STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223
01/12/2024

UNICARE HOMES INC
ORCHARD PARK ASSISTED LIVING
844 W ORCHARD DRIVE
BELLINGHAM, WA 98225

RE: ORCHARD PARK ASSISTED LIVING License # 1350

Dear Administrator:

This letter addresses Compliance Determination(s) 34542 (Completion Date 12/28/2023) and 28611 (Completion Date 10/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/28/2023 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 388-78A-2600-1-b, WAC 388-78A-2600-1-a

The Department staff who did the on-site verification:
Allison Nunn, Long Term Care Surveyor

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: ORCHARD PARK ASSISTED LIVING
License/Cert.#: 1350
Compliance Determination #: 28611
Investigator: Helen Fisher
Provider Type: Assisted Living Facility
Intake ID: 95424
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 08/28/2023 through 10/27/2023
Complainant Contact Date(s): 08/28/2023

Allegation(s):

1) The Named Resident (NR) had bilateral leg wounds.
2) The facility was using a transfer device which caused discomfort to the NR.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 3 Closed records sample size: 0
Observations:	NR leg wounds and appearance. Environment. Apartment.
Interviews:	NR, Collateral Contact, Executive Director, Director of Nursing, Med Tech.
Record Reviews:	NR records. Facility records. Eden Home Health report.

Investigation Summary:

1) The staff stated that the NR leg wounds were managed by Eden Home Health and Wound Clinic. Hospital notes dated 08/07/2023 showed NR's skin ulcers were pressure wounds from the swelling of the NR legs. The care plan showed the NR had a history of recurrent heel and ankle wounds. The NR stated that they felt like their legs wounds are getting worse especially when legs were not elevated. The NR stated that staff were nice but had been forgetting to check on them in the bathroom and had to wait for a long time. The Staff stated that on 08/27/2023 and 08/28/2023 night shift they had Agency staff working to help during COVID-19 outbreak. The staff stated that when there was a need for 2 persons transfer there may be longer wait due to the number of staff on night shift. A citation was issued for non compliance with WAC 388-78A-2600 Policies and procedures.
2) The staff stated that the NR refused to use a gait during transfers and complained the use of a transfer disc. The staff stated that they were concerned about the NR's safety with transfer. The NR was assessed as appropriate to utilize a transfer disc. The staff stated that they stopped using the transfer disc 3 days prior to the unannounced

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onsite visit due to NR complaints. The staff stated that the NR had since been provided 2-person assistance with transfers for safety. No failed facility practice identified.

Conclusion / Action:

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

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Statement of Deficiencies
Plan of Correction
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License #: 1350
ORCHARD PARK ASSISTED LIVING
Licensee: UNICARE HOMES INC

Compliance Determination # 28611
Completion Date
10/27/2023

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 08/28/2023 and 08/28/2023 of:

ORCHARD PARK ASSISTED LIVING
844 W ORCHARD DRIVE
BELLINGHAM, WA 98225

This document references the following complaint number(s): 94224, 94862, 95424

The following sample was selected for review during the unannounced on-site visit: 3 of 57 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

11/06/2023
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

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Statement of Deficiencies	License #: 1350	Compliance Determination # 28611
Plan of Correction	ORCHARD PARK ASSISTED LIVING	Completion Date
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Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to implement the ALF's policy to respond to residents' requests for care needs in 15 minutes for 2 of 3 residents (Resident 1 and 2) when residents had extended wait times after using their call lights. This failure resulted in Resident 1 and 2 having to wait between one and a half to two hours before receiving care and placed Resident 1 and 2 at risk for unmet care needs and noncompliance of the ALF's Call Response Policy and Procedure.

Findings included...

Review of ALF's Call Response Policy and Procedure showed; when you see a call light come to your pager it is Orchard Park's policy to try and answer that light within 15 min. If you are tied up in another room, please call a coworker to either assist the resident who is calling or to let that resident know that their caregiver or Med tech will be in as soon as possible. Please do not reset the call light until you have assisted the resident with the needs they may have (so they will not be forgotten) BUT you do need to reset the pendent each time you finish with the resident.

Resident 1
Resident 1 was admitted to the ALF on [redacted] 2020 with multiple diagnoses including [redacted] and [redacted]

The negotiated service agreement dated 03/27/2023, showed Resident 1 needed assistance with dressing and toileting and 2 persons assistance with transfers.

Resident 2
Resident 2 was admitted to the ALF on [redacted] 2023 with multiple diagnoses including [redacted]

The negotiated service agreement dated 03/32/2023, showed Resident 2 able to make

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their needs known, needed 2 person assistance with transfers using sit to stand, bladder incontinent when not able to bathroom in a timely manner.

In an interview on 08/28/2023 at 11:32 AM, Collateral Contact stated that Resident 1 waited for hours to be helped on 08/28/2023 at 3:00 in the morning.

In an interview on 08/28/2023 at 1:35 PM, Resident 1 stated that at 3:30 in the morning of 08/28/2023 the staff assisted them to the toilet. Resident 1 stated that they told the staff to go ahead and leave but to check on them shortly, but the staff did not comeback until 3 hours later. Resident 1 stated that they were using their call pendant.

In an interview on 08/28/2023 at 2:15 PM, Resident 2 stated that in the last 2 days they had to wait longer for someone to answer their call for help. Resident 2 stated that staff are very nice but were having trouble answering the call pendant especially at night.

In an interview on 08/28/2023 at 1:00 PM, Staff B, Director of Nursing, stated that they did not receive reports regarding the delay in a call response that morning.

In an interview on 09/27/2023 at 12:32 AM, Staff A, Executive Director, stated that they had an agency caregiver who helped them during COVID-19 outbreak and may have not been prompt in responding to resident's call. Staff A was not aware of the delay in call response. Staff A stated that some of the staff were afraid of Resident 1 because Resident 1 was mean to some of the staff.

In an interview on 10/27/2023 at 10:51 AM, Staff C, Evening Nurse, stated that the ability to do a transfer that they're going to need to have two bodies available even in the evening times sometimes it's difficult but overnight it would be harder because there's just less staff covering the night through till the morning and residents a little heavier demand of care it's possible that they had waited for an hour.

In an interview on 10/27/2023 at 1:38 PM, Staff D, Night Med Tech/ Caregiver, stated that sometimes there's other things that they have going on and the call happens to be going off when there's other stuff going on like for example there's other residents that cares take a little bit longer.

Review of Resident 1 call response report dated 08/27/2023 to 08/28/202, showed Resident 1 waited 1 hour and 36 minutes and on 08/28/2023, showed Resident 1 waited 2 hours and 17 minutes at 2:39 AM for staff to respond.

Review of Resident 2 call response report on 08/27/2023 to 08/28/2023, showed Resident wait for up to 1 hour and 54 minutes in two occasions.

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, ORCHARD PARK ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 12-9-2023.

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

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Administrator (or Representative)

11-9-2023
Date

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