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) 39519 (Completion Date 04/11/2024) and 36480 (Completion Date 02/16/2024).

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-2210-2, WAC 388-78A-2210-1-b

The Department staff who did the on-site verification:
Christine Banta, ALF Licensor

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

Sincerely,

Kim Ripley

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 36480
Investigator: Helen Fisher
Investigation Date(s): 01/10/2024 through 02/16/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 116015
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) was receiving medication everyday that had been discontinued 5 months ago.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 3 Closed records sample size: 0
Observations:	NR appearance and demeanor, sample residents, med cart, medication pass, living quarters, hallways, general cleanliness.
Interviews:	NR, sample residents, Executive Director, med techs, caregiver.
Record Reviews:	NR and sample residents' records Incident investigation. Physician's order. Medication services policy and procedure.

Investigation Summary:
The NR was lying in bed, dressed and pleasant during an unannounced onsite visit. The NR stated that they were told of the medication error by the staff. The Executive Director stated that on 01/04/2024 they were asked by the NR's doctor's office why the NR was still on that was supposed to be discontinued on 07/27/2023. The facility did an investigation and found that the doctor's order to discontinue the Flomax was unprocessed resulted in the NR receiving the medication continuously for 5 months. Failed practice. A citation was issued for noncompliance with WAC 388-78A-2210 Medication services. Previously cited during full survey.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 36480
Investigator: Helen Fisher
Investigation Date(s): 01/10/2024 through 02/16/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 116574
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) received an extra dose of a medication.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 3 Closed records sample size: 0
Observations:	Med Cart, medication pass, NR and other residents appearance and demeanor, living quarters, social interaction, general facility cleanliness.
Interviews:	NR, Executive Director, Health and Wellness Director, Med Tech.
Record Reviews:	NR records. Assisted Living Facility (ALF) records. NR's Medication administration record (MAR) Medication services policy and procedure.

Investigation Summary:
The NR was observed lying in bed, well groomed, alert, and oriented during an unannounced ALF's visit. The NR stated that they received an extra dose medication and was sent to the hospital for observation. While at the hospital the NR had a hard time picking their feet and felt depressed which could be related to the medication mishap. The NR was unable to recall the exact date. Review of MAR dated 02/2024 showed the NR received extra dose due to unprocessed physician's order dated 02/26/2024 to discontinue the Mondays and Thursdays. Failed practice. A citation was issued for noncompliance with WAC 288-78A- 2210 Medication Services. Previously cited during full survey.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 36480
Investigator: Helen Fisher
Investigation Date(s): 01/10/2024 through 02/16/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 118148
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) did not received the correct dosage of prescribed medication.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 3 Closed records sample size: 0
Observations:	Med Cart, medication pass, other residents appearance and demeanor, living quarters, social interaction, general facility cleanliness.
Interviews:	Collateral contact, Executive Director, Med Tech, Health and Wellness Director.
Record Reviews:	NR's medication administration record, medication list, medication order, progress notes, care plan. Medication services

Investigation Summary:
The NR was out of the Assisted Living Facility (ALF) during an unannounced onsite visit. The Health and Wellness Director stated that NR physician's order dated 01/31/2024 to increase was not processed by the ALF resulting in the NR not receiving the prescribed doses. Failed practice. A citation was issued for noncompliance with WAC 288-78A- 2210 Medication Services. Previously cited during full survey.

Conclusion / Action:

- [x] 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

Statement of Deficiencies	License #: 2481	Compliance Determination # 36480
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 1 of 6	Licensee: PSL Associates, LLC	02/16/2024

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 complaint investigation on 01/10/2024, 02/08/2024 and 01/29/2024 of:

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

This document references the following complaint number(s): 116574, 118148, 116015

The following sample was selected for review during the unannounced on-site visit: 3 of 84 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator
Judith Mellon, RN, Licensor

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

02/27/2024
Date

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

Administrator (or Representative) 3/11/24 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.

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

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 4 of 4 residents (Residents 1, 2, 3, and 4) received medications as prescribed and doctor's orders were documented on the medication administration records (MAR). These failures resulted in Resident 1 receiving a medication that had been discontinued for 5 months, Resident 2 missing 6 consecutive doses of an antiseizure medication, Resident 3 receiving 2 extra doses of an antidepressant medication and being sent to the hospital, and Resident 4 missing 72 doses of multiple medications over a three month period and placed all residents at risk for receiving and or not receiving prescribed medications as ordered.

Findings included...

Review of the ALF's procedure, "Physician Orders" dated 01/2020 showed:
2. Physician Fax Orders. The physician fax form (HS 018) may be used to request orders from the physician. The Wellness Director, Executive Director, or a designated trained Community Associate may complete the fax form to request a medication change, inform physician of non-emergency resident status needs with a request for directions or to provide routine physician requested information.
• Follow all of the steps when completing the form using all identifying information on the top of the form; be thorough and factual in the information provided to the physician in the middle section of the form. This will be the information needed to determine if the request will be accepted or a different course of action is needed. Remember, the order is not valid until the physician has completed and signed the bottom section and returned it to the Community.
• After the form has been completely filled out, you should fax the form to the physician. Give one copy of the order to the Wellness Director for his/her follow up file (signed order). The most current order should always be placed on the top in the Resident's chart file.
• Once the order is faxed back from the physician with completed and signed information, faxed the order into the pharmacy. Place one copy in the Resident's record under the tab

labeled "Health". You may wish to follow up with a call to verify they received the complete order at the pharmacy. - If the community is using an EMAR system, follow the direction for sending an input of physician orders.
• Community Associates should continue with the normal procedures for new medication orders. The Wellness director or appropriately trained/delegated Community Associates, should write the order on the MAR, or input into the EMAR system and complete the process.
• If no response comes from the physician within 24 hours for non-emergency needs, a follow up phone call should be made to the physician's office. This must be documented along with the original fax and must be continued until contact is made and the issue is resolved by the HWD or designated Community Associate.
• If the fax was informational with no requested or expected response, the fax should be filed in the Resident binder under the "Health" tab.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted]). A negotiated service agreement dated 12/21/2023 showed Resident 1 received medication assistance.

Review of a physician's order dated 07/27/2023 showed Resident 1's order for Flomax (urinary retention medication) was to be discontinued on 07/27/2023 due to Resident 1's lightheadedness and orthostatic hypotension (low blood pressure when standing up from sitting or lying down).

Review of the MAR dated December 2023 showed Resident 1 had been receiving Flomax 0.4 mg (milligrams, a unit of measurement) daily from 07/27/2023 until 01/03/2024, 5 months after it was ordered to be discontinued.

Interview on 01/29/2024 at 2:33 PM, Staff A, Executive Director, stated that on 01/04/2024 they received a call from Resident 1's doctor's office questioning why Flomax had not been discontinued on 07/27/2023.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted] A negotiated service agreement dated 12/31/2023 showed Resident 2 received medication assistance.

A physician's order dated 01/31/2024 showed Resident 2's Depakote (seizure disorder and mental/mood condition medication) was to be increased to two 500 mg tablets each, twice daily totaling 2,000 mg per day.

Two MARs dated January and February 2024 showed Resident 2 received Depakote 250 mg in the morning and 375 mg in the evening totaling 625 mg per day from 01/31/2024 until 02/06/2024. Resident 2 failed to receive 1,375 mg per day for 7 days.

On 02/08/2024 at 1:47 PM, Staff B, Health and Wellness Director, stated that during the

pharmacy's chart audit on 02/07/2024 it was found the physician's order to increase Resident 2's Depakote was not processed, which resulted in Resident 2 not receiving the prescribed dose.

Review of the incident report dated 02/07/024 showed the physician's order to increase Resident 2's Depakote was received and stamped by the facility on 01/31/2024.

On 02/26/2024 at 9:17 AM, Collateral Contact (CC), stated that Resident 2 was sent to the hospital on 02/07/2024 due to a fall. The CC stated that while at the hospital the doctor told them that Resident 2's fall may have been due to not receiving the increased Depakote as ordered.

Resident 3

Resident 3 was admitted to the ALF on [redacted] 2020 with multiple diagnoses including [redacted] A negotiated service agreement dated on 01/09/2024 showed Resident 3 received medication assistance.

A physician's order dated on 01/27/2024 showed Resident 3's extra dose of Depakote 250 mg 3 tablets (750 mg) each day on Mondays and Thursdays was to be discontinued.

Review of a MAR dated 02/2024 showed Resident 3 had three separate written entries in the MAR for Depakote. First, Depakote ER 250 mg 3 tablets (750 mg) by mouth daily. Second, to give Depakote ER 250 mg 2 tablets (500mg) by mouth extra dose for Monday and Thursdays at 8:00 PM initiated on 11/23/2023. Third, to give Depakote ER 250 mg 1 tablet by mouth extra dose on Mondays and Thursdays at 8:00 PM initiated on 11/23/2023. The MAR showed Resident 3 received a total of 750 mg on 02/05/2024 at 8:00 PM in addition to their regular Depakote ER dose.

On 02/08/2024 at 1:52 PM, Staff B, Wellness Director, stated that during the pharmacy's chart audit on 02/06/2024 it was found that the order to discontinue the extra doses of Depakote for Mondays and Thursdays was not processed which resulted in a medication error.

On 02/08/2024 at 2:20 PM, Resident 3 stated that did not feel good after taking extra dose of Depakote and was sent to the hospital. Resident 3 stated that they could not lift their feet up while at the hospital and felt depressed.

Resident 4

Resident 4 was admitted into the ALF on [redacted] /2014 with multiple medical diagnoses including [redacted] and [redacted]

Review of Resident 4's negotiated service agreement (NSA) dated 01/09/2024 showed Resident 4 was confused and needed medication assistance. The NSA showed the ALF staff

were responsible to Re-order medications or assist resident/responsible adult to re-order medications.

Review of Resident 4's electronic medication administration records (EMAR) for three months of November and December 2023, and January 2024 showed Resident 4 had the following medications listed in the EMAR as: medications not available, does not have this med, have faxed multiple times in past regarding this med and family provides medication waiting for them. The following medication doses were not available for Resident 4:

Armour Thyroid 60 mg (milligrams, a unit of measurement) daily, used to replace missing thyroid hormones (chemical substance in the body), total of two missed doses.
Aspirin EC 81 mg daily, anti-inflammatory and blood thinner, total of three doses.
Dorzolamide 2% eye drops, one drop in both eyes twice a day, used to treat high pressure in the eye for glaucoma, one missed dose.
Guaifenesin 100 mg/5 ml (millilIter, a unit of measurement) give 30 ml twice a day, loosens mucus in airways (respiratory tract that allow airflow during ventilation), eight missed doses.
Magnesium Oxide 400 mg daily, used to help treat low magnesium levels, one missed dose.
Nattokinase 35 mg daily, dissolves blood clots, 39 missed doses.
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), one missed dose.
Omeprazole 20 mg every morning, used to reduce the amount of acid your stomach makes, 17 missed doses.

In an interview on 01/10/2024 at 4:18 PM, Staff B, LPN, Health and Wellness Director, stated that the ALF was still providing Resident 4's medications and that she was still in the process of reviewing EMARs for inconsistencies.

In an interview on 01/10/2024 at 4:30 PM, Staff A, Executive Director stated there was nothing in Resident 1's medical record to show the physician was notified that Resident 4's medications were not available.

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) 4/1/24.

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

Administrator (or Representative) [signature] Date 3/11/24