00 AM for peripheral vascular disease (a condition that reduces blood flow to the arms, legs, or other body parts).

Review of Resident 2's NSA dated 09/03/2024, showed no documentation how to monitor and the risks associated with long-term daily aspirin therapy including signs of unusual bruising, bleeding, or symptoms of internal bleeding.

Resident 4
Record review showed the ALF admitted Resident 4 on [redacted]/2022 with disabling diagnoses including [redacted]. Record review showed Resident 4 took prescription medications including aspirin, prescribed on 02/23/2022. Record review of the NSA, dated 02/13/2024, showed Resident 4 required assistance with all medication administration.

Record review of eMARs for September, October, and November 2024 showed Resident 4 took aspirin 81 mg daily at 8:00 AM for coronary artery disease (a condition where the major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath).

Review of Resident 4's NSA, dated 02/13/2024, showed no documentation how to monitor and the risks associated with long-term daily aspirin therapy including signs of unusual bruising, bleeding, or symptoms of internal bleeding.

Resident 10
Record review showed the ALF admitted Resident 10 on [redacted]/2024 with disabling diagnoses including [redacted]. Record review showed Resident 10 took prescription medications including aspirin, prescribed on 12/26/2023. Record review of the NSA, dated 11/18/2024, showed Resident 10 required assistance with medication administration.

Record review of eMARs for September, October, and November 2024 showed Resident 10 took aspirin 325 mg daily at 8:00 AM.

Review of Resident 10's NSA dated 11/18/2024, showed no documentation how to monitor and the risks associated with long-term daily aspirin therapy including signs of unusual bruising, bleeding, or symptoms of internal bleeding.

During an interview, on 12/04/2024 at 9:55 AM, Staff H (Registered Nurse)

acknowledged that blood thinner safety instructions should be part of the 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, Legacy House is or will be in compliance with this law and / or regulation on (Date) ~~01/21/2025~~ 1/24/2025 with IJR sent on 12/16/24

SB confirmed ammended POC date with provider on 1/29/2025.

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

Administrator (or Representative) — Date: 12/20/24

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

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate for any negative outcomes when 1 of 2 sampled residents (Resident 2) refused their prescribed medications. This placed Resident 2 at risk for a compromised health condition.

Findings included...

Review of the ALF's Medication Refusal Policy, dated 11/28/2023, showed to notify the prescribing physician of missed or refused medications. The Policy included Resident Assistants (RA) would report to Registered Nurse (RN) using a Blue Form. The RN would

acknowledged that blood thinner safety instructions should be part of the 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, Legacy House 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

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate for any negative outcomes when 1 of 2 sampled residents (Resident 2) refused their prescribed medications. This placed Resident 2 at risk for a compromised health condition.

Findings included...

Review of the ALF's Medication Refusal Policy, dated 11/28/2023, showed to notify the prescribing physician of missed or refused medications. The Policy included Resident Assistants (RA) would report to Registered Nurse (RN) using a Blue Form. The RN would

evaluate the resident and notify the prescriber of repeated medication refusals and documented in the progress notes (PN). The RN would follow the prescriber's directions regarding medication refusals or missed medications.

Record review showed the ALF admitted Resident 2 on [redacted]/2019 with multiple diagnoses. Review of Services Plan (SP – equivalent to Negotiated Service Agreement), dated 09/03/2024, showed Resident 2 required staff assistance with medication administration.

Record review of a physician order, dated 03/29/2024, showed a prescription for Lubricant ophthalmic solution 0.5% (used to dry eyes) one drop four times daily. On 09/30/2024, Resident 2's physician also ordered Vevey ophthalmic solution for dry eyes syndrome of bilateral lacrimal glands (caused by plugged or inflamed oil glands along the eyelid).

Review of the electronic Medication Administration Records (eMARs) for September 2024, showed a pattern of refusals for Resident 2's eye drops on 10/03/2024, 10/19/2024, and 10/24/2024.

Record review showed no documentation that the ALF evaluated or notified the physician of Resident 2's medication refusals.

In interview, on 12/04/2024 at 9:55 AM, Staff H (Registered Nurse) acknowledged the lack of reporting by RAs to the nurses to evaluate Resident 2's medication refusals and notify the physician. Staff H acknowledged Resident 2's medication refusals were not reported to the prescriber.

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, Legacy House is or will be in compliance with this law and / or regulation on (Date) 12/31/2024 .

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

Administrator (or Representative) 12/20/2024 Date

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical,

evaluate the resident and notify the prescriber of repeated medication refusals and documented in the progress notes (PN). The RN would follow the prescriber's directions regarding medication refusals or missed medications.

Record review showed the ALF admitted Resident 2 on [redacted]2019 with multiple diagnoses. Review of Services Plan (SP – equivalent to Negotiated Service Agreement), dated 09/03/2024, showed Resident 2 required staff assistance with medication administration.

Record review of a physician order, dated 03/29/2024, showed a prescription for Lubricant ophthalmic solution 0.5% (used to dry eyes) one drop four times daily. On 09/30/2024, Resident 2's physician also ordered Vevey ophthalmic solution for dry eyes syndrome of bilateral lacrimal glands (caused by plugged or inflamed oil glands along the eyelid).

Review of the electronic Medication Administration Records (eMARs) for September 2024, showed a pattern of refusals for Resident 2's eye drops on 10/03/2024, 10/19/2024, and 10/24/2024.

Record review showed no documentation that the ALF evaluated or notified the physician of Resident 2's medication refusals.

In interview, on 12/04/2024 at 9:55 AM, Staff H (Registered Nurse) acknowledged the lack of reporting by RAs to the nurses to evaluate Resident 2's medication refusals and notify the physician. Staff H acknowledged Resident 2's medication refusals were not reported to the prescriber.

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, Legacy House 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-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to coordinate care for 1 of 1 sampled resident (Resident 6), who was prescribed to wear a compression stocking (TED hose) daily. This placed Resident 6 at risk for compromised health.

Findings included...

Record review showed the facility admitted Resident 6 on [redacted]/2020 with multiple diagnosis including [redacted]. Review of the Service Plan (equivalent to a Negotiated Service Agreement), dated 12/20/2023, showed Resident 6 required moderate assistance with activities of daily living (a term used in healthcare to refer to people's daily self-care activities such as dressing, grooming, bathing, ambulation, etc.).

Review of a Physician's Order, dated 03/29/2023, showed Resident 6 was to wear TED hose daily for 12 hours, on in the morning and off in the evening for edema (or swelling - a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body).

Review of the electronic Medication Administration Records (eMARs) for September, October, and November 2024, showed the ALF were to don Resident 6's TED hose at 6:00 AM, and remove and wash the TED hose at 6:00 PM. The eMARs under TED hose, showed facility frequently entered, "OTH," to indicate Resident 6 had removed her TED hose. There was no documentation as to when and reason why Resident 6 had removed her TED hose.

Review of the eMARs showed the ALF documented that Resident 6 removed their TED hose, prior to 6:00 PM, 27 times in September, 28 times in October, and 18 times in November 2024.

Review of the Progress Notes showed no documentation that Resident 6 had refused to wear her TED hose or her pattern of removing her TED hose. There was no documentation whether Resident 6's physician had been notified she was removing her TED hose, and therefore not wearing them or getting the therapeutic benefit from them.

During an interview, on 12/04/2024 at 9:55 AM, Staff H (Registered Nurse) acknowledged the ALF had not notified Resident 6's refusal or removing of their TED hose.

Statement of Deficiencies	License #: 2493	Compliance Determination # 50703
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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, Legacy House is or will be in compliance with this law and / or regulation on (Date) 12/12/2024 .

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

Administrator (or Representative) — Date: 12/20/2024

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff members (Staff A) completed the required one step tuberculin skin test (TST). This placed 68 residents at risk of exposure to a communicable disease.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2480 Tuberculosis—Testing—Required. (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Record review showed the ALF hired Staff A (Registered Nurse) on 07/27/2024. Record review showed Staff A had documentation of two negative TST on 06/14/2023 and 06/30/2023. Record review showed the ALF did not complete a one step TST following a documented history of a negative two-step TST.

In interview, on 11/22/2024 at 2:35 PM, Staff I (Employee Health Administrator) stated Staff I was not aware that Staff A required to take a one-step TST following a documented history of a negative two-step TST.

Plan/Attestation Statement

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, Legacy House 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-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff members (Staff A) completed the required one step tuberculin skin test (TST). This placed 68 residents at risk of exposure to a communicable disease.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2480 Tuberculosis—Testing—Required. (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Record review showed the ALF hired Staff A (Registered Nurse) on 07/27/2024. Record review showed Staff A had documentation of two negative TST on 06/14/2023 and 06/30/2023. Record review showed the ALF did not complete a one step TST following a documented history of a negative two-step TST.

In interview, on 11/22/2024 at 2:35 PM, Staff I (Employee Health Administrator) stated Staff I was not aware that Staff A required to take a one-step TST following a documented history of a negative two-step TST.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2493	Compliance Determination # 50703
Plan of Correction	Legacy House	Completion Date
Page 12 of 12	Licensee: International Community Health Services	12/10/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Legacy House is or will be in compliance with this law and / or regulation on (Date) ~~2/21/2025~~ 1/24/2025 with. IJR sent on 12/16/2024

SB confirmed ammended POC date with provider on 1/29/2025.

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

Administrator (or Representative) Date 12/20/24

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, Legacy House 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