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

Cogir Management USA Inc
Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

RE: Cogir Vancouver Orchards License # 2472

Dear Administrator:

This letter addresses Compliance Determination(s) 33129 (Completion Date 12/26/2023) and 30118 (Completion Date 10/11/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/26/2023 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-2210-2

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just Jody Just Region 3 Field Serices Administrator

Jody Just, Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir Vancouver Orchards **Provider Type:** Assisted Living Facility

License/Cert.#: 2472
Intake ID: 98386
Compliance Determination #: 30118
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 09/26/2023 through 10/11/2023
Complainant Contact Date(s):

Allegation(s):

1. Quality of care/treatment: Allegation that the facility was not providing a residents medications as prescribed.

2. Falsification of records/reports: Allegation that the facility was documenting incorrect medication delivery times.

Investigation Methods:

Sample:	Total residents: 3 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Residents Nursing staff Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of care/treatment: Failed practice identified. The facility was not providing a medication as prescribed for a resident.

2. Falsification of records/reports: Failed practice identified. The facility was not documenting the correct times that medications were being provided.

Conclusion / Action:

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

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2472	Compliance Determination # 30118
Plan of Correction	Cogir Vancouver Orchards	Completion Date
Page 1 of 4	Licensee: Cogir Management USA Inc	10/11/2023

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 09/26/2023 and 10/03/2023 of:

Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

This document references the following complaint number(s): 98386, 96675

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

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
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.

Residential Care Services — Date: 10/12/2023

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.

Statement of Deficiencies	License #: 2472	Compliance Determination # 30118
Plan of Correction	Cogir Vancouver Orchards	Completion Date
Page 2 of 4	Licensee: Cogir Management USA Inc	10/11/2023

Debbie Wooley
Administrator (or Representative)

10/13/2023
Date

WAC 388-78A-2210 Medication services.

(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 :

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement safe medication services for 1 of 3 residents (Resident 1) reviewed for safe medication practices. This failure placed the resident at risk for health complications due to not receiving their prescription as ordered by the prescribing Primary Care Provider (PCP).

Findings included...

An unannounced visit was conducted on 09/26/2023 at 12:12 PM.

Review of an undated face sheet showed Resident 1 (R1) was admitted to the facility on [redacted]/2023.

In an interview on 09/21/2023 at 8:15 AM, Collateral Contact 1 (CC1), Home Health Occupational Therapist for R1, reported that the Facility is not providing R1's Levothyroxine at the prescribed time. CC1 confronted Staff A, LPN and Health and Wellness Director, about this mistake and Staff A acknowledged the mistake, did not verbalize intentions to correct the mistake, and reported intentions to change the prescription to be given at night. CC1 reported that the PCP was notified of this and sent Staff A a reminder fax to reinforce that Levothyroxine needs to be given in the morning on an empty stomach.

In an interview on 09/26/2022 at 12:22 PM, Staff A, Health and Wellness Director, reported changing R1's Levothyroxine order, 09/16/2023 from "GIVE ONE TABLEY BY MOUTH EVERY MORNING FOR HYPOTHYROIDISM" due at 8:00 AM to "1 Tablet by mouth One time per day Every day at 7:00PM." Staff A faxed R1's PCP a request to change the Levothyroxine prescription verbiage and time, did not wait for the provider to respond, and implemented the prescription change without receiving the appropriate prescribing provider approval for the order. Staff A admitted that it is not acceptable to do this because Staff A does not have any medication prescribing authority.

In an interview on 09/26/2022 at 1:17 PM, R1 reported that Levothyroxine is currently given to R1 in the evening because the facility nurse, Staff A, decided to make that prescription time change.

In an interview on 09/26/2022 at 2:15 PM, Staff B, Executive Director, reported that it was a regulatory violation for Staff A to have changed a prescription order without appropriate PCP authorization and that Staff A performed outside of Staff A's scope of authority as an LPN.

In an interview on 09/29/2023 at 4:29 PM, Collateral Contact 2 (CC2), Representative for R1, reported wanting R1 to receive Levothyroxine prescription in the morning, a half hour before breakfast because that is what R1's PCP recommended.

In an interview on 09/29/2022 at 4:43 PM, Staff C, Medication Technician, stated they documented a faxed note in the progress noted on 09/19/2023, stating "Doctor says to administer Levothyroxine in the morning on an empty stomach".

Record review of R1's Negotiated Service Agreement (NSA), dated 06/07/2023, showed "Staff perform medication management for resident [R1] requires assistance with medications as ordered by MD, task is done by Med techs or nurses..." and documented R1 had a diagnosis of [redacted]

Record review of R1's September 2023 Medication Administration Record (MAR) dated 09/01/2023-09/15/2023 documented the medication Levothyroxine Sodium oral tablet 100 Micrograms (a medication to treat hypothyroidism by increasing the metabolic rate of cells of all tissues in the body) "GIVE ONE TABLEY BY MOUTH EVERY MORNING FOR HYPOTHYROIDISM" due at 8 AM and showed that the prescription had been discontinued 09/16/2023.

Record review of R1's September 2023 (MAR) dated 09/16/2023-09/25/2023 documented the medication Levothyroxine Sodium oral tablet 100 Micrograms "1 Tablet by mouth One time per day Every day at 7:00PM." And showed the medication start date of 09/16/2023.

Record review of progress note for R1, dated 09/19/2023 at 4:53 PM, showed Staff C, documented "Doctor says to administer Levothyroxine in the morning on an empty stomach."

Record review of untimed fax from Staff A to R1's PCP, dated 09/26/2023, showed "We sent a fax on 9/15/23 requesting approval to change the time for [R1's} levothyroxine to evening pass due to resident not up at 6am and dining room does not open until 7am. This way [R1] gets it on a empty stomach. Fax was misplaced and not reply for your office. This has been changed in our MAR please reply."

Record review of fax from an Advanced Practice Registered Nurse prescriber to Facility regarding R1, dated 09/15/2023 at 8:20 PM, showed "Please ensure you are administering

Levothyroxine in the morning on an empty stomach."

The facility was unable to produce a record to show that they received an appropriate PCP prescription order to change the Levothyroxine prescription time from 8:00 AM to 7:00 PM.

Record review of R1's PCP medication list shows "levothyroxine 100 MCG tablet take 100 mcg by mouth Daily at 6:00 AM".

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, Cogir Vancouver Orchards is or will be in compliance with this law and / or regulation on (Date) 11/13/2023 .

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

Debbie Woodery
Administrator (or Representative)

10/13/23
Date

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

10/12/2023

Cogir Management USA Inc
Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

RE: Cogir Vancouver Orchards # 2472

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 10/11/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Michael Burdick, Field Manager
Residential Care Services

Region 3, Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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:

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

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

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

The facility's Policy titled "Medication Services" states "Medications may be given up to one hour before or up to one hour after the prescribed time to accommodate resident schedules unless otherwise indicated by the physician." A system failure was identified, discovering several residents' medications documented as provided several hours later than the prescribed times. Interviews with staff unanimously concluded that the reason why medications were frequently being documented as given several hours late was due to staff completing their late entry charting and not documenting the time that medications were provided. The Executive Director and Director of Nursing Servies reported that this process failure was unacceptable because the process did not show the exact time when a medication was given. The Facility had staff meetings to retrain staff on the expectation of medication administration charting to fix this identified process failure.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;

- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services

Enclosure

COGIR OF VANCOUVER
PLAN OF CORRECTION

CITATION NUMBER	NAME OF SECTION	PLAN OF CORRECTION	RESPONSIBLE PERSON FOR CORRECTION
WAC 388-78A-2210	MEDICATION SERVICES	Medications changes will not be done until we receive proper doctor's orders.	Debra Compton

COGIR OF VANCOUVER
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PLAN OF CORRECTION

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