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

06/27/2024

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) 42262 (Completion Date 06/05/2024) and 37261 (Completion Date 04/16/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/05/2024 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-2450-2-d

The Department staff who did the on-site verification:
Helen Fisher, Complaint Investigator

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 #: 37261
Investigator: Judith Mellon
Provider Type: Assisted Living Facility
Intake ID: 118420
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 03/01/2024 through 04/16/2024
Complainant Contact Date(s): 02/22/2024

Allegation(s):

1) A Named Resident (NR) received eye drops and felt like staff did not seem to know what they were doing.
2) Medication Technicians are not nurse delegated or trained to administer diabetic eye drops or insulin.
3) The Named Resident's medication lisinopril was not scored and the Assisted Living Facility staff were administering the lisinopril incorrectly by cutting the pills in half resulting in the Named Resident receiving improper medication dosages.
4) A Named Resident's was supposed to receive Plavix (anticoagulant medication) for an upcoming medical procedure and a surgeon stated there was no sign of Plavix in the Named Resident's body system.
5) The Named Resident was supposed to receive an antibiotic for ten days and only had six of the medication doses.
6) The Facility Executive Director and staff were not certified in the care of people with Alzheimer's and Dementia.
7) The Facility failed to make reports to the State when staff were aware of care concerns.
8) A Named Medication Technician worked 30 days straight, 16 hours each day when other staff were off shift and was responsible to give 120 residents their medication every day.
9) The Facility doorbell remains inoperable despite facility staff stating it would be fixed.

Investigation Methods:

Sample:	Total residents: 79 Resident sample size: 6 Closed records sample size: 2
Observations:	Entrance door signs, resident common areas, secured memory care unit, facility postings including statement of deficiencies, Collateral Contact cell phone pictures, eye drop administration
Interviews:	Executive Director, Regional Vice President of Health and Wellness, Medication Technicians, Memory Care Director, Regional Registered Nurse, Nurse Delegators, outside providers, former staff

Record Reviews: Collateral Contact records and email correspondence, two Named Residents and five sample residents medical records including facility investigations, Nurse Delegation Records, facility policies and procedures

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Investigation Summary:

1) NR no longer at ALF. A sample resident was observed for eye drops by a Medication Technician. The Medication Technician informed the sample resident of the eye drop procedure, maintained infection control precautions and administer eye drops correctly. No failed practice identified. No citation written.

2) Current nurse delegation certifications were reviewed and showed Medication Technicians working the medication cart had nurse delegation certifications. The Nurse Delegator consultant stated she was hired to replace the former nurse delegator, had reviewed eye drops and insulin, and delegation binders had related information for staff reference. No failed practice identified; no citation written. Nurse Delegation was previously investigated and cited, see statement of deficiencies dated 07/03/2023. Citation WAC 388-112A-0550 (1)(a)(2)(a)(b) was written. Facility was under a plan of correction for nurse delegation and a new nurse delegator consultant was hired.

3) The NR's lisinopril was not a scored tablet. A prescription showed lisinopril dosage was decreased from 10 mg to 5 mg twice a day and staff were to use 10 mg tablets on hand. The physician stated that an order clarification was needed related to scored tablets and that cutting the lisinopril in approximately half would not alter the NR's blood pressure. Failed practice identified, citation for WAC 388-78A-2210 (1)(b) Medication Services, see statement of deficiencies dated 01/10/2024. ALF under current plan of correction.

4) The ALF was notified after a physician visit by Family that NR's Plavix platelet function test, showed a result of 198 with an off-drug reference range of 182-335 the ALF completed an internal incident report for a medication error. The Medication Administration Record for May 2023 showed seven missed Plavix doses listed as LOA (leave of absence), hospital and medication not available. The NR's primary care physician was notified by the NR's family. The NR's physician stated that she did not see a notification from the ALF related to missed Plavix doses and was notified by the NR's family. A facility incident report showed the former nurse notified the physician on 05/19/2023. No failed practice identified. No citation written. ALF under current plan of correction see statement of deficiencies dated 01/10/2024.

5) The NR had an antibiotic order for doxycycline monohydrate 100mg twice daily for seven days. The ALF completed an internal incident report/investigation for a medication error with an incident date of 05/16/2023 and had conflicting reporting dates. The ALF investigation showed a bottle of doxycycline two tablets a day was prescribed on 05/02/2023, had contained seven pills and family, physician were notified. The NR’s MAR for May 2023 showed double entries for doxycycline orders for 100mg twice daily for seven days with two different start dates. A total of fifteen doses were given for the month of May 2023. Failed practice identified; a citation was issued for non-compliance with WAC 388-78A-2210 (1)(b) Medication Services. ALF under current plan of correction see statement of deficiencies dated 01/10/2024.

6) Facility staff not certified in specialty training were identified during the full inspection and the ALF was under plan of correction. Certifications in specialty training were obtained. No failed practice identified; no citation written.

7) Review of the Department's secure tracking and reporting system showed the Assisted Living Facility notified the State hotline and self-reported information related to the Named Resident for medication errors including blood pressure medication and missed doses of medication, an unwitnessed fall and injury of unknown origin in January and February 2024. No failed findings, no citation issued.

8) Not able to substantiate, unknown dates, time period. Named Staff no longer employed at the ALF. Three attempts to contact Named former staff unsuccessful. No

Staffing schedules as planned or as worked available for review other than January 2024. Failed practice identified; a citation was issued for non-compliance for WAC 388-78A-2450 (2)(d) Staff.
9) The facility doorbell was observed to have signage posted and in working order. Staff carry a cell phone type apparatus with an app for the doorbell. The doorbell had an audible ring to alert staff to the front door. A reset was completed with the pad access in the entry vestibule. No failed practice identified. No citation issued.

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 #: 37261
Investigator: Judith Mellon
Investigation Date(s): 03/01/2024 through 04/16/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 118353
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
A Named Med Technician applied steri-strips and bandage to a Named Resident's (NR) arm.

Investigation Methods:

Sample:	Total residents: 79 Resident sample size: 6 Closed records sample size: 2
Observations:	Entrance Doorbell and signage, resident common areas including, resident common areas, secured memory care unit, facility postings including statement of deficiencies, Collateral Contact cell phone pictures, eye drop administration
Interviews:	Executive Director, Regional Vice President of Health and Wellness, Medication Technicians, Memory Care Director, Regional Registered Nurse, Nurse Delegators, outside providers, former staff
Record Reviews:	Nurse Delegation, Staff files, Policies and Procedures for skin care, falls and medications. two Named Residents and five sample residents medical records including facility investigations, facility policies and procedures

Investigation Summary:
When a NR requested assistance for a band aide to an arm a former nurse was notified. The nurse completed an assessment and found a dressing to a skin tear of the right forearm with several steri-strips applied to a skin tear. The nurse notified family, physician, facility administration, completed an incident report and an investigation. The NR received medical follow up and an antibiotic was prescribed. The NR was unable to recall who the staff person was at the time of the incident that applied the bandage. The NR is no longer at the ALF. The Nurse Delegator stated that the Medication Technicians were not delegated to provide wound care as part of nurse delegation. No staffing schedules were available to review. Failed Practice identified. A citation was issued for non-compliance with WAC 388-78A-2450 (2)(E) Staff.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2481	Compliance Determination # 37261
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 1 of 3	Licensee: PSL Associates, LLC	04/16/2024

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 03/01/2024 and 04/16/2024 of:

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

This document references the following complaint number(s): 118420, 118353

The following sample was selected for review during the unannounced on-site visit: 6 of 79 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

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

04/30/2024
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)

4/30/2024
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to maintain staffing schedules for staff to show scheduled and as worked hours. This failure placed all residents at risk for injury and unmet care needs.

Findings included...

On 03/08/2024 at 12:50 PM, Staff A, Executive Director stated that the staffing schedule showed they had agency staff working mostly on the day and evening shift. Staff A stated that the night shift was staffed mostly by facility staff.

On 03/08/2024 at 3:21 PM, Staff A, Executive Director, stated that Staff B, Resident Care Coordinator, had been responsible to maintain the staffing schedules and Staff B was no longer employed at the ALF. Staff A stated that the staffing schedules were disorganized and not located together. Staff A stated that she was having a hard time finding anything and the schedules were not complete as they should be. Staff A stated that the only staffing schedule available for review was for January 2024. Staff A stated that the January 2024 staffing schedule is just what was posted and showed areas highlighted in yellow where there were openings that needed to be filled by staff.

Record review of a staffing schedule for January 2024 showed multiple openings highlighted where staff were needed to fill the openings.

On 03/08/204 at 3:24 PM Staff A, stated that this was all the copies of the schedule that the ALF had and the ALF no longer had any other copies for 2023.

No other staffing schedules were available for review to show planned and as worked schedules for the ALF staff or additional agency staff.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2481	Compliance Determination # 37261
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 3 of 3	Licensee: PSL Associates, LLC	04/16/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/31/2024 .

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

Administrator (or Representative) 4/30/2024 Date