STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Santé Shoreline ALF Op Co LLC
Laurel Cove Community
17201 15th Ave NE
Shoreline, WA 98155

RE: Laurel Cove Community License # 2389

Dear Administrator:

This letter addresses Compliance Determination(s) 59142 (Completion Date 05/06/2025) and 56140 (Completion Date 03/12/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/06/2025 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-2260-1

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 follow-up on 03/11/2025 of:
Laurel Cove Community
17201 15th Ave NE
Shoreline, WA 98155

This document references the following SOD dated: 03/12/2025

The following sample was selected for review during the unannounced on-site visit: 2 of 67 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

03/24/2025
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.

3/26/2025
~~04/24/2025~~

Administrator (or Representative)

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to safely store medications for 1 of 2 sampled residents (Resident 2) who had a physician's order requiring ALF medication management. This failure resulted in Resident 2 having unmonitored access to medications and placed them at risk for ingesting expired prescription medications.

Findings included...

Record review of an undated Face Sheet showed the ALF admitted Resident 2 on [redacted]/2024 with multiple medical diagnoses including [redacted]. Record review of signed Physician's Move-In Orders, dated 04/16/2024, showed Resident 2 was not able to self-administer, store or coordinate their medications without staff assistance.

Observation, on 03/11/2025 at 11:50 AM, with Staff B (Resident Care Coordinator) showed Resident 2 had expired metoprolol 25 milligrams (mg) (a prescription medication used to treat high blood pressure) and expired duloxetine 30 mg (a prescription medication used to treat depression) sitting unsecured and unlocked on their bathroom shelf in their apartment.

In an interview, on 03/11/2025 at 12:16 PM, Staff A (Registered Nurse) stated that she was not aware Resident 2 had medications in their apartment that were not secured by

the facility. Staff A confirmed the ALF provided Resident 2 with medication assistance and were supposed to ensure Resident 2's medications were secured.

This an uncorrected and recurring deficiency previously cited on 01/15/2025 and 10/24/2024.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 04/24/2025

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

Administrator (or Representative)

02/26/2025
~~04/24/2025~~ (EJ)

Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 follow-up on 12/10/2024 of:
Laurel Cove Community
17201 15th Ave NE
Shoreline, WA 98155

This document references the following SOD dated: 01/15/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 77 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2389	Compliance Determination # 51563
Plan of Correction	Laurel Cove Community	Completion Date
Page 2 of 3	Licensee: Santé Shoreline ALF Op Co LLC	01/15/2025

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.

Jamie Singer
Residential Care Services

01/28/2025
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)

1/28/2025
Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to safely store medications for 1 of 1 sampled residents (Resident 5) who had a physician's order requiring ALF assistance. This failure resulted in Resident 5 having access to medications and placed them at risk for ingesting medications they were not ordered to self-administer.

Findings included...

Record review of an undated Face Sheet showed the ALF admitted Resident 5 on [redacted]/2024 with multiple medical diagnoses. Record review of signed Physician's Move-In Orders, dated 08/21/2024, showed Resident 5 was not able to self-administer, store or coordinate all their medications without staff assistance.

Observation, on 12/10/2024 at 3:30 PM, showed Resident 5 had over-the-counter acetaminophen PM (used for to treat fever or mild pain with a sleep aid) and over-the-counter anti-diarrhea/anti-gas medication (used to treat diarrhea and symptoms of gas) sitting unsecured and unlocked on their bedside table in their apartment.

In an interview, on 12/10/2024 at 3:47 PM, Staff B (Registered Nurse) stated that she was not aware Resident 5 had medications in their apartment that were not secured by the facility.

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.

Jamie Singer
Residential Care Services

01/28/2025
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)

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to safely store medications for 1 of 1 sampled residents (Resident 5) who had a physician's order requiring ALF assistance. This failure resulted in Resident 5 having access to medications and placed them at risk for ingesting medications they were not ordered to self-administer.

Findings included...

Record review of an undated Face Sheet showed the ALF admitted Resident 5 on [redacted]2024 with multiple medical diagnoses. Record review of signed Physician's Move-In Orders, dated 08/21/2024, showed Resident 5 was not able to self-administer, store or coordinate all their medications without staff assistance.

Observation, on 12/10/2024 at 3:30 PM, showed Resident 5 had over-the-counter acetaminophen PM (used for to treat fever or mild pain with a sleep aid) and over-the-counter anti-diarrhea/anti-gas medication (used to treat diarrhea and symptoms of gas) sitting unsecured and unlocked on their bedside table in their apartment.

In an interview, on 12/10/2024 at 3:47 PM, Staff B (Registered Nurse) stated that she was not aware Resident 5 had medications in their apartment that were not secured by the facility.

Statement of Deficiencies	License #: 2389	Compliance Determination # 51563
Plan of Correction	Laurel Cove Community	Completion Date
Page 3 of 3	Licensee: Santé Shoreline ALF Op Co LLC	01/15/2025

This an uncorrected deficiency previously cited on 10/24/2024.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 2/24/2025 .

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

Administrator (or Representative) 1/28/2025 Date

This an uncorrected deficiency previously cited on 10/24/2024.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Laurel Cove Community
Provider Type: Assisted Living Facility

License/Cert.#: 2389
Intake ID: 144609
Compliance Determination #: 47471
Region/Unit #: RCS Region 2 / Unit J
Investigator: Michelle Mcglon
Investigation Date(s): 09/19/2024 through 10/24/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident's (NR) medication was discontinued, and the Named Staff (NS) had refused to discuss it with the resident at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Resident rooms Resident care equipment
Interviews:	Identified resident Nursing staff Executive Director
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. Interview and record review showed the medication was placed on hold until labs results were received. The NR stated that they were currently receiving the medication. Record review showed the ALF failed to correctly transcribe the physician's orders, resulting in the NR receiving the wrong dose. See Statement of Deficiency WAC 388-78A-2210.

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: Laurel Cove Community

Provider Type: Assisted Living Facility

License/Cert.#: 2389

Intake ID: 148357

Compliance Determination #: 47471

Region/Unit #: RCS Region 2 / Unit J

Investigator: Michelle Mcglon

Investigation Date(s): 09/19/2024 through 10/24/2024

Complainant Contact Date(s):

Allegation(s):

1. The Named Staff (NS) incorrectly transcribed physician's orders, resulting in the Named Resident (NR) receiving additional doses of a medication for an unknown amount of days and being hospitalized.

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	State reporting log Incident investigation Resident records

Investigation Summary:

1. Interview and record review showed the Assisted Living Facility (ALF) failed to administer the NR the correct doses of medications. The NR was hospitalized. The ALF completed an investigation. The NS received corrective action. See Statement of Deficiency WAC 388-78A-2210 and 388-78A-2260.

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: Laurel Cove Community

Provider Type: Assisted Living Facility

License/Cert.#: 2389

Intake ID: 147025

Compliance Determination #: 47471

Region/Unit #: RCS Region 2 / Unit J

Investigator: Michelle Mcglon

Investigation Date(s): 09/19/2024 through 10/24/2024

Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR), their assistive device, and apartment had an odor and were unclean at the Assisted Living Facility (ALF).
2. The NR had redness and scratches to legs.
3. The NR's call light or pendant was out of reach.
4. The NR was transferred with one person assist.

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. Observation showed no odor on the resident, their assistive device, or in their apartment. Observation showed a clean apartment and bathroom. No failed practice identified.
2. Observation showed no redness or scratches to the NR's legs. Staff reported no redness or scratches to the NR's legs. No failed practice identified
3. Observation showed the NR had a emergency pendant within reach. No failed practice identified.
4. Observation, interview and record review, showed the NR was transferred with a two person assist. No failed practice identified.

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: Laurel Cove Community

Provider Type: Assisted Living Facility

License/Cert.#: 2389

Intake ID: 147148

Compliance Determination #: 47471

Region/Unit #: RCS Region 2 / Unit J

Investigator: Michelle Mcglon

Investigation Date(s): 09/19/2024 through 10/24/2024

Complainant Contact Date(s):

Allegation(s):

1. The Named Staff (NS) incorrectly transcribed physician's orders, resulting in the Named Resident (NR) receiving additional doses of medication for an unknown amount of days and being transported to the hospital.

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:

1. Interview and record review showed the Assisted Living Facility (ALF) failed to administer the NR the correct doses of medications. The NR was hospitalized. The ALF completed an investigation. The NS received corrective action. See Statement of Deficiency WAC 388-78A-2210 and 388-78A-2260.

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: Laurel Cove Community
Provider Type: Assisted Living Facility

License/Cert.#: 2389
Intake ID: 149226
Compliance Determination #: 47471
Region/Unit #: RCS Region 2 / Unit J
Investigator: Michelle Mcglon
Investigation Date(s): 09/19/2024 through 10/24/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident's (NR) family representative was not informed of any injuries, infections or new medications.
2. The Assisted Living Facility (ALF) staff were not assisted the NR with walking.
3. The ALF withdrew additional money from the NR's personal account.
4. The NR's care increased without notifying the NR's family representative.

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Staff to resident interactions Resident rooms
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. Interview and record review showed the ALF staff failed to notify the NR's family member when there was a change of condition. See Statement of Deficiency WAC 388-78A-2640.
2. Observation and record review showed the ALF staff were following the NR's Negotiated Service Agreement. No failed practice identified
3. In an interview, the NR's family member stated that the funds had been returned to the NR's account. No failed practice identified
4. In an interview, the ALF's Regional Director of Operations stated that the NR had an increase in care. The NR's family representative stated they were out of the country for several months. Unable to substantiate. No failed practice identified.

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

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 09/19/2024, 09/19/2024, 09/27/2024, 10/03/2024 and 10/10/2024 of:

Laurel Cove Community
17201 15th Ave NE
Shoreline, WA 98155

This document references the following complaint number(s): 144550, 144609, 148357, 147025, 147148, 149226

The following sample was selected for review during the unannounced on-site visit: 4 of 78 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

11/01/2024
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) — Date: 11-4-2024

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to correctly transcribe physician's orders for 2 of 2 sampled residents (Resident 1 and 2). This failure resulted in Resident 1 receiving their medication at the wrong time, and Resident 2 receiving additional doses of medications and contributed to a hospitalization.

Findings included...

RESIDENT 1
Record review of an undated Face Sheet showed the ALF admitted Resident 1 on [redacted]/2023 with multiple medical diagnoses. Review of an Assessment, 09/27/2024, showed Resident 1 required assistance with medication management.

Record review of a signed Physician's Order, dated 09/04/2024, showed that Resident 1 was to receive a thyroid support dietary supplement, two capsules by mouth daily. Record review of the Physician's Order showed a section where an ALF staff had placed a check mark that they had received, reviewed and the order to the Medication

Administration Record (MAR). The ALF staff placed their initials and the date of 09/05/2024 on the Physician's Order.

Record review of a September 2024 MAR showed the thyroid support dietary supplement had been transcribed as one capsule two times a day instead of the ordered two capsules daily. The MAR showed the ALF staff had been administering the incorrect dose for 15 days.

RESIDENT 2
Record review of an undated Face Sheet showed the ALF admitted Resident 2 on [redacted] 2024 with multiple medical diagnoses including [redacted] and [redacted]. Review of an Assessment, dated 09/23/2024, showed Resident 2 required assistance with medication management. Medication Administration Records showed the facility assumed medication management on 09/11/2024.

Record review of a Physician's Order, dated 09/09/2024, showed an order for Lidocaine (a numbing medication) 5% patch, apply to the affected area every day, on for 12 hours, then off for 12 hours. Record review of the September 2024 MAR did not show the order was transcribed directing staff to remove the patch after 12 hours.

Record review of a signed Physician's Order, dated 09/09/2024, showed Resident 2 was to receive losartan (used for high blood pressure) 25 mg. Record review of the September 2024 MAR showed the ALF transcribed losartan 50 MG, instead of 25 mg and administered double the dose as ordered, on 09/11/2024 and 09/12/2024.

Record review of a signed Physician's Order, dated 09/09/2024, showed Resident 2 was prescribed insulin glargine (used to treat high blood sugar) 30 units twice a day. Record review of the September 2024 MAR showed the ALF had transcribed 35 units instead of the ordered 30 units and administered insulin only once on 09/10/2024, twice on 09/11/2024 and only once on 09/12/2024.

Record review of a signed Physician's Order, dated 09/09/2024, showed Resident 2 was to receive rivaroxaban (a blood thinner used to treat atrial fibrillation) 20 mg daily with a meal. Record review of a September 2024 MAR showed the ALF administered Resident 2's rivaroxaban three times, instead of the ordered one time, on 09/11/2024. The ALF administered Resident 2's rivaroxaban two times, instead of the ordered one time, on 09/12/2024.

Record review of a hospital Discharge Summary, dated [redacted] 2024, showed Resident 2 was hospitalized following an unresponsive episode at the ALF on [redacted] 2024. The Discharge Summary stated Resident 2's excess blood pressure medication may have contributed to their low blood pressure and unresponsive episode.

In an interview, on 09/27/2024 at 11:49 AM, Staff A (Registered Nurse) stated that she had incorrectly transcribed the rivaroxaban on Resident 2's MAR. When asked for details regarding the incorrect dosing Resident 2's insulin and losartan Staff B stated, "I give up", and walked away from the Department Representative.

This is a recurring deficiency previously cited on 02/01/2023 and 03/29/2023.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 11-4-2025 . 2024

SB confirmed ammended POC date with provider on 11/4/2024.

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

Administrator (or Representative) 11-4-2024 Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed safely store medications for 1 of 2 sampled residents (Resident 2) who required staff assistance with medications. This failure placed Resident 2 at risk of adverse side effects and possible overdosing, when their medications were stored on a bedside table.

Findings included...

Record review of an undated Face sheet showed the ALF admitted Resident 2 on [redacted]/2024 with multiple medical diagnoses. Review of a Negotiated Service Agreement (NSA), dated 09/10/2024, noted to follow physicians order for medication.

Record review of signed Physician's Move-In Orders, dated 08/21/2024, showed Resident 2 was not able to self-administer, store or coordinate all their medications without staff assistance.

Observation, on 09/27/2024 at 1:35 PM, showed Resident 2 had an Albuterol inhaler (used for shortness of breath) and Refresh Tears (used to lubricate the eyes) sitting on their bedside table in their apartment.

In an interview, on 09/27/2024 at 1:55 PM, Staff A (Registered Nurse) stated that she was not aware Resident 2 had medications in their apartment and not secured by the facility.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 11-4-2025 . 2024

SB confirmed ammended POC date with provider on 11/4/2024.

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

Administrator (or Representative) 11-4-2024 Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify 1 of 1 sampled resident's (Resident 3) family representative, when the resident had skin breakdown. This failure placed Resident 3 at risk of not having their Durable Power of Attorney (DPOA) advocate and make decisions regarding health care needs.

Findings included...

Record review of a Physician's Progress Note, dated 09/27/2024, showed the ALF admitted Resident 3 on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted].

Record review of a Progress Note (PN), dated 09/26/2024, showed the ALF staff had documented observing a closed blister on Resident 3's right groin. A PN, dated 09/27/2024, showed Resident 3's physician had prescribed iodine to be applied to the blister daily for two weeks.

A PN, dated 09/29/2024, showed the ALF documented the blister had opened. Resident 3 now had a stage 2 (when the top layer of skin has opened creating a shallow wound) area on her right groin.

Record review showed no documentation the ALF had notified Collateral Contact 1 (CC1- Resident 3's DPOA) that Resident 3 had any kind of skin breakdown.

In an interview, on 10/02/2024 at 8:24 AM, CC1 stated that the ALF had not notified them that Resident 3 had skin breakdown. CC1 stated they would like to have known.

In an interview, on 10/14/2024 at 11:47 AM, Staff A (Registered Nurse) stated that she had not notified Resident 3's DPOA when the skin breakdown had occurred.

In an interview, on 10/14/2024 at 11:48 AM, Staff B (Memory Care Director) confirmed she had not notified Resident 3's DPOA when the skin breakdown had occurred.

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, Laurel Cove Community is or will be in compliance with this law and / or regulation on (Date) 12-4-2024 .2024

SB confirmed ammended POC date with provider on 11/4/2024.

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

Administrator (or Representative) — Date: 11-4-2024