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

08/09/2023

Greenlake Management Everett, LLC
Everett Heritage Court
4441 W. Airport FWY Ste 160
Oriving, TX 75062

RE: Everett Heritage Court License # 2612

Dear Administrator:

This letter addresses Compliance Determination(s) 27724 (Completion Date 08/07/2023) and 20225 (Completion Date 06/01/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/07/2023 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2630-1-a, WAC 388-78A-2600-2-a, WAC 388-78A-2260-2-b

The Department staff who did the on-site verification:
Jodi Condyles, ALF Licensor

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 Heritage Court
Provider Type: Assisted Living Facility
License/Cert.#: 2612
Compliance Determination #: 20225
Intake ID: 70971
Investigator: Karen Glover
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/24/2023 through 06/01/2023
Complainant Contact Date(s):

Allegation(s):
The Named Resident has had several falls that have not been reported to the family.

Investigation Methods:

Sample:
Total residents: 45
Resident sample size: 17
Closed records sample size: 0

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Infection control practices

Interviews:
Identified resident
Nursing staff
Residents
Family members
Administration

Record Reviews:
Facility policies
Incident investigation
Negotiated service agreement

Investigation Summary:
The Named Resident was independent with ambulation. Review of chart notes showed in 2022 the facility had completed incident reports, investigations and notified family and medical provider on all reported falls. Record review showed no incident report or investigation had been completed on a reported fall on 03/25/2023. Failed practice was identified for noncompliance with Washington Administrative Code (WAC) 388-78A-2371 Investigations, WAC 388-78A-2630 Reporting abuse and neglect, and WAC 388-78A-2600 Policies and procedures.

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 #: 2612	Compliance Determination # 20225
Plan of Correction	Everett Heritage Court	Completion Date
Page 1 of 15	Licensee: Greenlake Management Everett, LLC	06/01/2023

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 02/24/2023, 03/16/2023, 03/22/2023, 04/07/2023, 04/10/2023 and 05/18/2023 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 70078, 70971, 73229

The following sample was selected for review during the unannounced on-site visit: 17 of 45 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karen Glover, Complaint Investigator
Yulia Bondarchuk, LTC Surveyor

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

06/09/2023
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.

Administrator (or Representative) 6/19/23 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview,
observation, and record reviews the Assisted Living Facility (ALF) failed to ensure falls and injuries for 14 of 17 sampled residents (Residents 1, 4, 5 ,7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17) were fully documented and thoroughly investigated. The ALF failed to document details of the occurrence, collect witness statements, show how abuse and neglect was ruled out, and failed to identify interventions to prevent reoccurrence. This failure placed Residents 1,4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17 at risk for abuse, neglect, unidentified care needs and interventions, and a diminished quality of life.

Findings included...

Review of the Assisted Living Guidebook; Partners in Protection (p. 9-13) dated 02/2018 showed State law requires the assisted living facility to do a thorough investigation of the incident. In order for the facility to provide evidence of the thoroughness of the investigation the information must be documented. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Resident 1
Resident 1 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted], and [redacted]. Record review of Resident 1's resident assessment dated 03/01/2023 showed Resident 1 was independent with ambulation/transfer and falls

occasionally.

In an interview on 04/07/2023 at 10:25 AM, Staff B, registered nurse, stated that Resident 1 fell on 03/25/2023 and there was no incident report completed. Staff B stated that an email had been sent by Staff B to the responsible party.

Resident 4

Resident 4 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted]. Record review of Resident 4's resident care plan dated 11/08/2022 showed Resident 4 needed supervision with ambulation and was independent in their room. Resident 4 used a walker and had occasional falls.

On 03/22/2023 at 11:48 AM Resident 4 was observed sitting in the main floor dining room. Observed a purple/blue bruise below the right eye and right eyelid. Resident 4 had a bruise on the right hand and right arm.

In an interview on 04/07/2023 at 9:35 AM, Staff B, stated that Staff L, medication technician (med tech), sent a text to Staff B regarding the fall. The text showed Staff L went to Resident 4's room about an hour after dinner and found Resident 4 on the floor. Staff B was unable to provide an incident report or an investigation. Staff B stated that no progress notes were available for Resident 4 regarding the bruising noted on the right eye and eyelid. Staff B found an after-visit summary (AVS) dated 03/08/2023 and provided as documentation regarding the unwitnessed fall in the resident's room.

Record review of Resident 4's AVS dated 03/08/2023 was for an emergency room visit regarding a fractured finger that happened during a different fall that took place on 02/21/2023.

In an interview on 04/07/2023 at 10:00 AM, Staff B stated that there was no documentation for the fall on 03/08/2023, no incident report or an investigation for either fall on 02/21/2023 or 03/08/2023.

Resident 5

Resident 5 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including [redacted] and [redacted]. Record review of DSHS care assessment dated 09/08/2022 showed staff would provide oversight with ambulation and provide cueing to complete eating tasks. Resident 5 was oriented to person only and had periods of confusion and problems with concentration.

On 03/16/2023 at 8:41 AM, Resident 5 was observed sitting in a chair in the hallway, outside of her room. Resident 5 was slumped in the chair, holding her head. Resident 5 had a bruise on the right hand and right elbow.

In an interview on 03/16/2023 at 8:45 AM, Staff B stated that Resident 5 was independent with ambulation but had a recent decline. Staff B stated that they did not have a report regarding the dark blue bruise on Resident 5's right hand and a reddish bruise near the right elbow.

Record review of Resident 5's incident report dated 03/16/2023 showed Staff B completed the report. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

In an interview on 03/22/2023 at 11:58 AM, Staff B stated that Resident 5's bruises were not reported to CRU as they did not believe they were reportable. Staff B stated they were not in a suspicious place and when asked the resident stated nobody had hurt them.

Resident 7
Resident 7 was admitted to the ALF on [redacted]/2020 with multiple diagnoses including [redacted]. Review of DSHS care assessment dated 05/12/2022 showed Resident needed limited assistance with ambulation and extensive assist with transfers. Resident 7 had a history of falls.

On 03/22/2023 at 11:48 AM, Resident 7 was observed sitting in the main floor dining room. Resident 7 was noted to have bruising around the right eye and right side of face.

In an interview 03/22/2023 at 11:49 AM, Staff I, caregiver stated that she thought Resident 7 had fallen last week.

In an interview on 03/22/2023 at 12:30PM, Staff B, stated that an incident report and investigation had been completed and Staff A had notified the family.

Record review of the incident report for Resident 7 dated 03/19/2023 showed Staff B had completed the report. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 8
Resident 8 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted]. Record review of Resident 8's Resident Care plan dated 08/22/2022 showed Resident 8 was an extensive assist with ambulation and transfers and falls occasionally. There was no evidence of any fall prevention interventions.

Record review of Resident 8's incident report dated 01/11/2023, showed Staff I, caregiver, completed the incident report. No documentation was made regarding notification of responsible party or medical provider. An investigational worksheet was attached with no

name, date, or identification of who completed the worksheet.

Record review of Resident 8's incident report dated 02/27/2023, showed Resident 8 had fallen out of the chair. No second page was attached which included who completed the form and the notifications to responsible party or medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Record review of Resident 8's incident report dated 03/20/23, showed Resident 8 had fallen out of the chair. No second page was attached which included who completed the form and the notifications to responsible party or medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Record review of Resident 8's incident report dated 04/04/2023 showed Staff K, caregiver, completed the incident report. There was no documentation made regarding notification of responsible party or medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

In an interview on 04/07/2023 at 10:15AM, Staff B stated that most of the incident reports on her desk are from Resident 8. Staff B stated that Resident 8 slips out of the wheelchair and Resident 8 pulls themselves out of the chair while sitting at the table. Staff B stated they make sure one caregiver was always in the dining room.

Resident 9
Resident 9 was admitted to the ALF on [redacted] 2019 with multiple diagnoses including [redacted]. DSHS care assessment dated 05/27/2022 showed independent with ambulation. Record review of Resident 9's Resident Care Plan dated 09/12/2022 showed caregivers to make sure pathway to restroom and room exit was free of obstacles to avoid trips and falls during the night.

Record review of Resident 9's incident report dated 02/24/2023, showed Staff F, med tech, completed the incident report. There was no documentation made regarding notification of responsible party or medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Record review of Resident 9's discharge summary dated 03/02/2023 from the local hospital showed, Resident 9 had been sent to the hospital on 02/26/2023 after 1-2 days of the inability to bear weight. Resident 9 was diagnosed with a [redacted].

In an interview on 04/07/2023 at 10:35 AM, Staff B stated that Resident 9 fell on 02/24/2023 and went to the hospital on 02/26/2023. Staff B could not provide any documentation regarding Resident 9's fall on 02/24/2023 or documentation regarding the signs and symptoms of what led staff to send Resident 9 to the hospital.

Resident 10

Resident 10 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted]. DSHS care assessment dated 04/08/2022 showed standby assistance and at time contact guard with ambulation secondary to quick movements, poor balance, and unsteady gait with a significant fall history.

Record review of Resident 10's Resident Care Plan dated 07/26/2022 showed Resident 10 was independent with ambulation/transfer and no history of falls.

Record review of Resident 10's incident report dated 02/07/2023 showed a medication technician completed the report. The incident stated the location was the bedroom but did not include any details regarding what happened. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 11
Resident 11 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted]. Record review of Resident 11's Resident Care Plan dated [redacted]/2022 showed Resident 11 was totally dependent with ambulation and was a 1-person extensive assist with transfers.

Record review of Resident 11's incident report dated 04/02/2023 showed Staff K, caregiver, completed the report. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 13
Resident 13 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including a [redacted]. Record review of Resident 13's Resident Care Plan dated [redacted]/2022 showed Resident 13 was independent with ambulation/transfer and falls occasionally.

Record review of Resident 13's incident report dated 02/14/2023 showed Staff I, caregiver, completed the report. There was no evidence of any notifications being made to the responsible party or the medical provider. Two witness statements had been completed by Staff F, med tech and Staff I, caregiver.

Record review of Resident 13's incident report dated 02/28/2023 showed Staff G, caregiver, completed the report. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out. One witness statement had been completed by Staff G, caregiver.

Record review of Resident 13's incident report dated 03/07/2023 was missing the second page. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 14
Resident 14 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted]. Record review of Resident 14's Resident Care Plan dated 02/20/2023 showed Resident 14 used a wheelchair and was a one person assist with transfers and had a history of falls.

Record review of Resident 14's incident report dated 02/26/2023 showed Staff G, caregiver, completed the report. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 15
Resident 15 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted]. Record review of Resident 15's resident assessment dated 01/27/2023 showed Resident 15 needed physical assistance with ambulation/transfer and was wheelchair dependent.

Record review of Resident 15's incident report dated 01/26/2023 showed no second page. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Record review of Resident 15's incident report dated 02/01/2023 showed it was missing the second page. There was no evidence of any notifications being made to the responsible party or the medical provider. Two witness statements had been completed by Staff D, caregiver and Staff F, medication technician. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 16
Resident 16 was admitted to the ALF on [redacted]/2014 with multiple diagnoses including [redacted]. Record review of Resident 16's Resident Care Plan dated 09/22/2022 showed Resident 16 was independent with ambulation/transfer and no history of falls.

Record review of Resident 16's incident report dated 04/04/2023 showed Staff D, caregiver, had completed the report. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out.

Resident 17
Resident 17 was admitted to the ALF on [redacted]/2020 with multiple diagnoses including [redacted]. Review of Resident 17's Resident Care Plan dated 08/23/2022 showed Resident 17 was an extensive ambulation/transfer assist and occasional falls.

Record review of Resident 17's incident report dated 02/14/2023 showed only the first page was started and was missing the second page. There was no evidence of any notifications being made to the responsible party or the medical provider. There was no evidence a thorough investigation was documented or how abuse and neglect was ruled out. A witness statement had been completed by Staff G, caregiver.

In an interview on 04/07/2023 at 10:40 AM, Staff A, Executive Director stated that they review incident reports at the stand-up meeting and not all falls are being reported to them.

In an interview on 04/07/2023 at 10:42 AM, Staff B, stated that caregivers don't have access to point click care (PCC)(computer software program) and the medication technicians (med techs) are not trained on alert charting. Staff B stated they have no place for staff to document any issues or concerns regarding the residents. Staff B stated the med techs are responsible for calling the responsible party and stated they do not have a place to document calls. Staff B stated that when they receive an incident report it was reviewed and if it was questionable then an investigation would be completed.

In an interview on 04/07/2023 at 11:09 AM, Staff F, med tech, stated that the process for when a resident falls- is to grab the vital signs, check to make sure they are stable, looking for skin tears, fractures, head injury. If they are stable, we get them up and give them some water and make them comfortable. If there was an injury, we call 911 and then we get Staff B. The med techs fill out the incident reports and give to either Staff A or Staff B. Staff F stated that any changes with the care of the residents was communicated during pass down between shifts and they check PCC dashboard for any updates. Staff B will also call in the morning to let us (med techs) know of any changes.

In an interview on 04/11/2023 at 2:00 PM, Collateral Contact (CC) 1, medical provider, reviewed the following residents:
Resident 4- CC1 knew about the fractured finger but not the fall that caused the bruising.
Resident 5- CC1 did not receive any notification of the bruises.
Resident 8- CC1 did not receive notifications of recent falls.
Resident 9- CC1 did not receive notification of the fall or being sent to the hospital.
Resident 16- CC1 did not receive any notification of the fall.
Resident 17- CC1 did not receive notifications of recent fall.

In an interview on 05/18/2023 at 11:57 AM, Staff B stated that they follow the investigation guidelines in the ALF guidebook.

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 Heritage Court is or will be in compliance with this law and / or regulation on (Date) 7/24/23 .

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

Administrator (or Representative) — Date: 6/19/2023

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
observation, interview, and record review the Assisted Living Facility (ALF) failed to report to the department's complaint resolution unit (CRU) when 10 of 17 sampled residents (Residents 4, 5, 7, 8, 9, 10, 11, 13, 15, and 17) had incidents with no investigations. This failure placed Residents 4, 5, 7, 8, 9, 10, 11, 13, 15, and 17 at risk for abuse, neglect, additional falls, injuries, and a diminished quality of life.

Findings included...

Review of the Assisted Living Guidebook; Partners in Protection (p.7) dated 02/2018 showed facilities are required to report to the Department's 24-hour hotline when there is reasonable cause to believe an incident involves abuse, neglect, or a substantial injury of unknown source. Appendix D, Reporting Guidelines for Assisted Living Facilities showed injuries of an unknown source, and repeated injuries, even when determined by a process of evaluation/assessment to be reasonably related to a resident's condition, diagnoses, known environmental interactions or known sequence of prior events, may become abuse or neglect if preventative measures are not taken should be reported to the Department's

24-hour hotline.

Record review for the below sampled residents showed unwitnessed falls, bruising, repeat falls with no evidence of a documented investigation.

Resident 4
Resident 4 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted]. Record review of Resident 4's resident care plan dated 11/08/2022 showed Resident 4 needed supervision with ambulation and was independent in their room. Resident 4 used a walker and had occasional falls. Resident 4 displayed a shuffled gait and often forgot walker. If caregivers find Resident 4 without the walker, they are to assist Resident 4 to safety and retrieve the walker.

Resident 5
Resident 5 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including [redacted] and [redacted]. Record review of DSHS care assessment dated 09/08/2022 showed staff would provide oversight with ambulation and provide cueing to complete eating tasks. Resident 5 was oriented to person only and had periods of confusion and problems with concentration.

On 03/16/2023 at 8:41 AM, Resident 5 was observed sitting in a chair in the hallway, outside of her room. Resident 5 was slumped in the chair, holding her head. Resident 5 had a bruise on the right hand and right elbow.

In an interview on 03/22/2023 at 11:58 AM, Staff B, Registered Nurse, stated that Resident 5's bruises were not reported to CRU as they did not believe they were reportable. Staff B stated they were not in a suspicious place and when asked the resident stated nobody had hurt them.

Resident 7
Resident 7 was admitted to the ALF on [redacted]/2020 with multiple diagnoses including [redacted]. Review of DSHS care assessment dated 05/12/2022 showed Resident needed limited assistance with ambulation and extensive assist with transfers. Resident 7 had a history of falls.

On 03/22/2023 at 11:48 AM, Resident 7 was observed sitting in the main floor dining room. Resident 7 was noted to have bruising around the right eye and right side of face.

In an interview on 03/22/2023 at 12:40 PM, Staff B stated that she did not report the bruise to the complaint resolution unit (CRU) because the bruises were of unknown origin and were not on a questionable part of the body. Staff B stated that the way she ruled out abuse and neglect was to ask the resident if anybody had hurt her.

Resident 8
Resident 8 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted]. Review of DSHS care assessment dated 02/03/2023 showed Resident 8 was not able to ambulate and was totally dependent with transfers and uses a manual wheelchair.

Resident 9
Resident 9 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including [redacted]. Record review of Resident 9's Resident Care Plan dated 09/12/2022 showed caregivers to make sure pathway to restroom and room exit was free of obstacles to avoid trips and falls during the night.

Resident 10
Resident 10 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted]. DSHS care assessment dated 04/08/2022 showed standby assistance and at time contact guard with ambulation secondary to quick movements, poor balance, and unsteady gait with a significant fall history. Record review of Resident 10's Resident Care Plan dated 07/26/2022 showed Resident 10 was independent with ambulation/transfer and no history of falls.

Resident 11
Resident 11 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted]. Record review of Resident 11's Resident Care Plan dated [redacted]/2022 showed Resident 11 was totally dependent with ambulation and was a 1-person extensive assist with transfers.

Resident 13
Resident 13 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted]. Record review of Resident 13's Resident Care Plan dated [redacted]/2022 showed Resident 13 was independent with ambulation/transfer and falls occasionally.

Resident 15
Resident 15 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted]. Record review of Resident 15's resident assessment dated 01/27/2023 showed Resident 15 needed physical assistance with ambulation/transfer and was wheelchair dependent.

Resident 17
Resident 17 was admitted to the ALF on [redacted]/2020 with multiple diagnoses including [redacted]. Review of Resident 17's Resident Care Plan dated 08/23/2022 showed Resident 17 was an extensive ambulation/transfer assist and occasional falls.

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Review of Department records showed no reports were made for any of the above unwitnessed falls and injuries. Without the investigation, the facility was not able to identify interventions, new care needs, rule out abuse and neglect or determine if the incident needed to be called into CRU.

Cross reference with WAC 388-78A-2371 Investigations.

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 Heritage Court is or will be in compliance with this law and / or regulation on (Date) 7/24/23 .

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

Susan Daily 6/19/23

Administrator (or Representative) 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:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview
and record review the Assisted Living Facility (ALF) failed to have written policies for incident investigations and when to report to the Complaint Resolution Unit (CRU) and failed to implement their Falls Response Procedures for 14 of 17 sampled residents (Residents 1,4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17) who had unwitnessed falls or bruising. This failure placed Resident's 1,4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17 and all memory care residents at risk for abuse, neglect, additional falls, and a diminished quality of life.

Findings included...

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Record review of the ALF's policy titled, Fall Response Procedures dated 08/10/2021 showed:

-Should a resident fall, to summon immediate assistance from Wellness director or med tech on duty.
-After the resident is assessed for injuries, the physician is contacted immediately for further instructions, the responsible party is to be notified immediately.
-48 hours after any fall, the wellness director or med tech on each shift will monitor the resident and make a brief narrative charting entry.
-The Negotiated Service Agreement is updated as needed.
-Internal incident report is completed and presented to the wellness director.
-A state incident reporting form is completed if required per state regulations.
-The wellness director informs the physician of subsequent falls.

Record review showed no documentation of monitoring following an incident/injury for Residents 1, 4, 7 ,8, 9, 10, 11, 12, 13, 14, 15, 16 and 17.

In an interview on 05/18/2023 at 11:57 AM, Staff B stated that they do not have a policy regarding investigations and they follow guidelines in the ALF guidebook.

Cross reference with WAC 388-78A-2371 Investigations
Cross reference with WAC 388-78A-2630 Reporting Abuse and Neglect

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 Heritage Court is or will be in compliance with this law and / or regulation on (Date) 7/24/23.

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

Administrator (or Representative) — Date: 6/19/23

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

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(b) Together for each resident and physically separated from other residents' medications;

This requirement was not met as evidenced by:

Based on
observation, record review and interview the Assisted Living Facility (ALF) failed to ensure delivered medications from the pharmacy and expired and/or discontinued medications were kept in a safe and secure area for all memory care residents living on the basement floor of the facility. The ALF failed to ensure 1 of 17 sampled residents (Resident 6) inhalers were stored in a safe and secure area. This failure resulted in memory care residents being able to access unlocked medications.

Findings included...

Review of the ALF's "Medication disposal and destruction" policy dated 08/10/2021 showed under Disposal and Destruction of Non-controlled Substance Medications:
To properly dispose of non-controlled substance medications the Nurse/Med Tech on duty or Wellness Director and another adult witness who is an employee of the Community:
-returns the medication to the dispensing pharmacy for disposal; or
-Disposes of the medication in a medical waste receptacle in accordance with the manufacturer's instructions. Both staff members must witness the destruction of medication.

Resident 6 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted]. Review of DSHS care assessment dated 03/04/2023 showed short- and long-term memory concerns with confusion. Resident 6 needed medication management which included assistance with an inhaler. Resident 6's room is on the main floor of the facility.

On 03/16/2023 at 9:34 AM one inhaler was observed belonging to Resident 6 on the top of Resident 6's dresser. In the top drawer of Resident 6's bedside stand was observed three more inhalers. Two of the inhalers belonged to Resident 6. One inhaler had expired, and one inhaler belonged to a discharged resident.

In an interview on 03/16/2023 at 9:55 AM, Staff B, Registered Nurse, stated that Resident 6's current inhaler is in the med cart and Staff B had not had the chance to check the resident rooms for any medications.

In an interview on 03/16/2023 at 9:56 AM, Staff A, Executive Director, stated that the caregivers should be looking for medications at the bedside and they would talk about that at the next staff meeting.

On 04/07/2023 at 9:50 AM in the unlocked nurse's office on the basement floor was observed one large black garbage bag full of medications and 2 separate piles of medications on the back counter of the unlocked nurse's office. The main floor and

basement floor of the facility are separated by a locked door. The nurse's office had an unlocked baby gate across the open door.

In an interview on 04/07/2023 at 9:53 AM, Staff B, stated the medications on the back counter were just delivered and needed to be put away. Staff B stated that the medications in the black garbage bag were discontinued medications and needed to be destroyed.

On 05/18/2023 at 12:05 PM, three cards of medications were observed sitting on the back counter of the unlocked nurse's station.

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 Heritage Court is or will be in compliance with this law and / or regulation on (Date) 7/24/23 .

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

Administrator (or Representative) 6/19/23 Date