



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

04/15/2024

PSL Associates, LLC
Cordata Court, Assisted Living & Memory Care
4415 Columbine Dr
Bellingham, WA 98226

RE: Cordata Court, Assisted Living & Memory Care License # 2481

Dear Administrator:

This letter addresses Compliance Determination(s) 39516 (Completion Date 04/11/2024) and 35003 (Completion Date 01/10/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/11/2024 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-2210-1-b, WAC 388-78A-2474-2-a, WAC 388-112A-0400-3-b, WAC 388-112A-0400-3-c, WAC 388-112A-0400-4-b, WAC 388-112A-0400-4-c, WAC 388-78A-2480-1, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2100-2-b

The Department staff who did the on-site verification:

Christine Banta, ALF Licenser

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

Sincerely,

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

This document was prepared by Residential Care Services for the Locator website.



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 #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 1 of 10	Licensee: PSL Associates, LLC	01/10/2024

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

The department completed data collection for an unannounced on-site follow-up on 01/10/2024 and 01/10/2024 of:

Cordata Court, Assisted Living & Memory Care
4415 Columbine Dr
Bellingham, WA 98226

This document references the following SOD dated: 01/10/2024

The following sample was selected for review during the unannounced on-site visit: 8 of 84 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licenser
Judith Mellon, RN, Licenser

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

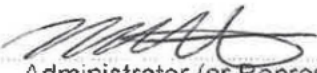
01/23/2024

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.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 2 of 10	Licensee: PSL Associates, LLC	01/10/2024


Administrator (or Representative)

2/02/24
Date

WAC 388-78A-2210 Medication services.

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
- (b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide safe medication services for 2 of 8 residents (Resident 2 and 4). This failure resulted in Resident 2 taking medication not prescribed by their physician and Resident 4 not receiving medications as prescribed and placed these residents at risk for medical complications.

Findings included...

Resident 2

Resident 2 was admitted to the ALF on [REDACTED]/2022 with multiple diagnoses including [REDACTED], and [REDACTED].

Review of a negotiated service agreement (NSA) dated 01/10/2024 showed Resident 2 required medication assistance and ALF staff were responsible for assisting Resident 2 with their medications.

On 01/10/2024 at 3:10 PM, a bottle of AREDS eye vitamins (a vitamin used to help slow down vision loss in certain eye diseases) was on Resident 2's kitchen counter.

In an interview on 01/10/2024 at 3:11 PM, Resident 2 stated that they still independently take their AREDS eye vitamins twice a day.

Review of an Electronic Medication Administration Record (EMAR) dated November 2023 showed no record of AREDS eye vitamin being one of Resident 2's prescribed medications. An EMAR dated December 2023 and an EMAR dated January 2024 did not show AREDS

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 3 of 10	Licensee: PSL Associates, LLC	01/10/2024

being prescribed and administered to Resident 2.

In an interview on 01/10/2024 at 3:55 PM, Staff A, Executive Director, stated that they were fairly confident that they didn't have an order for Resident 2's AREDS. Staff A stated that they knew this was an issue earlier this year, but they did not know that Resident 2 was still taking the AREDS. Staff A stated that they needed to obtain an order for this medication.

In an interview on 01/10/2024 at 4:12 PM, Staff G, Health and Wellness Director, stated that they do not have an order for Resident 2's AREDS. Staff G stated that they will have to reach out to Resident 2's physician to let them know Resident 2 was taking AREDS and get an order for it.

This is an uncorrected deficiency previously cited on 10/04/2023.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>3/18/24</u> .
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.
 _____ Administrator (or Representative) <u>02/02/24</u> _____ 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;

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

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(b) Dementia specialty training as described in WAC 388-112A-0440 ;

(c) Mental health specialty training as described in WAC 388-112A-0450 .

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 4 of 10	Licensee: PSL Associates, LLC	01/10/2024

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

- (b) Dementia specialty training as described in WAC 388-112A-0440 ; and
- (c) Mental health specialty training as described in WAC 388-112A-0450 .

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 6 of 6 staff members (Staff A, B, C, D, E and F) completed specialized dementia training. This failure resulted in Staff A, B, C, D, E, and F not being trained to support residents with dementia issues and placed the residents with a [REDACTED] diagnosis at risk of unmet care needs.

Findings included...

Record review of the resident characteristic roster, dated 01/10/2024, showed the ALF had 18 residents with a diagnosis of [REDACTED]

Record review showed that Staff A, Executive Director, was hired on 09/28/2021. Staff A's files showed no evidence that dementia training was completed.

Record review showed that Staff B, Caregiver, was hired on 05/26/2023. There was no evidence that the dementia training was completed.

Record review showed that Staff C, Caregiver, was hired on 08/01/2022. There was no evidence that the dementia training was completed.

Record review showed Staff D, Caregiver, was hired on 08/10/2022. There was no evidence that the dementia training was completed.

Record review showed Staff E, Caregiver, was hired on 02/14/2020. There was no evidence that the dementia training was completed.

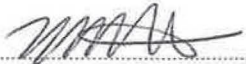
Record review showed Staff F, Resident Care Coordinator, was hired on 07/18/2017. There was no evidence that the dementia training was completed.

In an interview on 01/10/2024 at 1:21 PM, Staff A stated that they knew they were getting

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 5 of 10	Licensee: PSL Associates, LLC	01/10/2024

a recitation for this. Staff A stated that all six sampled staff members, including themselves, had not completed the specialty dementia training yet as they are still looking into scheduling a class.

This is an uncorrected deficiency excluding WAC 388-112A-0400(3)(c) and (4)(c), previously cited on 10/04/2023.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>3/18/24</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>2/2/24</u> Date

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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff members (Staff B and C) were screened for tuberculosis (TB) (a potentially fatal infectious disease that mainly affects the lungs) within three days of hire. This failure resulted in Staff B and C not being screened for TB and placed the safety of all the residents at risk for potentially being exposed to an infectious respiratory disease.

Findings included...

Record review showed Staff B, Caregiver, was hired on 05/26/2023. There was no documentation that a TB test was completed.

In interview on 01/10/2024 at 1:00 PM, Staff A, Executive Director, stated that Staff B had not been tested at all for TB. Staff A stated that Staff B still needed to get a blood test to confirm they do not have TB.

In an interview on 1/10/2024 at 1:10 PM, Staff B stated that they have not gotten any TB screening tests yet.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 6 of 10	Licensee: PSL Associates, LLC	01/10/2024

Record review showed Staff C, Caregiver, was hired on 08/01/2022. There was no documentation that a TB test was completed.

In an interview on 01/10/2024 at 1:03 PM, Staff C stated that they had not completed their TB screening test yet.

In an interview on 01/10/2024 at 1:06 PM, Staff A stated that they need to make sure they complete Staff C's test.

This is an uncorrected deficiency previously cited on 10/04/2023.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>3/19/24</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>2/02/24</u> 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;

(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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Physician was notified for 1 of 1 Resident (Resident 3) when Resident 3 refused to take medications as prescribed. This failure resulted in Resident 3's physicians not being aware of the missed medications and placed Resident 3 at risk for not receiving informed decisions by their health care provider and complications related to untreated health care needs.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 7 of 10	Licensee: PSL Associates, LLC	01/10/2024

Findings included...

Resident 3 was admitted into the ALF on [REDACTED] /2014 with multiple medical diagnoses including

[REDACTED] and [REDACTED].

Review of the negotiated service agreement (NSA) dated 08/17/2023 showed Resident 3 was confused and needed medication assistance. The NSA showed the ALF staff were responsible to re-order medications.

Review of Resident 3's electronic medication administration records (EMAR) for the month of November and December 2023 showed Resident 3 refused the following medications:

Armour Thyroid 60 mg (unit of measurement) daily, used to replace missing thyroid hormones (chemical substance in the body), one dose on 12/13/2023.

Aspirin EC 81 mg daily, anti-inflammatory and blood thinner, one dose on 12/13/2023.

Cholestyramine one 4 gram (gm) packet twice a day in 4-8 ounces of fluid, used to lower cholesterol levels (shows how much cholesterol is circulating in the blood), two doses on 12/13/2023.

Dicyclomine 10 mg twice a day, used to treat irritable bowel syndrome (an intestinal disorder), two doses on 12/13/2023.

Dorzolamide 2% eye drops, one drop in both eyes twice a day, used to treat high pressure in the eye for glaucoma (eye disease that can cause vision loss and blindness), two doses on 12/13/2023, one dose on 12/27/2023, and one dose on 12/28/2023.

Spironolactone 25 mg, two times a day, treats high blood pressure and heart failure, two doses on 12/13/2023.

Latanoprost 0.005% eye drops one drop in both eyes every evening, used to treat increased eye pressure/glaucoma, one dose on 12/13/2023 and one dose on 12/28/2024.

Omeprazole 20 mg every morning, used to reduce the amount of acid your stomach makes, one dose on 12/23/2023.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 8 of 10	Licensee: PSL Associates, LLC	01/10/2024

In an interview on 01/10/2024 at 4:15 PM, Staff G, LPN, Health and Wellness Director stated that Resident 3 received care from an outside agency who communicated with the physician, and the ALF was still providing Resident 3's medications. Staff G stated that the outside agency was notified of only one missed dose of omeprazole and no other missed medications.

In an interview on 01/10/2024 at 4:30 PM, Staff A, Executive Director stated that Resident 3 received services from an outside provider in December 2023. Staff A stated that there were no other physician medication notifications other than one missed dose of omeprazole to show the physician was notified of any missed medications.

Review of a fax notification form dated 12/13/2023 at 1:00 PM showed the outside agency was notified of one missed dose of omeprazole.

The ALF's plan of correction showed for WAC 388-78A-2230 (1)(c)(ii) Medication refusal showed by 11/18/2023 Medication Technicians would notify the Health and Wellness Director of refusals and the Health and Wellness Director would follow-up with the physician. No other physician notifications were available for review.

This is an uncorrected deficiency previously cited on 10/04/2023.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>2/10/24</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>2/02/24</u> _____ Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

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

(b) When the resident's negotiated service agreement no longer addresses the resident's

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 9 of 10	Licensee: PSL Associates, LLC	01/10/2024

current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to complete an assessment for 1 of 1 resident (Resident 2) for the use of a transfer pole and bedrail. This failure resulted in Resident 2 not being assessed to safely use these assistive devices and placed Resident 2 at risk for injury.

Findings included...

Review of the ALF's policy "Bed Mobility Device" dated 09/14/2021 showed it was the responsibility of the Executive Director and Health and Wellness Director to determine if the resident can use the device safely and understand potential hazards by completing the ALF's Bed Mobility Device Assessment and Acknowledgement Form. The policy showed that the ALF would obtain a physician's order for the use of mobility devices and train staff on how to inspect the device for safety and understanding the hazards of using a mobility device that attaches to the bed.

Resident 2 was admitted in the ALF on [REDACTED] /2022 with multiple diagnoses including [REDACTED] and [REDACTED].

On 10/04/2023 the ALF was cited on WAC 388-78A-2100(2)(b) On-going assessments, when the ALF had failed to address Resident 2's current needs including the use of a transfer pole and bedrail in their assessment. The ALF submitted an attestation stating that they would be back in compliance with this WAC on 11/18/2023.

On 01/10/2024 at 3:11 PM, Resident 2 was in a wheelchair in their room. A transfer pole was observed in the middle of the room. A half bedrail was attached on the left side of Resident 2's bed.

In an interview on 01/10/2024 at 3:12 PM, Resident 2 stated that they use the bedrail and transfer pole multiple times a day to help them get out of bed and into their wheelchair independently.

Review an assessment dated 01/10/2024 showed that Resident 2 was able to transfer independently. The assessment showed that Resident 2 self-ambulates with a walker. There was no mention of the transfer pole or the bed rail.

In an interview on 01/10/2024 at 2:00 PM, Staff G, Health and Wellness Director, stated

Statement of Deficiencies	License #: 2481	Compliance Determination # 35003
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page: of 10	Licensee: PSL Associates, LLC	01/10/2024

that there had not been any assessments completed on Resident 2's ability to safely use a bedrail and transfer pole.

In an interview on 01/10/2024 at 2:00 PM, Staff A, Executive Director, stated that no assessment for the use of a bedrail and transfer pole had been completed for Resident 2. Staff A stated that they do not have a physician's order for the bedrail or transfer pole.

This is an uncorrected deficiency previously cited on 10/04/2023.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>3/18/24</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>2/02/24</u> _____ Date

This document was prepared by Residential Care Services for the Locator website.



Residential Care Services Investigation Summary Report

Provider/Facility: Cordata Court, Assisted
Living & Memory Care
License/Cert.#: 2481

Provider Type: Assisted Living Facility

Intake ID: 93223

Compliance Determination #: 28530

Region/Unit #: RCS Region 2 / Unit A

Investigator: Judith Mellon

Investigation Date(s): 08/23/2023 through 10/04/2023

Complainant Contact Date(s):

Allegation(s):

- 1) A Named Resident (NR) was believed to be neglected by an unknown Staff person and was not checked on by Assisted Living Facility (ALF) Staff.
- 2) The NR was lying in bed in urine as if not changed during the night.
- 3) The Staff did not want to get the NR up out of bed and take the NR to the dining room.
- 4) The Staff stated the NR was difficult to get out of bed because the NR was aggressive.
- 5) The NR had lice and was put in quarantine.
- 6) The Staff may have been mentally abusing the NR by restricting social activities.
- 7) The NR was not receiving care when outside and providers are not there.
- 8) The NR's living quarters were never clean, there was a urine and feces odor in the NR's bathroom.
- 9) The NR had no fitted sheet and was lying on plastic with a few throw blankets beside the NR.
- 10) The Staff take the NR's meal order and then it takes 45 minutes to get food while the staff take breaks.

Investigation Methods:

Sample:

Total residents: 56
Resident sample size: 9
Closed records sample size: 1

Observations:

Named Resident and Named Resident's living quarters, staff response to resident care needs, NR shower, transfers and care, medication administration, Named Resident and Staff interactions

Interviews:

Named Resident, family, outside agency, outside provider, Executive Director, Assisting Health and Wellness Director/Nurse, Resident Care Coordinator, Caregivers, Medication Technician

Record Reviews:

NR medical records including electronic medication administration records from March 2023 through August 2023, Physician faxes, facility policies

Investigation Summary:

- 1, 7) The NR was observed during an unannounced visit to be well groomed, clean and neatly dressed sitting in a recliner chair watching television with an outside Agency Staff present. The NR was observed to be assisted by ALF Staff for a shower and hygiene care prior to outside Agency Staff arriving to the NR's living quarters. No findings.
- 2) The NR was observed to be lying in bed incontinent of urine in the morning. A Citation was written for WAC 388-78A-2160.
- 3) The NR was observed to be lying in bed in the morning and the NR was not at the Dining Room for meals. The NR was observed to have a take-out container brought to the NR's living quarters. Staff were notified by Nursing Staff requesting to know why the NR was not brought down to breakfast in the morning. A Citation was written for WAC 388-78A-2160.
- 4) The NR was observed to be pleasant, smiling and attempting to engage in conversation with ALF Staff. No aggression was observed. An ALF Caregiver stated that the NR was not at the dining room because the NR was aggressive. A Citation was written for WAC 388-78A-2160.
- 5) The NR was assessed by the Regional Nurse to have lice. The ALF Staff notified family and the Physician. The NR stayed in the NR's living quarters to prevent the spread of lice. The NR's Physician wrote a prescription to treat the NR with Rid Nix, however the prescription was not sent to the ALF. The family purchased an over-the-counter treatment and applied the treatment. No findings.
- 6) ALF documentation showed the NR refused activities and requested to stay in the NR's living quarters. No mental abuse observed. The NR denied any abuse by Staff. No findings.
- 8) The NR's kitchenette floor was sticky to walk on and the NR's bathroom had a toilet bowl unclean with feces. No urine or feces odor was present in the NR's living quarters. A Citation was written for 388-78A-3090 (1)(a)(c).
- 9) The NR was observed lying in bed. The bed had a fitted sheet, incontinence pad and blankets. No findings.
- 10) The NR's negotiated service agreement showed the NR was to be escorted to all meals. The NR was observed to not attend the dining room for breakfast. A breakfast take out container was observed carried into the NR's living quarters. Staff stated the NR did not go to breakfast. A Citation was written for 388-78A-2160.

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

10/09/2023

Licensee: PSL Associates, LLC
Cordata Court, Assisted Living & Memory Care
4415 Columbine Dr
Bellingham, WA 98226

RE: Cordata Court, Assisted Living & Memory Care License # 2481

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 10/04/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

PSL Associates, LLC
Cordata Court, Assisted Living & Memory Care # 2481
10/04/2023
Page 2 of 34

Kimberley Ripley, Field Manager
Residential Care Services
Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (360)651-6846.

Sincerely,

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

Enclosure

This document was prepared by Residential Care Services for the Locator website.



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

RECEIVED

NOV 06 REC'D

ALISA/RCS-ARLINGTON

Statement of Deficiencies	License #: 2481	Compliance Determination #28530
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 3 of 34	Licensee: PSL Associates, LLC	10/04/2023

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 08/23/2023 and 10/04/2023 of:

Cordata Court, Assisted Living & Memory Care
4415 Columbine Dr
Bellingham, WA 98226

This document references the following complaint numbers: 93223, 93683.

The following sample was selected for review during the unannounced on-site visit: 9 of 56 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Christine Banta, Community Complaint investigator
Judith Mellon, RN, Licenser

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

10/09/2023

Date

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

This document was prepared by Residential Care Services for the Locator website.


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

This requirement was not met as evidenced by:

Based on observations and interviews the Assisted Living Facility (ALF) failed to provide basic housekeeping and maintenance services to keep resident living quarters in a safe and sanitary condition. This failure resulted in an unsanitary and unclean environment for all residents and placed residents at risk for a diminished quality of life.

The ALF consists of three floors and a secured memory care unit located on the first floor.

Findings included...

On 08/23/2023 at 9:46 AM, the following was observed on the 3rd floor:

The ALF's Heating, Ventilation and Air Conditioning (HVAC) room was full of flooring/wood type supplies, two mini refrigerators, two boxes of baseboards, boxes and a box fan that was covered with black, dusty debris, the floor was dirty with dust and pieces of debris. Three used filters (furnace type) were on the floor and were covered with black dust.

In an interview on 08/23/2023 at 9:48, Staff I, Maintenance Director, stated that the stuff had been there for years, and all the extra supplies were there since the building was built. Staff I stated that he would clean it out.

On 08/23/2023 at 9:49 AM, the resident laundry room door had black scrapes and a garbage can without a lid filled with garbage.

In an interview on 08/23/2023 at 9:50 AM, Staff I stated that the laundry room was used by residents and he was unsure why the garbage can was uncovered.

On 08/23/2023 at 9:52 AM, a storage room had a metal, airflow type duct running through the storage room. Tossed on top of the duct were towels, blankets, and sheets. A dirty box fan was on the floor, building fixtures, a canopy was leaning in the room, a beauty shop chair was against the wall, 17 doors were stacked and leaning in the room, a dusty, and a plastic cabinet with drawers contained opened KN-95 masks, goggles, and gowns.

In an interview on 08/23/2023 at 9:55 AM, Staff I stated that the storage room was a "catch all closet". Staff I stated that he was not sure if the cabinet with the supplies was cleaned or not.

On 08/23/2023 at 9:58 AM, a janitor's closet on the north side had three dirty towels stuffed on shelving with clean cleaning items, a housekeeping floor type basin had a large pile of brown debris in the basin and the basin was dirty. A furnace type filter had black dust build-up and was lying on the floor.

In an interview on 08/23/2023 at 9:58 AM, Staff I stated that the stuff in the floor basin was from yesterday, he had cleaned the carpeting and had emptied the water from cleaning into the basin and that was what the brown stuff was.

On the 2nd floor:

On 08/23/2023 at 10:05 AM, Staff I was observed having difficulty opening and going into a storage room. As Staff I attempted to open the door, large, stacked boxes kept falling and blocked the door from opening.

In an interview on 08/23/2023 at 10:07 AM, Staff I stated that the storage room was one of the Covid supply closets and the boxes were stacked in a way that was blocking the door.

On 08/23/2023 at 10:10 AM, a Resident door near the storage room was observed to have heavy surface abrasions into the door with black marks.

On 08/23/2023 at 10:10 AM, Staff I stated that he needed to get a kickplate on the resident's door, that the resident had a wheelchair and had scraped the door with the wheelchair.

On 08/23/2023 at 10:11 AM, a storage room on the 2nd floor had 16 resident room doors propped up and three dresser drawers.

On 08/23/2023 at 10:15 AM, a laundry room on the north side had a garbage can without a lid and garbage in the garbage can.

On 08/23/2023 at 10:17 AM, an HVAC room had metal shelving with wheels in the room with nursing supplies. The supplies were on the shelves and on the floor. Personal protective equipment was observed on the floor under the shelving, a rubber glove was laying on the floor, Covid Binax-Now Testing supplies were left sitting on the floor in an open box with other shelving items sitting on top of the Covid testing supplies. Multiple boxes were stacked, open, or sitting on the floor with adult type briefs in them. Bed rails were stacked in the room. A sign posted showed, "Do not store items in front of HVAC equipment." Boxes were stacked against the HVAC. A large brown stain was on the floor.

On 08/23/2023 at 10:19 AM, Staff I stated that the HVAC room was always used as a nursing supply room and was unsure why the items were around the room. Staff I stated that it looked like someone must have spilled their coffee or something. Staff I stated that he would get all the HVAC rooms cleaned right away.

On the ALF's 1st floor:

On 08/23/2023 at 10:32 AM, an HVAC room had 20 five-gallon buckets of paint sitting against, around, and behind the furnace. A table near the furnace had bottles of peroxide, Goo Gone (cleaner), a paint primer can and an aerosol room deodorizer sitting on the table.

In an interview on 08/23/2023 at 10:32 AM, Staff I stated that the buckets shouldn't be around the furnace and that he would get the buckets moved out of there.

In an interview on 08/24/2023 at 10:27 AM, Collateral Contact, Fire Marshal, stated that the ALF should not have paint stored around the furnace or any aerosols located near the furnace.

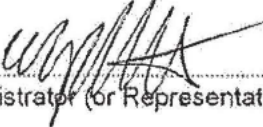
On 08/23/2023 at 10:44 AM the ALF's Bistro area had brown liquid stains and coffee grounds in the drawers of the cabinets. The Kitchen floor had black grime on the flooring surface. Paper, plastic debris, food spillage, a dirty spoon and a bird feather were observed on the floor. The base of a white mini stand-alone freezer was dirty. Food debris was built up on the front of the hot service table and on top of the electrical cables running on the side of the hot service table.

In an interview on 08/23/2023 at 10:49 AM, Staff G, Dining Service Director, stated that the floors were looking pretty bad. Staff G stated that the Dietary Staff had cleaning duties but they were short staffed.

On 08/28/2023 at 8:53 AM, Resident 1's apartment had an unclean toilet with stool observed on the bowl with the lid/seat area dirty. The floor in the kitchenette area was sticky.

On 08/28/2023 at 8:15 AM, two bathrooms for visitor and residents located on the first floor had no toilet paper in either bathroom. One of the bathrooms had stool splashed throughout the toilet.

On 08/28/2023 at 8:30 AM, the paper towel machine located in the employee bathroom was not working.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/3/2023</u> Date

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure visitors and staff were able to exit the secured memory care unit on their own when the door code was not posted. This failure resulted in visitors being unable to exit the ALF without assistance from staff.

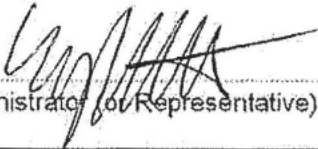
Findings included...

On 08/23/2023 at 10:40 AM, visitors were unable to exit the memory care unit without assistance. No signage or instructions on how to exit were observed to be posted near the exit door.

In an interview on 08/28/2023 at 4:00 PM, Staff J, Dietary Server, stated that they were not sure how people know how to exit. Staff J stated that they would have to "ask someone to get out".

On 08/28/2023 at 3:55 PM, visitors were unable to exit the secured memory care unit and requested assistance from staff to exit.

In an interview on 08/28/2023 at 3:55 PM, Staff K, Memory Care Director, stated that he could help get the visitor out of the memory care unit. Staff K stated that a Resident in the memory care unit had attempted an elopement and the door code was removed to prevent the Resident from leaving the memory care unit.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/18/2023</u> Date

WAC 246-215-04600 Objective Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (FDA Food Code 4-601.11).

(1) equipment, food-contact surfaces, and utensils must be clean to sight and touch.

(3) Nonfood-contact surfaces of equipment must be kept free of an accumulation of dust, dirt, food residue, and other debris.

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:

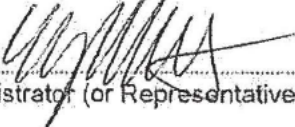
Based on observation and interview, the Assisted Living Facility (ALF) failed to keep the kitchen floor and the stove clean when the grease trap of their stove broke and caused grease to drip down the stove and on the floor. This failure resulted in the kitchen being unsanitary and placed the staff at risk for slipping and a grease fire.

Findings included...

On 08/23/2023 at 10:50 AM, a metal pan was observed on the floor, in front of the right-side of the main kitchen stove collecting grease that was dripping from the stove. The

grease trap of the stove was partially open. There was a trail of solidified grease about four inches wide starting from under the grease trap leading down to the drip pan placed under the stove. There were dark brown grease spots (2-3 inches wide in diameter) in numerous places on the floor including the front of the stove, under the stove and behind the stove.

In interview on 08/23/2023 at 10:50 AM, Staff G, Dining Director, stated that the grease trap had been broken for months and was not sure if a new one had been ordered. Staff G stated that they had placed the drip pan under the grease trap to catch the overflow.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/19/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/3/2023</u> Date

WAC 388-78A-2210 Medication services.

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
- (b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 4 of 9 Residents (Residents 1, 5, 8, and 9) received medications as prescribed by the physician. This failure resulted in Residents 1, 5, 8, and 9 not receiving medications as prescribed and placed residents at risk for medical complications related to missed medications.

Findings included...

Resident 1

Resident 1 was admitted to the ALF on [REDACTED] /2023 with multiple medical diagnoses including [REDACTED]

██████ and ██████.

Review of Resident 1's most recent negotiated service agreement (NSA) dated 08/23/2023 showed Resident 1 required assistance with medications and the Licensed Nurse (LN) or Med Technician (MT) would be responsible for assisting Resident 1.

Review of Resident 1's electronic medication administration records (EMAR) dated from March 2023 through August 2023 showed Resident 1 was prescribed the following medications:

Metformin 500 mg (unit of measurement) one tablet twice daily, medication that controls blood sugar levels
Potassium Cit ER 10 MEQ (unit of measurement), two tablets three times a day, helps make urine with less alkaline
Aspirin EC 81 mg once daily, works as anti-inflammatory and blood thinner
Fluticasone Prop nosespray, two sprays in each nostril daily, relieves nasal symptoms
Loperamide 2 mg Mon/Wed/Fri hold for constipation and notify Physician, used to treat diarrhea
Losartan 25 mg daily, treats high blood pressure reducing risk of stroke
Melatonin 3 mg every evening two hours before bedtime, used to help promote sleep
Omeprazole 20 mg take one capsule daily 30 minutes prior to meal, reduces stomach acid
Risperidone 0.25 mg one tablet daily at bedtime, antipsychotic medication
Sertraline 50 mg, take three tablets (150 mg) daily, mood enhancer
Simvastatin 40 mg at bedtime, used to treat high cholesterol and reduces the risk of heart attack and stroke
Tamsulosin 0.4 mg capsule at bedtime, relaxes muscles in the prostate and bladder
Vitamin D3 5,000 U capsule every day, supplement

In an interview on 08/25/2023 at 11:44 AM, Collateral Contact 3 (CC3) stated that Resident 1 had physically moved into the ALF on ██████/2023 with assistance by family. CC3 stated that when Resident 1 moved in, CC3 was told if CC3 did not give Resident 1 medications, then Resident 1 was not going to get the medications. CC3 stated that they said there was some kind of problem with the admission orders. CC3 stated that CC3 was worried because they didn't know how to give the medications. CC3 stated that there was a time during admission that Resident 1 wasn't getting metformin, and that Resident 1's blood sugars had been elevated over 300. CC3 stated that the medication cards were later found in the medication room and that staff had not provided the medication. CC3 stated that later the physician had discontinued Resident 1's metformin because of Resident 1's kidney disease.

In an interview on 08/25/2023 at 1:35 PM, Staff H, Assisting Health and Wellness Nurse, stated that Resident 1 did not have metformin prescribed on admission. Staff H stated that the metformin was initiated 03/27/2023, then later discontinued on 07/17/2023 by the Physician because of Resident 1's kidney disease.

Review of Resident 1's EMAR from March 2023 through August 2023 showed the following

Statement of Deficiencies	License #: 2481	Compliance Determination # 28530
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 11 of 34	Licensee: PSL Associates, LLC	10/04/2023

medication errors:

March 2023 – Resident 1's medications were started on 03/27/2023, one day after Resident 1 physically moved into the ALF on [REDACTED]/2023. The late medications included: metformin, Potassium Cit ER, Aspirin EC, Fluticasone Prop nosespray, Loperamide, Losartan, Melatonin, Omeprazole, Risperidone, Sertraline, Simvastatin, Tamsulosin and Vitamin D3.

April 2023 – Metformin was discontinued on 04/30/2023 and then reordered on 05/23/2023 and not provided until 05/24/2023. EMAR notes show metformin was not available on 05/23/2023, Potassium Cit ER had doses not provided. Resident 1's EMAR notes showed the Potassium Cit ER was not available and had an unknown status.

May 2023 – Potassium Cit ER was discontinued on 05/17/202 and re-entered into the EMAR the same day. The two combined entry changes showed four doses signed as being provided to Resident 1 on the same day. EMAR notes for Resident 1 showed two doses of Potassium Cit ER were not available and one showed a leave of absence with no documentation to show if medication was provided or not.

June 2023 – EMAR notes showed Potassium Cit ER was not available for ten doses and Rosuvastatin was not available for three doses. Other EMAR notes showed Sertraline, Melatonin and Loperamide were listed as not available or on order and not provided to Resident 1.

July 2023 – Resident 1's EMAR showed Metformin and Tamsulosin were not discontinued as per physician's orders on 07/17/2023 and had continued to be provided to Resident 1. The Metformin and Tamsulosin were not discontinued until 08/24/2023 showing additional medication dosages were provided to Resident 1.

In an interview on 08/28/2023 at 10:10 AM, Staff H stated that the Health and Wellness Director was responsible to audit the EMARs for accuracy. Staff H stated that she was currently reviewing the EMARs for Resident 1.

In an interview on 08/24/2023 at 1:34 PM, Staff M, Medication Technician, stated that the pharmacy comes nightly to deliver medications except on Sundays. Staff M stated that on Sundays an alternative local pharmacy may deliver medications. Staff M stated the pharmacy can satellite the medications, meaning to get the medications delivered the same day as prescribed.

Resident 5

Resident 5 was admitted in the ALF on [REDACTED]/2022 with multiple diagnoses including

[REDACTED]
and [REDACTED]

Review of Resident 5's most recent NSA dated 08/17/2023 showed Resident 5 required medication assistance and the LN or MT would be responsible for assisting with medications.

On 08/28/2023 at 11:09 AM, Resident 5 was observed with a bottle of AREDS eye vitamins out on the kitchen counter. There was one pill placed on the counter in front of the bottle. A stack of 3 empty pill cups were observed on the bedside table.

In interview on 08/28/2023 at 2:11 PM, Resident 5 stated that they took AREDS eye vitamins twice a day. Resident 5 stated that they would leave one pill out to remind the medication technician to add it in the medication cup they brought in with their sleep aid medication. Resident 3 stated that in the evening, the medication technician would come in with their "nighttime pill" and pick up the eye vitamin to add it to the medication they brought in. Then the medication technician would leave the medication cup containing the two pills at Resident 3's bedside for the night.

Review of the August 2023 Medication Administration Record (MAR), Resident 5 took the following medications: Acetaminophen (for pain relief) 325 milligrams (mg), allopurinol (treats gout) 300mg, aspirin (used as a blood thinner) 81mg, calcium antacid (supplement) 500mg, clopidogrel (helps prevent harmful blood clots) 75mg, ferrous sulfate (iron supplement) 325mg, levothyroxine (treats underactive thyroid) 125 micrograms (mcg), multivitamin with minerals, potassium chloride 10 milliequivalents (meq), sertraline (anti-depressant) 100 mg, simvastatin (treats high cholesterol) 40mg, trazodone (used for insomnia) 100mg, vitamin D3 25 mcg (supplement), guaifenesin (helps clear mucous congestion) 400mg, lidocaine 5% patch (pain relief), and meclizine (treats nausea, vomiting, and dizziness) 12.5mg. The MAR did not list AREDS eye vitamin as one Resident 5's medications.

In an email from Staff A, dated 09/18/2023, Staff A wrote that the ALF did not have a physician order for AREDS eye vitamin.

Resident 8

Resident 8 was admitted into the ALF on [REDACTED] /2023 with multiple medical diagnoses including [REDACTED] and [REDACTED].

Review of Resident 8's most recent NSA dated 07/12/2023 showed Resident 8 required

medication assistance and the Nurse or Medication Technician would be responsible for assisting with medications.

Review of Resident 8's EMAR for the month of July 2023 showed Resident 8 was to receive AZO D-Mannose (helps flush the urinary tract and protect it from bacteria) every twelve hours. Resident 8's medication was documented in the EMAR notes as not provided for 13 doses during the month of July 2023. The EMAR notes showed the reasons the medication was not provided as; "not available" and "I can't find it."

Review of Resident 8's EMAR for August 2023 showed Resident 8 was to receive Amlodipine (lowers blood pressure) daily. Resident 8's medication was documented in the EMAR notes as not provided for 11 doses. The EMAR notes showed the reasons the medication was not provided as; "not available", "I can't find it", "if someone knows where it is then it would be awesome to let me know", "doesn't seem to be anywhere" and "still can't find it."

In an interview on 08/28/2023 at 11:45 AM, Staff M stated that Resident 8 had a whole bottle of Amlodipine that was provided by family to use first. Staff M stated that staff thought the amlodipine ran out, tried to reorder it, and couldn't because it had just been filled. Staff M stated that the amlodipine was later found in the overflow drawer of the medication cart and staff did not know the medication was in the overflow drawer.

Resident 9

Resident 9 was admitted into the ALF on [REDACTED] /2021 with multiple medical diagnoses including [REDACTED] and [REDACTED].

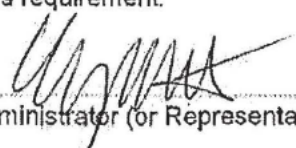
Resident 9's most recent NSA dated 06/28/2023 showed Resident 9 required medication assistance and medication re-order assistance.

Review of Resident 9's EMAR for the month of August 2023 showed Resident 9 was to receive Lactaid (helps body digest the enzyme lactose) every morning. Documentation in the August EMAR notes showed Resident 9 did not receive five doses of Lactaid. The August EMAR showed the reason the Lactaid was not provided as; not available. All the doses surrounding the five missed doses were provided as given.

In an interview on 08/28/2023 at 11:45 AM, Staff M stated that there were no problems with Resident 9's lactaid being missing. Staff M stated that she thought meds were not given because the other Medication Technicians do not know where to look.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 11/18/2023.

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


Administrator (or Representative)

11/3/2023
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;

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

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(b) Dementia specialty training as described in WAC 388-112A-0440 ;

(c) Mental health specialty training as described in WAC 388-112A-0450 .

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

(c) Mental health specialty training as described in WAC 388-112A-0450 .

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 6 of 6 staff members (Staff A, B, C, D, E and F) completed the required specialty training for dementia and mental health. This failure resulted in Staff A, B, C, D, E, and F not being trained to support residents with dementia and mental health issues and placed the residents with a dementia or mental health diagnosis at risk of unmet care needs.

Findings included...

Statement of Deficiencies	License #: 2481	Compliance Determination # 28530
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 15 of 34	Licensee: PSL Associates, LLC	10/04/2023

Record review of the resident characteristic roster, dated 08/24/2023, showed the ALF had multiple residents with [REDACTED] and one with a [REDACTED] diagnosis.

In record review of staff files with Staff A, Executive Director, showed Staff A was hired on 09/28/2021. Staff A's files showed no evidence that the required dementia and mental health training was completed.

Record review showed that Staff B, caregiver, was hired on 05/26/2023. There was no evidence that the dementia and mental health training was completed.

Record review showed that Staff C, caregiver, was hired on 08/01/2022. There was no evidence that the dementia and mental health training was completed.

Record review showed Staff D, caregiver, was hired on 08/10/2022. There was no evidence that the dementia and mental health training was completed.

Record review showed Staff E, caregiver, was hired on 02/14/2020. There was no evidence that the dementia and mental health training was completed.

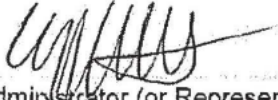
Record review showed Staff F, Resident Care Coordinator, was hired on 07/18/2017. There was no evidence that the dementia and mental health training was completed.

In interview on 08/24/2023 at 10:45, Staff A stated that they did not have any documents to show the training for dementia and mental health was completed for all 6 sample staff including herself. Staff A stated that they had not done any of the training for mental health and dementia and were in the process of enrolling the staff for these courses.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 11/18/2023.

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

 Administrator (or Representative)	11/3/2023 Date
--	-------------------

WAC 246-215-02120 Food worker cards.

(1) The permit holder and person in charge of the food establishment shall ensure that all food employees are in compliance with the provisions of chapter 69.06 RCW and chapter 246-217 WAC for obtaining and renewing valid foodworker cards.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 6 of 18 Staff (Staff B, C, D, E, F and L) had the required Washington State Food Handler Cards. This failure resulted in food workers not being trained in food safety awareness and placed all residents, staff, and visitors at risk of foodborne illness.

Findings included...

Review of the Department of Health website showed, "Washington State requires that all food workers have food safety training before handling food served to the public. Food workers who take a food safety training class and pass the State of Washington exam on food safety basics are issued a Food Worker Card (also called a Food Handler Permit). You are a food worker if you work with unpackaged food, food equipment or utensils, or with any surface where people put unwrapped food. All food workers are required (Chapter 246-217 WAC) to have a valid food worker card to work in Washington State. You must have a Washington State food worker card to be employed as a food worker in Washington State."

Record review of staff files showed Staff L, Cook, was hired on 03/17/2016. Staff L's employee file had an expired copy of a Food Handler Solutions American National Standards Institute (ANSI) certificate with an expiration date of 05/15/2023.

In an interview on 09/01/2023, at 2:04 PM, Staff A, Executive Director stated she saw Staff L had a different food handler card. Staff A was not sure where Staff L got it from and was researching it. Staff A stated that she saw that the card had expired in May (2023). Staff A stated that Staff L was scheduled currently to take the food handler class.

Review of Food Handler Solutions, showed that the ANSI program is not approved in the

state of Washington.

Record review of staff files showed:

Staff B, Caregiver was hired on 05/26/2023. Staff B had no food handlers card available for review.

Staff C, Caregiver was hired on 08/01/2022. Staff C had no food handlers card available for review.

Staff D, Caregiver was hired on 08/10/2022. Staff D had no food handlers card available for review.

Staff E, Caregiver was hired on 02/14/2020. Staff E had no food handlers card available for review.

Staff F, Resident Care Coordinator was hired on 08/10/2022. Staff F had no food handlers card available for review.

On 08/25/2023 at 10:30 AM, Staff A stated that Staff B, C, D, E and F did not have a current food handler cards. Staff A stated that Staff B, C, D, E and F all handle food for the residents.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u>. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
Administrator (or Representative) 	Date <u>11/3/2023</u>

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:

(d) Cardiopulmonary resuscitation and first aid; and

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff members (Staff B and C) had a valid Cardiopulmonary Resuscitation (CPR) or first aide card. This failure resulted in Staff B and C not being trained for medical emergencies and placed residents at risk for unmet emergency care needs.

Findings included...

Record review of staff files showed Staff B was hired on 05/26/2023 as a Caregiver. Staff B did not have a current CPR or First Aide Certification on file within 30 days of employment as required.

Record review of staff files showed Staff C was hired on 08/01/2022 as a Caregiver. Staff C did not have a current CPR or First Aide Certification on file within 30 days of employment as required.

In an interview on 08/24/2023 at 10:30 AM, Staff A, Executive Director, stated that Staff B and C were hired but have not done the CPR or First Aide certifications. Staff A stated that they had not completed the tests and was looking into getting Staff B and Staff C scheduled.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u>. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/3/2023</u> Date

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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) did not ensure 6 of 6 staff members (Staff A, B, C, D, E, and F) were screened for tuberculosis (TB) (a bacterial infection usually attacking the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain) within three days of hire. This failure resulted in six staff not screened for TB working with residents and placed the safety of the residents at risk potentially being exposed to an infectious respiratory disease.

Findings included...

Record review showed:

Staff A, Executive Director, was hired on 09/28/2021. Staff A's TB screening was done on 05/16/2022, past the 30 days of hire.

Staff B was hired on 05/26/2023. There was no record that a TB test was done.

In interview on 08/24/2023 at 10:45 AM, Staff A stated the Staff B had a history of reacting to the PPD and needed a chest x-ray. Staff A stated the chest x-ray had not been done.

Staff C was hired on 08/01/2022. There was no record that a TB test was done.

Staff D was hired on 08/10/2022. There was no record that a TB test was done.

Staff E was hired on 02/14/2020. Staff E's TB test was done on 05/17/2022, past the three days of hire.

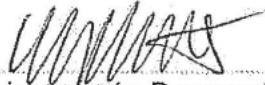
Staff F was hired on 07/18/2017. Staff F's TB test was done on 05/16/2022, past five years of hire.

In interview on 08/24/2023 at 10:45 AM, Staff A stated that these were the only documents they had on file. Staff A stated that they could not access any files prior to 2019 due to a change in ownership of the company.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 11/19/2023.

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


Administrator (or Representative)

11/3/2023
Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(b) A national fingerprint background check.

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 1 of 6 Staff (Staff B) had the required national fingerprint background check. This failure resulted in Staff B working with residents placed all residents at risk for being cared for by a caregiver with a possible negative background check.

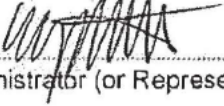
Findings included...

Staff B was hired on 05/26/2023 as a Caregiver. No national fingerprint background check was available for review.

Record review of a fingerprint appointment showed Staff B was scheduled on 06/16/2023 to complete a fingerprint background check.

In an interview on 08/24/2023 at 10:30 AM, Staff A, Executive Director stated that she had talked to Staff B and Staff B had not completed the appointment that was scheduled on 06/16/2023. Staff A stated that Staff B was rescheduled last week for a second fingerprint appointment, and that she had not seen any results yet. Staff A stated that she needed to meet with Staff B.

In an interview on 09/21/2023 at 11:33 AM, Staff A, Executive Director, stated that when Staff B had not completed her second fingerprint appointment that she removed Staff B from the schedule. Staff A stated that another fingerprint appointment was set up and completed on 09/01/2023 and she received the results on 09/04/2023 and Staff B had returned to work. Staff A stated that she believed there was previously a misinterpretation of how the WACs were interpreted by staff. Staff A stated that now all fingerprint background checks are being completed prior to a new hire entering the ALF.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/3/2023</u> 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;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure that 2 of 5 pets living on the premises were current on their examinations and immunizations. This failure resulted in residents being exposed to pets without immunizations and placed residents and staff at risk of contracting a transmittable disease from a potentially infected animal.

Findings included...

Record review of the ALF's Resident Pet Policy & Agreement, dated November 2018, showed the community requires licensing and proper vaccination of all pets. Proof of license and vaccination must be submitted to the Executive Director prior to move-in. The Executive Director has the sole discretion of deciding whether any pet is appropriate to live in the Community.

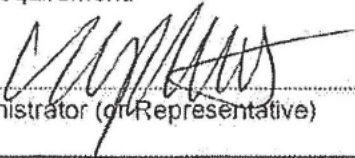
Review of the ALF's pet binder showed that a dog belonging to Resident 10 did not have

any records on file to show the pet's last veterinarian wellness visit or an immunization record.

In interview on 09/08/2023 at 5:00 PM, Staff A, Executive Director, stated that they had asked Resident 10's family for veterinarian records for Resident 10's dog. Staff A stated that they did not receive any records from the family.

Review of the ALF's pet records showed that a cat belonging to Resident 11 had their last veterinarian visit on 10/18/2012. The pet record showed that the rabies immunization was due on 10/23/2018.

In interview on 08/24/2023 at 10:45 AM, Staff A stated that Resident 11 had told them that they had not taken their cat to the veterinary clinic since before the Corona Virus pandemic.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>11/3/2023</u> _____ 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 investigate and document investigative actions for 2 of 2 sampled Residents (Resident 3 and 6) following unwitnessed falls and bruising of unknown origin. These failures resulted in the circumstances of these incidents not being determined and placed Resident 3 and 6 at risk for unmet care needs.

Findings included...

Review

of the Assisted Living Facility Guidebook; Partners in Protection dated 02/2018 showed the State law requires the assisted living facility to do a thorough investigation of the incident. In order for the facility to provide evidence of the thoroughness of the investigation, the information must be documented. Chapter 2 of this guidebook covers the investigation process. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Resident 3

Resident 3 was admitted to the ALF on [REDACTED]/2012. Resident 3's diagnoses included [REDACTED]

and [REDACTED]

Review of the progress notes from June 23, 2023 to August 25, 2023 showed Resident 5 had a fall on 7/8/2023 and 07/14/2023. There was no evidence of an incident report or a documented investigation for the falls on 07/08/2023 and 07/14/2023.

In interview on 08/28/2023 at 12:43 PM, Staff B stated that they did not have an incident report for the falls that occurred on 07/08/2023 or 7/14/2023. Staff B stated that the staff was entering the falls as a progress note in the electronic charting system instead of an incident report. Staff B stated there was no investigation done for these two falls.

Resident 6

Resident 6 was admitted to the ALF on [REDACTED]/2014 with multiple medical diagnoses including [REDACTED] and [REDACTED]

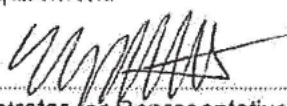
Review of Resident 6's most recent negotiated service agreement dated 08/17/2023 showed Resident 6 required re-orientation as needed, was identified as a fall risk and that care staff were to monitor and report any skin abnormalities during showers twice a week to the nurse,

Review of Resident 6's shower form dated 07/10/2023 at 10:30 AM showed Resident 6 had a visual assessment with bruising identified under Resident 6's left arm. A note on the assessment showed, "bruising on left underarm, leg and feet redness."

In an interview on 08/25/2023 at 3:00 PM, Staff H, Assisting Health and Wellness Director,

stated that she couldn't find any follow up information on Resident 6's bruising. Staff H stated that there was no documentation completed other than the shower form. Staff H stated that she had reviewed Resident 6's records and could not find any progress notes or investigation on the bruising. No investigation or shower documentation were available for review.

In an interview on 08/25/2023 at 3:15 PM, Staff F, Resident Care Coordinator stated that she was unaware of Resident 6 having had any bruising.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/18/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/5/2023</u> Date

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

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure blood pressure and blood glucose monitoring was coordinated with the Physician for 1 of 5 Residents (Resident 1) when the physician ordered Resident 1's blood pressure be taken daily and reported to the physician weekly for Resident 1. This failure resulted in Resident 1's physician not being informed of Resident 1's blood pressure and blood glucose readings, and placed Resident 1 at risk for medical complications.

Findings included...

The American Heart Association describes blood pressure (BP) of 130/80 mm Hg (millimeters of mercury) and higher as a hypertensive crisis needing physician attention. The BP upper number is called Systolic and is the pressure of blood against artery walls when the heart beats. The BP lower number is called Diastolic and is when the heart rests between beats.

Resident 1 was admitted to the ALF on [REDACTED]/2023 with multiple medical diagnoses

Statement of Deficiencies	License #: 2481	Compliance Determination # 28530
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 25 of 34	Licensee: PSL Associates, LLC	10/04/2023

including Insulin Dependent Diabetes (a chronic condition when the body makes little to no insulin), Hypokalemia (below normal level in potassium that can result with abnormal heart rhythms), and High Blood Pressure.

Review of Resident 1's most recent negotiated service agreement (NSA) dated 08/23/2023 showed Resident 1 required assistance with medications and the Licensed Nurse or Med Technician would be responsible to obtain Resident 1's blood glucose per Physician orders.

Review of Resident 1's electronic medication administration record (EMAR) dated for the months of July and August 2023 showed Resident 1 had a physician's order to take Resident 1's blood pressure every morning and fax to the physician every Friday.

In an interview on 08/31/2023 at 1:41 PM, Collateral Contact 1 (CC1), Physician, stated that they were Resident 1's Primary Care Physician (PCP). CC1 stated that the ALF had not sent the blood pressures or the blood glucose documentation that were asked for. CC1 stated that they had wanted Resident 1's blood pressure readings for weeks and were very concerned about the blood pressures and blood glucose levels. CC1 stated that they needed those levels so they could review them in combination with Resident 1's medication to determine Resident 1's medical care.

Review of the ALFs "Vitals Report" dated from 03/01/2023 through 08/31/2023 showed elevated blood glucose levels greater than 300. No documentation was available for review on Resident 1's medical record to show Resident 1's PCP was notified of blood glucose levels.

No documentation was available for review on Resident 1's medical record to show the Physician was notified of Resident 1's blood pressure or blood glucose readings.

Information related to Diabetes and Blood glucose (blood sugar) readings updated on 01/03/2023, showed information that blood glucose readings between 180 mg/dL and 250 mg/dL are considered high. A reading of 250 mg/dL or higher is dangerous and requires medical attention, and two or more readings of 300 mg/dL or higher in sequence are dangerous and can lead to complications like diabetic ketoacidosis and diabetic coma.

In an interview on 08/28/2023 at 3:05 PM, Staff H, Assisting Health and Wellness Director stated that she had printed a vitals report with Resident 1's blood glucose levels. Staff H stated that she had reviewed Resident 1's medical records and could not find any communication about blood glucose levels or blood pressure monitoring sent to the physician.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on
(Date) 11/10/2023

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


Administrator (or Representative)

11/3/2023
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;

(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 reviews the Assisted Living Facility (ALF) failed to ensure the Physician was notified for 1 of 5 Residents (Resident 6) when Resident 6 refused to take medications as prescribed. This failure resulted in Resident 6 not receiving medications as prescribed and placed Resident 6 at risk for medical complications.

Findings included...

Resident 6 was admitted into the ALF on [REDACTED] /2014 with multiple medical diagnoses including [REDACTED] and [REDACTED]

Review of Resident 6's most recent negotiated service agreement dated 08/17/2023 showed Resident 6 was confused and needed medication assistance.

Review of Resident 6's electronic medication administration records (EMAR) dated from June 2023 through August 2023 showed Resident 1 was prescribed the following medications:

Armour Thyroid 60 mg (unit of measurement) daily, replaces missing thyroid hormones
 Aspirin EC 81 mg daily, anti-inflammatory and blood thinner
 Cholestyramine one 4 gm (gram) packet twice a day in 4-8 ounces of fluid, lowers cholesterol levels
 Dicyclomine 10 mg twice a day, treats irritable bowel syndrome
 Digoxin, 0.125 mg daily, hold for pulse less than 60 for atrial fibrillation (irregular rapid heart rate), used to improve, control rate and rhythm of heartbeat
 Dorzolamide 2% eye drops, one drop in both eyes twice a day, treats high pressure in the eye for glaucoma
 Guaifenesin 100 mg/5 mL (unit of measurement) give 30 ml twice a day, loosens mucus in airways
 Magnesium Oxide 400 mg daily, helps treat low magnesium levels in body
 Nattokinase 35 mg daily, dissolves blood clots
 Spironolactone 25 mg, two times a day, treats high blood pressure and heart failure
 Aleve 220 mg every morning, treats pain and inflammation
 Latanoprost 0.005% eye drops one drop in both eyes every evening, treats increased eye pressure/glaucoma

Record review of Resident 6's EMAR from June 2023 through August 2023 showed Resident 6 had multiple medication refusals of the following medications:

June 2023 – The following medications had four or more medication refusals: Armour Thyroid, Aspirin EC, Cholestyramine, Dicyclomine, Digoxin, Dorzolamide 2% eye drops, Guaifenesin, Magnesium Oxide, Nattokinase, Spironolactone, Aleve, Latanoprost 0.005% eye drops.

July 2023 – The following medications had three or more medication refusals: Cholestyramine, Dicyclomine, Guaifenesin, Spironolactone, Armour Thyroid, Aspirin EC, Digoxin, Magnesium Oxide, Nattokinase. The EMAR showed Resident 6 had refused Dorzolamide 2% eye drops twice and Latanoprost 0.005% eye drops once during the month.

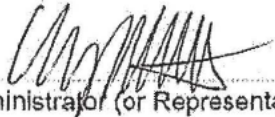
August 2023 – Resident 6 had refused one dose of the following medications: Cholestyramine, Dicyclomine, Dorzolamide 2% eye drops, Guaifenesin, Latanoprost 0.005% eye drops and Spironolactone.

In an interview on 08/28/2023 at 3:05 PM, Staff H, Assistant Health and Wellness Director stated that she could not find any Physician fax notifications or documentation of progress notes that the Physician was notified of medication refusals. No Physician notifications for Resident 6's medication refusals were available 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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on
(Date) 11/18/2023

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


Administrator (or Representative)

11/3/2023
Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

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

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

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the Assisted Living Facility (ALF) failed to complete an assessment for 2 of 2 residents (Resident 5 and 7) for the use of a transfer pole, bed rail, and foley catheter. This failure resulted in Resident 5 and 7 not having the proper assessments completed and placed both residents at risk for injuries including possible entrapment and unmet care needs.

Findings included...

Record review of the ALF's policy "Bed Mobility Device policy" dated 09/14/2021 showed it was the responsibility of the Executive Director and Health and Wellness Director to determine if the resident can use the device safely and understand potential hazards by completing the ALF's Bed Mobility Device Assessment and Acknowledgement Form. The policy showed that the ALF would obtain a physician's order for the use of mobility devices and train staff on how to inspect the device for safety and understanding the hazards of using a mobility device that attaches to the bed.

Resident 5

Resident 5 was admitted in the ALF on [REDACTED] /2022 with multiple diagnoses including [REDACTED], and [REDACTED].

On 08/28/2023 at 11:09 AM, Resident 5 was observed sitting in their wheelchair. There

Statement of Deficiencies	License #: 2481	Compliance Determination # 28530
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 29 of 34	Licensee: PSL Associates, LLC	10/04/2023

was a transfer pole installed in the middle of Resident 5's room. A half bedrail was attached on the left side of Resident 5's bed. The bedrail was in the low position.

In interview 08/28/2023 at 11:09 AM, Resident 5 stated that they used the bedrail as a handle to help pull themselves up. Resident 5 stated that the transfer pole has been helpful and likes to use the wheelchair to propel themselves around.

Record review of the most current assessment dated 08/17/2023 showed that Resident 5 was able to transfer independently. There was no mention of the transfer pole or the bed rail.

In an interview on 08/28/2023 at 4:32 PM, Staff H, Assisting Health and Wellness Director, stated that they did not find have an assessment on file regarding the need for a transfer pole and bedrail.

In an interview on 09/08/2023 at 5:00 PM, Staff A, Executive Director, stated that they would check Resident 5's file for a physician's order for the bedrail and the transfer pole, the Bed Mobility Device Assessment and Acknowledgement Form, and training documentation.

In an email from Staff A, dated 09/08/2023 at 5:52 PM, Staff A stated that they could not locate a physician's order, waiver, or any training documentation after reviewing Resident 5's records.

Resident 7

Resident 7's medical diagnoses included [REDACTED] and [REDACTED].

Review of the ALF's Resident Characteristic Roster (RCR) on 08/23/2023 showed Resident 7 was identified as requiring catheter care.

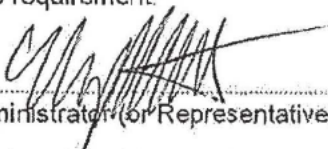
In an interview on 08/23/2023 at 1:49 PM, Staff F, Resident Care Coordinator stated Resident 7 had a catheter.

Review of Resident 7's notes dated 08/18/2022 at 2:00 PM, showed a note for a pre-move in assessment by a former Health and Wellness Director. The note showed Resident 7 would need assist with showers, family to manage medications, and was unsteady with ambulation to walk to the ALF twice a day for meals. No pre-admission information showed Resident 7 had a foley catheter in place.

Review of a second progress note dated 04/03/2023 at 10:10 AM for Resident 7 showed Resident 7 went to the nursing office with a catheter hanging out of Resident 7's pants, stated it was for the heart and needed help. The note showed a nurse told Resident 7 it was a urinary catheter and Resident 7 shouldn't mess with the urinary catheter.

In an interview on 08/28/2023 at 12:10 PM, Staff H, Assisting Health and Wellness Director stated that no foley catheter assessment was completed for Resident 7.

In an interview on 08/28/2023 at 12:20 PM, Staff F stated that she was not sure who was doing Resident 7's catheter care. Staff F stated that there was no information on when Resident 7 received the foley catheter.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>11/14/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/3/2023</u> Date

WAC 388-78A-2600 Policies and procedures.

- (2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:
- (b) When there is reason to believe a resident is not capable of making necessary decisions and no substitute decision maker is available;
- (l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to follow their policy when the ALF did not; complete an initial self-medication administration assessment, obtain a physician's order for self-medication administration, or conduct monthly self-medication administration assessments for 1 of 1 resident (Resident 3). This failure resulted in the ALF not having their assessments completed and placed Resident 3 at risk of harm by potentially taking medications incorrectly.

Findings included...

Review of the ALF's Medication Services Policy for Resident Self-Management of Medications/Monthly review, dated 11/2018, showed the first step is to verify that the resident's physician has indicated that the resident is capable of self-administering medications by checking 'yes' in the move in report. The policy showed that the Wellness Director or Executive Director must fill out a Self-Administration Assessment form at the time that the order was received. The policy also showed the ALF would conduct monthly self-medication assessments.

Resident 3 was admitted to the ALF on [REDACTED] 2012 with multiple diagnoses including [REDACTED]

and [REDACTED]

On 08/28/2023 at 2:11 PM, Resident 3 was observed with bottles of medications out on their desk and a few bottles of medication on their table.

In interview on 08/28/2023 at 2:11 PM, Resident 3 stated that they prepared their own medications the night before. Resident 3 stated that they used a pill organizer and organized the medication by AM and PM.

In interview on 08/28/2023 at 2:39 PM, Staff B, Assisting Health and Wellness Director, stated that they did not have the initial self-medication administration assessment or any monthly self-medication administration assessments on file. Staff B stated that they did not have the move in paperwork or a physician's order for self-medication administration.

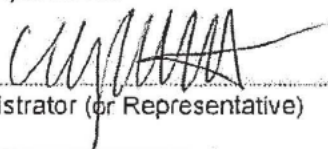
The ALF had no evidence of a self-medication administration physician order, an initial self-medication administration assessment, or a monthly self-medication administration assessment in file.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on

(Date) 11/18/2023

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


Administrator (or Representative)

11/3/2023
Date

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on Record Review and Interviews the Assisted Living Facility (ALF) failed to provide updated information related to nursing services as required on the ALF's Disclosure of Services for all residents, when the ALF did not have a nurse in the ALF for the hours showed in the ALF's Disclosure of Services. This failure resulted in the reduction of nursing availability not being provided to residents and their representatives and placed residents and their representatives at risk of not being aware of current levels of care and services provided by the ALF.

Findings included...

Record review of the ALF's Disclosure of Services showed in section three, titled Intermittent Nursing Services, part C, was checked off "yes" and showed the ALF had a Registered Nurse in the building for five days a week totaling 40 hours a week. Part D was not completed and showed the ALF had a licensed practical nurse in the building for seven days a week totaling 70 hours a week.

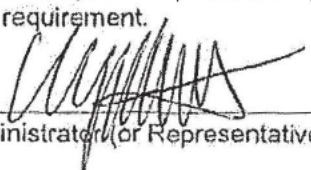
On 08/23/2023 at 11:39 AM, Staff H, Licensed Practical Nurse and Assisting Health and Wellness Director, stated that she was assisting the ALF with nursing care and was in the ALF Community on Tuesdays and Thursdays to help out.

On 08/24/2023 at 9:55 AM, Staff A, Executive Director stated that they currently don't have a nurse. Staff A stated that they had Staff H coming to the ALF twice a week to help out. Staff A stated that she was not aware the Disclosure of Services was not updated and would review the Disclosure of Service's information.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 11/18/2023.

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



Administrator (or Representative)

11/3/2023

Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the Assisted Living Facility (ALF) failed to provide care as agreed upon in the negotiated service agreement for 1 of 5 sampled Residents (Resident 1) when Resident 1 did not receive assistance to meals, hygiene care and toileting. This failure resulted in Resident 1 eating meals in their room, sitting in soiled briefs and bedding... and placed Resident 1 at risk for social isolation, skin breakdown and a diminished quality of life.

Findings included...

Resident 1 was admitted to the ALF on [REDACTED] /2023 with multiple medical diagnoses including [REDACTED]

and [REDACTED]

Review of Resident 1's most recent negotiated service agreement (NSA) dated 04/26/2023 and completed by Staff N, Health and Wellness Director, showed Resident 1 needed standby assistance with activities of daily living (ADL), escort service to meals, was independent or assist with transfers, toileting, and was able to complete hygiene care independently.

In an interview on 08/24/2023 at 3:15 PM Staff H, Assisting Health and Wellness Director stated that she had updated Resident 1's plan of care with increased care needs since Resident 1's previous NSA had not reflected the need for increased care. Staff H stated that she had talked with family about Resident 1 being escorted to the dining room for meals.

On 08/28/2023 at 8:53 AM, Resident 1 was observed lying in their bed wearing pajama pants and a dark color pull-over shirt. Staff O, Caregiver, entered Resident 1's living quarters. Staff O was observed talking to Resident 1 and attempted to sit Resident 1 up on the side of the bed to transfer Resident 1 to a wheelchair.

In an interview on 08/25/2023 at 11:44 AM, Collateral Contact 3 (CC3) stated that they were at the ALF on 08/18/2023 visiting Resident 1 and that an outside agency caregiver had placed Resident 1's pajama's on the bed for ALF staff to change Resident 1 at bedtime and that the outside agency left around 6:15 PM. CC3 stated that they let a caregiver know they leaving, and that Resident 1 would need assistance with evening care. CC3 stated that Resident 1's pajamas were still lying on the bed the next morning and Resident 1 was still

sitting in the recliner, in the same clothes from the previous day, with the television on.

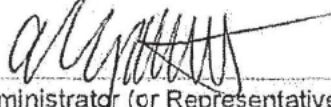
Documentation dated 08/19/2023 at 9:20 AM, from the outside agency in Resident 1's living quarters showed Resident 1 was found still sitting in Resident 1's recliner, wearing the same clothes, watching television with the pajama's untouched and still folded and laid on the bed by the outside agency staff the prior evening.

On 08/28/2023 at 9:00 AM, Staff O stated that it looked like Resident 1 had slept in their clothes again. Staff O stated that Resident 1 slept in pajamas but thought Resident 1 had slept in the same shirt they were wearing yesterday. Staff O's walkie talkie then activated, and a female voice stated, "why didn't Resident 1 get down to breakfast yet?" Staff O stated that Resident 1 didn't want to get up and was having behaviors. Staff O attempted to sit Resident 1 up on the side of the bed by holding onto Resident 1's forearms and began pulling Resident 1 forward. Resident 1's body was stiff and in a slanted position while balanced sideways across the edge of the mattress. Staff O paged three times for assistance. Resident 1 continued to be calm and was not speaking. Staff O stated to Resident 1, you are all soaked with urine, your shirt is all wet up the back, everything is soaked, did nobody come to change you last night? Resident 1 stated no. Resident 1's bedsheets were observed to be wet.

On 08/28/2023 at 9:25 AM a urine stain 14 inches in diameter that was wet through the pad and onto the fitted sheet was observed.

In an interview on 08/28/2023 at 9:08 AM, Staff P, Caregiver was observed bringing a white, Styrofoam take-out container into Resident 1's room and placing the container in the refrigerator and spilling the drink on the floor. Staff P stated that the container was Resident 1's breakfast and the drink would need replaced later.

Documentation on 08/28/2023 at 9:46 AM showed ALF staff had spilled Resident 1's juice and had not replaced the juice and that Resident 1's had breakfast in their living quarters.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on	
(Date) <u>11/19/2023</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>11/3/2023</u> _____ Date