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

07/24/2024

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) 44392 (Completion Date 07/19/2024) and 40169 (Completion Date 05/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/19/2024 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-2600-2-I

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 #: 40169
Intake ID: 121266
Investigator: Wesler Dumecquias
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/23/2024 through 05/20/2024
Complainant Contact Date(s): 04/10/2024

Allegation(s):

1. The Named Resident 1 (NR1) did not received their Vitamin B12 injection for the month of February.
2. The Assisted Living Facility (ALF) staff insisted on searching the Named Resident 2's (NR2) bag without their permission.

Investigation Methods:

Sample:	Total residents: 95 Resident sample size: 6 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Incident investigation Facility policies Care plans

Investigation Summary:

1. The Assisted Living Facility (ALF) failed to ensure that the NR1's injectable medication for the February 2024 dose was available for the 7th of the month. The record showed the ALF was late in administering the injectable dose on January 7, 2024, because the medication came after it was due to be given on January 7, 2024. The order showed the ALF staff would administer the medication every 7th of the month. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2600—Policies and Procedures.
2. The ALF Executive Director investigated the incident. The ALF determined that there was an incident where the ALF staff found the NR had a grocery sack with over-the-counter (OTC) medications. The ALF staff asked the NRs if they could check their bags.

NR2 got angry and dumped the contents of the grocery bag. NR2 gave the OTC medications to the ALF staff. The ALF staff checked on NR2's current orders and found the OTC medications did not match the orders from NR2's Primary Care physician. No failed practice was 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	License #: 1921	Compliance Determination # 40169
Plan of Correction	EVERETT PLAZA	Completion Date
Page 1 of 4	Licensee: EVERETT PLAZA ASSISTED LIVING COMMUNITY LLC	05/20/2024

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 04/23/2024 and 04/23/2024 of:

EVERETT PLAZA
2204 12th St
Everett, WA 98201

This document references the following complaint number(s): 125183, 123852, 126846, 121266, 127259

The following sample was selected for review during the unannounced on-site visit: 6 of 95 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community 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

06/04/2024
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)

6/18/2024
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on the interview and records review, the Assisted Living Facility (ALF) failed to implement their policy and ensure medication was ordered on time for 1 of 1 Resident (Resident 1) who was on medication administration for their Vitamin B12 injection. This failure resulted in Resident 1 not receiving their prescribed medication in a timely manner and placed Resident 1 at risk for health complications.

Findings included...

A review of the ALF's undated policy, "Unavailable Medications" showed all medications that are the responsibility of the facility will be re-ordered from the pharmacy at a pre-designated and negotiated timeframe.

A review of the ALF's undated policy, "Medication Ordering and Delivery" showed it was the policy of the ALF to have medications ordered and delivered in a timely and efficient manner to promote an excellent medication system.

Resident 1 was admitted on [redacted]2023 with multiple diagnoses, including [redacted]

A review of the ALF's undated and unsigned service plan showed Resident 1 was on medication assistance. The ALF staff would order and maintain all medications and treatments and assist residents with medications/treatments as per physician order and resident preference.

A review of the physician's order dated 05/17/2023 showed the Primary Care Physician prescribed Resident 1 Cyanocobalamin 1000 MCG/1 ML injection to be given subcutaneously once a day on the 7th of each month as a supplement for postsurgical malabsorption.

A review of the ALF's Medication Admin Audit Report (Report) from 10/01/2023 to 12/31/2023 showed the Cyanocobalamin injections were all scheduled on the 7th of October, November and December 2023. The report showed the injections were given on 10/11/2023 for the dose in October, 11/14/2023 for the dose in November, and 12/22/2023 for the dose in December.

On 05/20/2024 at 6:08 PM, Staff B stated that 10/07/2023 was a Saturday, and they were not working then. Staff B stated that on 10/09/2023, they worked at home, and on 10/10/2023, Resident 1 had a flu vaccine and requested the injectable medication to be administered by Staff B the following day. Staff B stated they do not have a progress note to explain why they did not give the injectable medication on 11/07/2023; instead, they gave it on 11/15/2023. Staff B stated that they were working on the cart in December 2023 and did not have an explanation as to why they gave it on 12/15/2023 instead of 12/07/2023.

On 04/10/2024 at 3:26 PM, Resident 1 stated that they did not receive their injectable medicine for February 2024. Resident 1 said it was supposed to be on the 7th of February, but the medicine had yet to arrive. Resident 1 stated they were worried that they would not receive it. Resident 1 stated that, for January 2024, they did not receive their injectable medicine until the middle of the month.

A review of the ALF progress notes (Note) dated 01/19/2024 at 11:49 AM showed Resident 1 could not receive their injectable medicine on the 7th of January because the Medication was unavailable then. The note showed Resident 1 received their injectable medicine on 01/19/2024.

A review of the ALF's incident investigation dated 04/29/2024 showed Resident 1 did not receive their February 2024 injectable dose because of the unavailability of the medication.

On 03/11/2023 at 2:33 PM, Staff B stated that they called their Pharmacy on 02/12/2024; however, no documentation showed the ALF called the Pharmacy after they claimed that there was no delivery of the injectable medicine on 02/10/2024 until 02/23/2024 when they faxed the Pharmacy.

On 04/10/2024 at 4:37 PM, CC1 stated that the ALF must call the Pharmacy to refill the injectable medicine. CC1 stated that the ALF did not call the Pharmacy after they claimed the injectable medicine was not delivered on 02/10/2022. CC1 stated the Pharmacy only received a fax on 02/23/2024 from the ALF letting them know the injectable medicine was

not delivered, and the ALF requested a delivery. CC1 stated that they offered and delivered another dose of the injectable medicine again on 02/24/2024 because the ALF insisted they did not receive the delivery on 02/10/2024.

On 04/30/2024 at 11:36 AM, Staff B stated that the ALF's Med Techs would reorder the medications when there was only a week's supply left for the residents. Staff B said they would order injections that a licensed nurse would administer. In this case, Staff B stated they did not need to call the pharmacy for Resident 1's injectable medicine because they had been coming without them calling. Staff B stated they did not give Resident 1's injection for February.

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) 07/04/2024.

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

Laura Williams — Administrator (or Representative)

6/17/2024 — Date

EVERETT PLAZA ASSISTED LIVING

June 18, 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 40169 PLAN OF CORRECTION

Dear Ms. Ripley,

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

WAC 388-78A-2600 Policies and procedures.

- Date of Correction 07/04/2024
- Responsible persons, Director of Nursing, Administrator
- The Director of Nursing set a monthly reminder on Calendar to order all LPN administered injections in accordance with physician's orders.
- Director of Nursing and Administrator will review Medication Policy and Procedure to ensure proper administration.
- DNS requesting B12 injection order changed to first Thursday of every month, no longer date specific.

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