STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

09/30/2024

EVERETT PLAZA ASSISTED LIVING COMMUNITY LLC
EVERETT PLAZA
2204 12th St
Everett, WA 98201

RE: EVERETT PLAZA License # 1921

Dear Administrator:

This letter addresses Compliance Determination(s) 47500 (Completion Date 09/20/2024) and 43010 (Completion Date 07/10/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/20/2024 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-2630-1-a, WAC 388-78A-2210-1-b

The Department staff who did the on-site verification:
Wesler Dumecquias, Community 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:** EVERETT PLAZA
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 1921
**Compliance Determination #:** 43010
**Intake ID:** 130686
**Investigator:** Nicholette Flynn
**Region/Unit #:** RCS Region 2 / Unit A
**Investigation Date(s):** 06/04/2024 through 07/10/2024
**Complainant Contact Date(s):**

**Allegation(s):**
The Named Resident (NR) informed the Assisted Living Facility (ALF) that a person scammed them of money through online dating.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 95<br>Resident sample size: 7<br>Closed records sample size: 0 |
| **Observations:** | Identified resident<br>Residents<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Nursing staff<br>Residents<br>Family members<br>Administrator |
| **Record Reviews:** | Incident investigation<br>Facility policies<br>Care plan |

**Investigation Summary:**
The Assisted Living Facility (ALF) knew about the alleged incident on 04/30/2024, where the Named Resident (NR) mentioned a person scammed them of money in online dating. The ALF did not report the incident to the Department of Social Health and Services Hotline (Department) because they stated they knew the NR; the ALF believed the NR was not scammed because the NR knew what they were doing. The NR noted as a result of being scammed, they were not able to pay their rent. The ALF did not report to the Department for them to have the opportunity to determine if financial exploitation did occur and did not report to Law enforcement to protect the resident from a potential crime. The ALF did not investigate because they believed no financial exploitation occurred. A failed practice was identified for noncompliance with WAC 388-78A-2630 (1) (a)- Reporting Abuse and Neglect.

**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:** EVERETT PLAZA
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 1921
**Compliance Determination #:** 43010
**Intake ID:** 132062
**Investigator:** Nicholette Flynn
**Region/Unit #:** RCS Region 2 / Unit A
**Investigation Date(s):** 06/04/2024 through 07/10/2024
**Complainant Contact Date(s):**

**Allegation(s):**

1. The Named Resident (NR) was given by the ALF's Med Tech someone else's medications in a cup.
2. There were residents who were not getting their morning medications until close to lunchtime because of the line.
3. The NR's eye drops did not come on time, or the Med Techs could not locate the NR's eye drops. The NR missed two doses of their eye drops because the Med techs could not find them.
4. The ALF- Med Techs were not putting the eye drops in the refrigerator as they were supposed to be.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 95<br>Resident sample size: 7<br>Closed records sample size: 0 |
| **Observations:** | Identified resident<br>Residents<br>Resident rooms<br>Medication administration |
| **Interviews:** | Identified resident<br>Nursing staff<br>Residents<br>Family members |
| **Record Reviews:** | Incident investigation<br>care plan<br>Assessments<br>Medication Administration Records.<br>Doctor's orders. |

**Investigation Summary:**

1. The NR stated a Named Staff delivered them the wrong medication in a medication cup. The NR did not take them because they recognized that it was not their medication. The NR stated that they had medications in a cup at that time,

which was ready to be discarded when they prepared the NR's medications. The NS stated they grabbed the medication, which was to be discarded instead of that of the NR, but realized it was not the correct medication and did not give it to the NR. The NS said they prepared the NR's medicines in their Medication room and delivered them to the NR's apartment.

2. The NR administers their eyedrops. The record showed the NR had an order from their Doctor to keep and self-administer their eyedrops themselves. The NR would inform the ALF staff if the eyedrops were about to be consumed so the ALF staff could reorder them. Observation and interview showed the ALF Med Techs have a refrigerator in the ALF's Medication room where they store unopened eyedrops that require refrigeration. Interviews with the ALF Med Techs indicated they knew their protocol for storing unopened eyedrops that needed refrigeration. The NR was self-administering their eyedrops. The ALF Medication Administration Record does not track or keep a record of when the eyedrops were not taken or administered. During the unannounced visit, the NR had their eyedrops available in their room for administration. The ALF spoke with the NR to inform the ALF Med Techs earlier so they could order and have the eyedrops arrive on time.
3. Record review showed the NR could administer and store their eyedrops in their room. Observation and interview showed the ALF Med Techs have a refrigerator in the ALF's Medication room where they store unopened eyedrops that require refrigeration. The ALF staff stated that once the Med Tech or Resident opened the eye drops, the ALF staff or Resident would keep or store the eyedrops at room temperature either in the Medication cart or in the Resident's room. The opened NR's eyedrops were in their room during the unannounced visit.

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**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 #: 1921 | Compliance Determination # 43010 |
| Plan of Correction | EVERETT PLAZA | Completion Date |
| Page 1 of 6 | Licensee: EVERETT PLAZA ASSISTED LIVING COMMUNITY LLC | 07/10/2024 |

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 complaint investigation on 06/04/2024 and 06/21/2024 of:

EVERETT PLAZA
2204 12th St
Everett, WA 98201

This document references the following complaint number(s): 130686, 129829, 132062, 130250

The following sample was selected for review during the unannounced on-site visit: 7 of 95 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator
Nicholette Flynn, AFH Field Manager

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

07/19/2024
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.

Laura Williams
Administrator (or Representative)

7/31/2024
Date

**WAC 388-78A-2630 Reporting abuse and neglect.**

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

**This requirement was not met as evidenced by:**

Based on the interview and record review, the Assisted Living Facility (ALF) failed to report to the Department's Aging and Disability Services Administration Complaint Resolution Unit hotline when 1 of 1 resident (Resident 1) reported to an ALF employee that they were scammed of money. The failure resulted in the Department of Social Health and Services not being able to investigate and determine if the Resident 1 was a victim of financial exploitation.

Findings included...

A review of ALF's policy on "ABUSE-NEGLECT- EXPLOITATION" dated 09/28/2024 showed it was the responsibility of each staff member to immediately contact the Department Hotline directly regarding suspected (financial) exploitation. An ALF employee who first receives a report or becomes aware of an allegation of exploitation should be responsible for reporting the incident to the DSHS (Department of Social Health and Services) Hotline as soon as possible.

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses, including [redacted]), and [redacted]).

On 05/13/2024 at 1:51 PM, Resident 1 stated that they were behind their rent in the ALF because they gave their money, eight thousand dollars, to a scammer through online dating. Resident 1 stated that they were scammed twice, once in February and March 2024. Resident 1 stated that they mentioned to Staff A, Executive Director about being

scammed.

A review of progress notes (NOTES), dated 04/30/2024 showed Staff A spoke with Resident 1. The NOTES showed Resident 1 stated that they had been scammed by willingly sending the money to someone they thought was their boyfriend.

An email dated 05/31/2024 from Staff A showed they did not feel Resident 1 was scammed, so they did not report it. The email showed Resident 1 had a history of finding lovers/friends and giving them money. Staff A stated that Resident 1 transferred their money from their account to a "friend" on multiple occasions.

An email dated 06/03/2024 from Staff A showed they did not have a reasonable cause to believe that Resident 1 was financially exploited because they sent their money willingly to the alleged scammer. Staff A stated that Resident 1 engaged in an online affair and sent money.

On 06/07/2024 at 4:40 PM, Staff A stated that they did not investigate the incident to rule out financial exploitation. Staff A stated that they knew Resident 1 had a history of willingly sending money online.

**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, EVERETT PLAZA is or will be in compliance with this law and / or regulation on (Date) 8/21/2024 .

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

Laura Williams 07/31/2024

Administrator (or Representative) 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 the interview and record review, the Assisted Living Facility (ALF) failed to correctly follow the prescribed times of insulin administration and gave incorrect medication for 1 of 1 Resident (Resident 1) who was on medication assistance. The

failure resulted in Resident 1 getting their fast-acting insulin injection late, receiving insulin administrations too close to each other, and being handed a pre- poured incorrect medication.

Findings included…

A review of the ALF's undated policy on Medication Services procedures for Residents who were on medication assistance showed; ALF staff would inform the resident that they were delivering their medications; Unlock the medication cupboard, Take out medication from the cupboard, hand container to the resident ensuring the residents were aware of the medication and amount they were to take; Observe the resident; Provide water and ensure the resident would swallow the medication; and Return medication to the cupboard then document.

Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses, including [redacted].

Review of the Service Plan (SP) dated [redacted]/2024 showed Resident 1 was on medication assistance services. The SP showed facility staff were to assist Resident 1 in their medications or treatments as per physician order.

Insulin

Review of physician's order (Order) dated 05/10/2024 showed Resident 1 was prescribed Humalog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) 100U/ML (units per milliliter) 3 ML, inject as per sliding scale: if 0-150= 0; 151- 200= 2; 201- 250= 4; 251= 300 = 6. If over 301, give eight units, subcutaneously, three times a day related to type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. If Glucose is below 80 two times in a row, or over 350 two times in a row, notify the Provider. The order showed administration times of 7:00 AM, 12:00 PM, and 5:00 PM.

A review of the Medication Administration Record (MAR) for the Humalog injection dated May 2024 showed the following administration times for Resident 1:
On 05/19/2024, the 5:00 PM injection was given at 7:50 PM, two hours and 50 minutes late; On 05/20/2024, the 5:00 PM injection was given at 7:15 PM, two hours and 15 minutes late; On 05/21/2024, the 5:00 PM injection was given at 9:31 PM, four hours and 21 minutes late; and, on 05/27/2024, the 5:00 PM injection was given at 8:03 PM, three hours and three minutes late.

A review of the MAR dated June 2024 showed the following sliding-scale insulin administration times for Resident 1:

On 06/03/2024, the 7:00 AM injection was given at 11:25 AM, 4 hours and 25 minutes late; On 06/03/2024, the 12:00 PM injection was given at 1:24 PM, less than two hours from the last administration at 11:25 AM; On 06/09/2024, the 7:00 AM injection was given at 10:46 AM, three hours and 46 minutes late, and the 12:00 PM injection was given at 1:36 PM, one hour and 36 minutes late; and, On 06/10/2024, the 7:00 AM injection was given at 10:06 AM, three hours and six minutes late, and the 12:00 PM injection was given at 2:05 PM, two hours and five minutes late.

On 06/07/2024 at 3:29 PM, Resident 1 stated that Staff E, Med Tech, gave their morning Humalog injection almost always at 11:00 AM. Resident 1 stated that they told Staff E not to give their noon injection because they just took the Morning injection at 11:00 AM. Resident 1 stated that sometimes their blood sugar was checked after they ate because Staff E would come late to give their insulin injection. Resident 1 stated that Staff E was aware because they were the ones who gave their injection late.

On 06/26/2024 at 9:20 AM, Staff E stated that they gave Resident 1's injection late because Resident 1 was refusing to give their blood sugar reading to Staff E. Staff E stated they did not notify their ALF nurse or Resident 1's primary care physician of the refusal. Staff E stated that they gave the Humalog injection around 1:30 PM, even if they gave the morning dose at 10:00 AM or 11:00 AM. Staff E stated that they were getting Resident 1's blood sugar readings after eating instead of before meals. Staff E stated that they should have taken the blood sugar reading before Resident 1 ate their meals.

An email on 07/03/2024 from Staff B, Director of Nursing Services, showed they did not notify Resident 1's primary care physician regarding their sliding scale insulin injection given by the ALF staff. Staff B stated that it was a sliding scale and there were no adverse effects.

An email dated 07/10/2024 from Staff B showed blood sugar readings for a sliding scale should be a fasting number. Staff B stated that the Med Techs knew they needed to check blood sugars before a resident ate.

Incorrect medications

On 06/07/2024 at 3:29 PM, Resident 1 stated that Staff E brought their medications in a cup. Resident 1 stated that they noticed they were the wrong medications. Resident 1 stated that they refused to take the incorrect medications despite Staff E insisting they were the proper medications. Resident 1 stated that Staff E later left the room after delivering the incorrect medications. Resident 1 stated that Staff E returned to their apartment and told them not to take the medications that they brought earlier.

On 06/07/2024 at 2:35 PM, Staff C, Med Tech, stated that they would prepare the

medications in the medication room, pour them into the medication cup, bring them to the resident's room, and tell them they have their medications.

On 06/26/2024 at 9:20 AM, Staff E stated that there was an instance where they almost gave Resident 1 the wrong medications. Staff E stated that they had poured Resident 1's discontinued medications in a medication cup. Staff E stated that they intended to throw away or destroy the discontinued medications. Staff E prepared and poured Resident 1's current medication into a separate cup. Staff E stated that they grabbed the wrong medication cup, the one they intended to discard, and delivered it to Resident 1 in their room instead of their current medications. Staff E stated that they always prepare the medications in the medication room by pouring them into a medication cup and then delivering it to residents' rooms.

**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, EVERETT PLAZA is or will be in compliance with this law and / or regulation on (Date) 08/21/2024 .

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

Laura Williams 7/31/2024

Administrator (or Representative) Date

EVERETT PLAZA
ASSISTED LIVING

July 31, 2024

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

RE: EVERETT PLAZA ASSISTED LIVING SOD 43010 PLAN OF CORRECTION

Dear Ms. Ripley,

Please find the plan of correction for the investigation and citation:

WAC 388-78A-2630 Reporting abuse and neglect

- Date of Correction 08/21/2024
- Responsible persons, Administrator
- Administrator to retrain on Abuse Prevention, Investigation, and Reporting

WAC 388-78A-2210 Medication services

- Date of Correction 08/21/2024
- Responsible persons, Administrator and Director of Nursing
- Caregiver training on Medication Management
- Caregiver training on Diabetes

If you have any questions, please do not hesitate to contact me. Thank you.

Sincerely,

Laura Williams

Laura Williams
Executive Director
Everett Plaza 425-258-6408
ExecDir@EverettPlazaAssistedLiving.com