



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Highland Court Operating Company LLC
Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

RE: Highland Court Memory Care License # 2378

Dear Administrator:

This letter addresses Compliance Determination(s) 35463 (Completion Date 01/17/2024) and 32264 (Completion Date 11/07/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/17/2024 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-2703

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.



Residential Care Services Investigation Summary Report

Provider/Facility: Highland Court Memory Care
License/Cert.#: 2378
Compliance Determination #: 32264
Investigator: Phan Pham
Investigation Date(s): 11/06/2023 through 11/07/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility
Intake ID: 103295
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Quality of care - Named resident was found on the floor with an injury to her head.

Investigation Methods:

Sample: Total residents: 33
Resident sample size: 2
Closed records sample size: 1

Observations: Named resident, residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.

Interviews: Named resident, residents, and interdisciplinary team members.

Record Reviews: Sampled residents and incident reports.

Investigation Summary:

An investigation was conducted, and allegation identified in the intake related to fall with injury, and quality of care and services were reviewed. The facility failed to ensure a staff member locked the wheels on the resident's wheelchair during a transfer to prevent avoidable injuries. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

11.14.2023 10:55:00

State of Washington

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 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License # 2378	Compliance Determination # 32264
Plan of Correction	Highland Court Memory Care	Completion Date
Page 1 of 3	Licenses: Highland Court Operating Company LLC	11/07/2023

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 11/08/2023, 11/08/2023 and 11/06/2023 at:

Highland Court Memory Care
 1704 Melody Ln
 Port Angeles, WA 98362

This document references the following complaint number(s): 103295

The following sample was selected for review during the unannounced on-site visit: 2 of 33 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit E
 800 NE 136th Ave Ste 200
 Vancouver, WA 98684

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.

Cory Cisneros
 Residential Care Services

11/14/2023
 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.

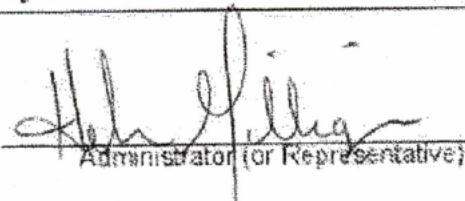
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11.14.2023 10:55:00

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Statement of Deficiencies	License #: 2378	Compliance Determination #32264
Plan of Correction	Highland Court Memory Care	Completion Date
Page 2 of 3	Licensee: Highland Court Operating Company LLC	11/07/2023


 Administrator (or Representative)

11.16.23
 Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a staff member locked the wheels on the resident's wheelchair during a transfer to prevent avoidable injuries for 1 of 2 current sampled residents (Resident 1) reviewed for safety measures. This failure placed the resident at risk for sustaining avoidable injuries.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [REDACTED]/2023 with medical diagnoses including [REDACTED]

Review of Resident 1's negotiated service plan, dated [REDACTED] 2023, documented Resident 1 required staff assistance with her activities of daily living and mobility.

On 11/06/2023 at 12:30 PM, Resident 1 was observed sitting in a wheelchair in the dining room and neatly groomed. Resident 1 stated she had fallen and sustained injury to her head and had to be sent to the hospital.

On 11/06/2023 at 1:23 PM, Staff B, Caregiver, was observed assisting Resident 1 to transfer from the resident's wheelchair on to the toilet. Staff B did not lock the wheels on the resident's wheelchair.

In an observation on 11/06/2023 at 1:26 PM, Staff B assisted Resident 1 to transfer from the toilet into the resident's wheelchair. Staff B did not lock the wheels on the resident's wheelchair.

In an interview on 11/06/2023 at 1:28 PM, Resident 1 said she needed assistance to transfer and was not able to provide additional details related to the transfers.

This document was prepared by Residential Care Services for the Locator website.

11.14.2023 10:55:00

State of Washington

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Statement of Deficiencies	License #: 2376	Compliance Determination # 32264
Plan of Correction	Highland Court Memory Care	Completion Date
Page 3 of 3	Licensee: Highland Court Operating Company LLC	11/07/2023

In an interview on 11/06/2023 at 1:30 PM, Staff B said she had been trained to lock the wheels on the resident's wheelchair during transfers and she did lock Resident 1's wheelchair during the transfer to and from the toilet.

In an interview on 11/06/2023 at 1:33 PM, Staff C, Medication Tech, stated she had been trained to lock the wheels on the residents' wheelchairs during transfers. Staff C said the staff member that assisted the resident was responsible for locking the wheelchair.

In an interview on 11/06/2023 at 1:42 PM, Staff A, Administrator, said staff members had been trained to lock the wheels on the residents' wheelchairs during transfers. Staff A stated staff members had safety training and wheelchair transfers training upon hire and annually. Staff A stated she observed staff members routinely to ensure proper transfer techniques were being followed and wheelchairs were being locked.

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, Highland Court Memory Care is or will be in compliance with this law and / or regulation on (Date) 11.30.23

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


Administrator (or Representative)

11.16.23
Date

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