



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

08/17/2023

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) 28187 (Completion Date 08/16/2023) and 24554 (Completion Date 07/03/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/16/2023 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 388-112A-0550, WAC 388-112A-0550-1, WAC 388-112A-0550-1-a, WAC 388-112A-0550-2, WAC 388-112A-0550-2-a, WAC 388-112A-0550-2-b

The Department staff who did the on-site verification:

Judith Mellon, RN, Licenser

If you have any questions, please contact me at (425)670-6070.

Sincerely,

A handwritten signature in cursive script that reads "Jamie Singer".

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



Residential Care Services Investigation Summary Report

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

Provider Type: Assisted Living Facility

Compliance Determination #: 24554

Intake ID: 83182

Investigator: Helen Fisher

Region/Unit #: RCS Region 2 / Unit A

Investigation Date(s): 05/30/2023 through 07/03/2023

Complainant Contact Date(s):

Allegation(s):

It was alleged the Named Resident (NR) was to be given Morphine ER 15 mg in tablet form as a routine order, but the Med Tech gave Morphine 2.5ml in liquid form.

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 3 Closed records sample size: 0
Observations:	Resident appearance and demeanor Equipment Apartment cleanliness
Interviews:	NR, Med Tech, Director of Nursing, Collateral Contact.
Record Reviews:	Resident records Facility records

Investigation Summary:

The Director of Nursing (DNS) did an investigation when the NR was to be given Morphine ER 15mg tablet, but the Med Tech (MT1) gave Morphine 2.5ml in liquid form. The DNS determined that MT1 made an error in giving the NR the wrong morphine dose and form. Review of the NR's medication administration record dated 05/01/2023, showed MT1 were administering Resident 1's insulin. Review of the personnel records showed MT1, and 3 other Med Techs did not have Nurse Delegation and Diabetes Core Training while providing medication administration. During an interview DNS stated that they found out that 4 of 8 Med Techs had no Nurse Delegation and Diabetes Core Training. The DNS stated that they pulled off all the med techs off the med cart for retraining and hired agency med techs to cover. During an interview, Collateral Contact stated that they were concerned of the lack med techs training in the facility. During an interview MT1 stated that they did not receive the Nurse Delegation and Diabetes Core training while providing medication administration. During an interview Med Tech (MT2) stated that they did not receive Diabetes Core training but were giving insulin. Failed practice was identified. A citation was issued for noncompliance with WAC 246-840-930.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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Statement of Deficiencies License #: 2481 Compliance Determination # 24554
Plan of Correction Cordata Court, Assisted Living & Memory Care Completion Date
Page 1 of 4 Licensee: PSL Associates, LLC 07/03/2023

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 an unannounced on-site complaint investigation on 05/30/2023 and 05/30/2023 of:

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

This document references the following complaint number(s): 82592, 83071, 83182, 83870, 82598

The following sample was selected for review during the unannounced on-site visit: 3 of 55 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator

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

07/14/2023

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.

Statement of Deficiencies License #: 2481 Compliance Determination # 24554
 Plan of Correction Cordata Court, Assisted Living & Memory Care Completion Date
 Page 2 of 4 Licensee: PSL Associates, LLC 07/03/2023

Administrator (or Representative)

Date 7/19/2023

WAC 388-112A-0560 Who is required to complete nurse delegation core training and nurse delegation specialized diabetes training and by when?

- (1) Before performing any delegated nursing task, long-term care workers in adult family homes and assisted living facilities must:
- (a) Successfully complete the DSHS designated nurse delegation core training, "nurse delegation for nursing assistants & home care aides";
 - (2) Before long-term care workers in adult family homes and assisted living facilities may perform the task of insulin injections, the long-term care workers must:
 - (a) Meet the requirements in subsection (1)(a) and (b) of this section; and
 - (b) Successfully complete the DSHS designated specialized diabetes nurse delegation training.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 2 residents (Residents 1 and 2) requiring nurse delegation for medication administration received their medications from trained staff. This failure resulted in Residents 1 and 2 receiving medication administration from untrained med techs and placed all residents receiving medication administration for nurse delegated tasks, at risk for receiving medication administration from untrained med techs.

Findings included

Resident 1

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

and [REDACTED]

[REDACTED] Review of the
 care plan dated 05/23/2023
 showed Resident 1 required Insulin administration. Review of Resident 1's medication administration
 record dated 05/01/2023
 to 05/30/2023, showed Staff B, C, D and E had signed off for insulin administration, a

Statement of Deficiencies License #: 2481 Compliance Determination # 24554
Plan of Correction Cordata Court, Assisted Living & Memory Care Completion Date
Page 3 of 4 Licensee: PSL Associates, LLC 07/03/2023

nurse delegated task.

Resident 2

Resident 2 was admitted to the facility on [REDACTED] 2022 with multiple diagnoses including [REDACTED]

[REDACTED] Review of the care plan dated 04/11/2023 showed Resident 2 required medication assistance. Review of Resident 1's medication administration record dated 05/01/2023 to 05/30/2023, showed Staff B, C, D and E had signed off liquid morphine administration a nurse delegated task.

Interview on 05/30/2023 at 12:35 PM, Staff A, Director of Nursing, stated that Staff B, C, D and E did not have a Nurse Delegation and Core Diabetes training while administering insulin and liquid morphine.

Interview on 06/29/2023 at 10:51 AM, Staff B, Med Tech, stated that they received training to give pills but did not receive the training to draw and administer insulin and liquid morphine. Staff B stated that they didn't receive nurse delegation and diabetes core training until 06/15/2023 two months after providing nurse delegated tasks. Staff B stated that they were told by the former Director of Nursing that they didn't need a nurse delegation core training.

Interview on 07/03/2023 at 3:56 PM, Staff C, Med Tech, stated that they were administering insulin. Staff C stated that they did not receive diabetes core training.

Statement of Deficiencies	License #: 2481	Compliance Determination # 24554
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 4 of 4	Licensee: PSL Associates, LLC	07/03/2023

Review of the personnel records showed 4 of 8 med techs (Staff B, C, D and E) did not have Nurse Delegation and Diabetes Core Training Certificate on 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) 8/19/2023

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


Administrator (or Representative)

7/19/2023
Date