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

12/29/2023

Greenlake Management Everett, LLC
Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

RE: Everett Heritage Court License # 2612

Dear Administrator:

This letter addresses Compliance Determination(s) 34356 (Completion Date 12/21/2023) and 26242 (Completion Date 10/31/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/21/2023 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-2120-2-b, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-1-c, WAC 388-78A-2640-1, WAC 388-78A-2170-1, WAC 388-78A-2600-2-e, WAC 388-78A-2060-8, WAC 388-78A-2060-7, WAC 388-78A-2060-4, WAC 388-78A-2060-3, WAC 388-78A-2060-2, WAC 388-78A-2060-1

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 #: 26242
Intake ID: 95615
Investigator: Karen Glover
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 07/10/2023 through 10/31/2023
Complainant Contact Date(s):

Allegation(s):

The Named Resident (NR) could not be located in the Assisted Living Facility (ALF) . The NR was last seen at 3:30 PM and at 4:00 PM the staff could not locate.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 6 Closed records sample size: 2
Observations:	Identified resident Residents Dining
Interviews:	Identified resident Identified staff Nursing staff Family members
Record Reviews:	Incident investigation Resident records Police report

Investigation Summary:

The NR was found by police 2 miles from the facility. The NR was brought back to the ALF by police. The ALF initiated an investigation and notified the NR's representative, medical provider and the department hotline. The ALF identified an unlocked door in the kitchen that could have been how the NR left the building. During an onsite visit an unalarmed door with a locked outside gate was found unlocked. The ALF staff had been using that gate to enter the ALF and it was not getting locked. Failed practice was identified and the facility was cited WAC 388-78A-2170 (1) Required assisted living facility services.

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: Everett Heritage Court
Provider Type: Assisted Living Facility
License/Cert.#: 2612
Compliance Determination #: 26242
Intake ID: 88582
Investigator: Karen Glover
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 07/10/2023 through 10/31/2023
Complainant Contact Date(s): 06/29/2023

Allegation(s):

The Named Resident (NR) had a 30 pound weight loss and the only intervention was one can of ensure a day which the resident must pay for.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 6 Closed records sample size: 2
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	weight records negotiated service agreement

Investigation Summary:

1. Record review of the NR's weight showed a 15 pound weight loss over 4 months. The ALF was not identifying the weigh losses. Review of the medical provider chart notes showed the medical provider was not aware of the weight loss. Failed practice was identified and the ALF was cited for WAC 388-78A-2120 Monitoring residents well-being.

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: Everett Heritage Court
Provider Type: Assisted Living Facility
License/Cert.#: 2612
Compliance Determination #: 26242
Intake ID: 87345
Investigator: Karen Glover
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 07/10/2023 through 10/31/2023
Complainant Contact Date(s): 07/06/2023, 09/18/2023

Allegation(s):

1. The Named Resident (NR) was neglected due to extreme weight loss and neglectful care.
2. The NR fell at the facility and had a head injury.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 6 Closed records sample size: 2
Observations:	Residents Dining Resident rooms Staff to resident interactions
Interviews:	Nursing staff Guardian Administration
Record Reviews:	Facility policies Incident investigation Negotiated Service Agreement

Investigation Summary:

1. The NR was weighed every month. In the past six months the NR had lost 6 pounds. The NR's body mass index (BMI) was documented as 15.97 kg/m2 at the hospital and hospital staff observed and documented the NR to be "thin and malnourished". Failed practice was identified and the ALF was cited for WAC 388-78A-2120 Monitoring residents well-being.
2. The NR had a witnessed fall and as requested by the medical provider at the facility, 911 was called and the NR was transported to the local hospital. The facility initiated an incident report and investigation and notified family, complaint resolution unit and the medical provider was at the facility at the time of the incident. The NR will not be returning to the facility. 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: Everett Heritage Court
Provider Type: Assisted Living Facility
License/Cert.#: 2612
Compliance Determination #: 26242
Intake ID: 92440
Investigator: Karen Glover
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 07/10/2023 through 10/31/2023
Complainant Contact Date(s): 08/09/2023, 08/17/2023, 08/31/2023, 09/05/2023

Allegation(s):

1. The Named Resident (NR) was not fed or given fluids or medications for more than 4 days.
2. The NR laid in bed with diarrhea all over him.
3. The NR was so dehydrated the family requested the NR be sent to the hospital.
4. The NR had pneumonia from sleeping in bedroom with the windows open.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 6 Closed records sample size: 2
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Identified staff
Record Reviews:	Medical records Hospital records Physician records

Investigation Summary:

1. Record review showed the NR had not received medications for 5 days before the NR was sent to the hospital for unrelated issues. Failed practice was found, however the ALF could not be cited as the ALF was under a plan of correction for WAC 388-78A-2240 Nonavailability of medication.
2. Staff reported that the NR had diarrhea and they had been cleaning him up as needed. Record and interview showed the NR received showers on a daily basis. The NR's family was doing the laundry and found multiple bags of dirty laundry in the NR's room showing the staff were changing the NR.
3. The NR was sent to the hospital as requested by the family. Review of hospital records showed lab values were appropriate for a patient with multiple days of diarrhea. The NR had not established with a medical provider at the time of the diarrhea and missed medications. The facility was cited for WAC 388-78A-2640

reporting significant change in resident's condition.
4. Staff reported they would open the bedroom window to air out the room. No determination could be made regarding how long the window was open or how it impacted the NR.

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
3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 2612	Compliance Determination # 26242
Plan of Correction	Everett Heritage Court	Completion Date
Page 1 of 14	Licensee: Greenlake Management Everett, LLC	10/31/2023

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 07/10/2023, 08/09/2023, 09/20/2023 and 10/04/2023 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 87345, 88582, 95615, 92440

The following sample was selected for review during the unannounced on-site visit: 6 of 44 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Karen Glover, 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

11/02/2023
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.

Statement of Deficiencies	License #: 2612	Compliance Determination # 26242
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Administrator (or Representative) 11/14/23 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interviews and record review the Assisted Living Facility (ALF) failed to ensure 3 of 8 sampled resident's (Resident 2, Resident 3, and Resident 7) weight loss was identified, evaluated, and interventions were put in place to prevent further weight loss. These failures resulted in the weights for Residents 2, 3, and 7 not being monitored and put the residents at risk for continued weight loss and malnutrition.

Findings included...

Review of the ALF's "Weight Variances Policy", undated, showed:

- when residents had a 3-pound weight difference, either higher or lower, this weight needed to be reported to the Health Services Director (HSD).
-when residents had more than a 5-pound weight loss over a few months
-when a resident's weight is far off, caregiver is to reweigh and make sure the weight is taken the same as the previous month ex: same wheelchair, same footrests, same location.

In an interview on 07/10/2023 at 1:30 PM, Staff A, Executive Director, stated that the staff take weights monthly. Staff A stated that they just rewrote the policy and had an in-service on it. Staff are to report if the resident has a 3-pound weight change higher or lower in a month.

In an interview on 08/09/2023 at 1:08 PM, Staff B, Nurse Director, stated that they have trained the staff to alert the nurse or executive director when the residents are not eating

at least 50% of their meal. Staff B stated weights are stable, and Staff B goes into the dining room and observes the residents during mealtime.

In an interview on 08/29/2023 at 3:18 Pm, Staff B stated that residents get reweighed if their weight is over or under more than 3 pounds in one month. If residents are not eating, they get an Ensure (protein drink). Staff B stated that the Ensure is kept on the med cart and in the storage area. Staff B stated that if the medical provider has ordered Ensure for a resident it is documented on the medication administration record.

In an interview on 09/20/2023 at 11:35 AM, Staff A stated that caregivers take the weight book when they are doing weights. This way if there is a discrepancy, they can re-weigh. Staff B will then put the weights in the computer. If residents eat less than 50%, staff will give an ensure and notify the nurse.

Record review showed weights were documented in both the weight book and the vitals section in the electronic record with no evidence that the weight loss was identified or any interventions put in place regarding weight loss for the sampled residents.

Resident 2

Resident 2 was admitted to the ALF on [redacted]2014 with multiple diagnoses including [redacted]
Review of Resident 2's HCS assessment dated 06/29/2023 showed Resident 2 was on a pureed diet and needed physical assist with eating tasks.

Review of a NSA, undated, showed Resident 2 was independent with eating and was on a pureed diet. The staff were to provide a supplement per medical provider's order. Resident 2 was at risk for a potential nutritional problem related to the disease process of dementia. Staff were to alert the nurse if food consumption was less than half for more than one day.

Review of the weight book for 2023 showed Resident 2 lost 15 pounds in four months. In March 2023 Resident 2 weighed 168 pounds, April 165 pounds-for a 3-pound weight loss from the previous month. In May Resident 2 weighed 162.3 pounds, June 156 pounds for a 6.3-pound weight loss from the previous month, and in July 153 pounds, for a 3-pound weight loss from the previous month.

Review of Resident 2's progress notes dated March 2023 - July 2023 showed no documentation that the weight loss had been identified.

Review of Resident 2's medical provider (CC7) visit notes dated 07/06/2023 showed Resident's 2 weight had been stable. No documentation was provided to the medical provider regarding Resident 2's weight loss.

In an email dated 10/12/2023 at 8:56 AM, CC8, medical provider office staff, stated that there was no documentation for weight loss between April to June. There was no reported concern on weight loss by the facility during these months.

In an interview on 10/31/2023 at 10:14 AM, Staff B stated that Resident 2 had no documentation that they received Ensure between the months of March and August.

Resident 3
Resident 3 was admitted to the ALF on [redacted]/2014 with multiple diagnoses including [redacted]
Review of HCS assessment dated 05/05/2023 showed that Resident 3 needed physical assist with eating tasks, was on a pureed diet and needed supervision while eating.

Review of the NSA dated 09/22/2022 showed Resident 3 was a total assist with eating, with a fair appetite on a pureed diet. If Resident 3 refused a meal, caregivers were to re-approach later, and bring them back to the table to encourage them to eat more. Fluids were to be encouraged and even if Resident 3 did not eat the solid foods they would drink fluids and protein shakes.

Review of the weight book showed Resident 3 lost 9.5 pounds in three months. In March Resident 3 had a weight of 113.5 pounds, in April 115 pounds, in May 112 pounds for a 3 pound weight loss, and June 104 pounds for a 8 pound weight loss.

Review of Resident 3's progress notes showed no evidence of any identified weight loss or interventions being put in place for the weight loss between March and June.

In an interview on 08/31/23 10:19 AM, Collateral Contact 6 (CC6), Hospice staff, stated that they are measuring arm circumference in place of getting Resident 3 on a scale to weigh. Resident 3's arm circumference was 21.3 cm on 07/25/2023 and 20.75 cm 08/30/2023. CC 6 stated that the Hospice RN/Executive Director stated that is a significant change in arm circumference for that short of time.

In an interview on 09/06/2023 at 1:39 PM, CC7, medical provider, stated that Resident 3 was on hospice now because of a "consistent decline". CC7 stated that Resident 3 was put on Ensure 3 times per day with meals in January 2023 because their meal consumption really went down.

In an interview on 09/20/2023 at 10:40 AM, Staff C, med tech, looked in the electronic medication administration record for Resident 3. For the months of April to July, the MAR showed no ensure had been provided to Resident 3.

In an interview on 09/20/2023 at 1:45 PM, Staff B stated that the ALF made a referral for hospice due to Resident 3's weight loss. Staff B stated that Resident 3 was denied hospice services in June. Staff B could not identify which hospice agency denied Resident 3. Staff B stated a different hospice agency had accepted Resident 3 and was placed on hospice services on 07/25/2023.

In an interview on 9/25/2023 at 1:32 PM, Collateral Contact 8 (CC8), medical provider office staff, stated that Resident 3 had an ensure order back on 01/26/2023 to start Ensure 1 can three times a day with meals. CC7 reviewed chart notes and their office had not received any calls or faxes regarding a decline in functioning before 07/21/2023 and that is when the hospice referral was written.

Record review of the order written by the medical provider on 01/26/2023 showed that Resident 3 was to receive Ensure three times a day (TID) with meals.

In an interview on 10/31/2023 at 10:14 AM, Staff B stated that Resident 3 did not have Ensure listed on their MAR between January-June.

Resident 7
Resident 7 was admitted to the ALF on [redacted]/2022 with multiple diagnosis including [redacted] and [redacted]

Record review of Resident 7's HCS assessment dated 12/07/2022 showed Resident 7 needed to be cued to complete eating tasks and needed to be monitored for adequate intake, often eating sweets rather than healthy foods and had been losing weight.

Record review of Resident 7's monthly weights showed a weight loss of 10 pounds in four months. In April Resident 7 weighed 133 pounds, in May 126.5 pound for a weight loss of 6.5 pounds. In June Resident 7 weighed 129 pounds, in July 122.5 pounds. (Staff reweighed at 126.3 pounds) for a weight loss of 2.7 pounds and in August 123 pounds for a 3.3 pound weight loss.

Record review of Resident 7's progress notes dated April to August 2023 showed no documentation identifying a weight loss or that weight loss interventions were put in place.

Review of the Resident 7's medication administration records from April 2023 to August showed only one Ensure was provided.

In an interview on 10/04/2023 at 11:30 AM, Staff B stated that Resident 7 was on Ensure as needed (PRN) and staff were to alert Staff B when less than 50% of their meal was eaten.

In an interview on 10/10/2023 at 2:43 PM, Staff A stated that Resident 7 was reweighed in July and weighed 126.3 pounds. Staff A reviewed the MAR for April and May showing Resident 7 was down 5 1/2 pounds between April and May with no interventions put in place. Staff A stated that Staff B would be getting an order for scheduled ensure twice a day.

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) 12/5/23 .

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

Administrator (or Representative) 11/14/23 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;

(b) The resident is relocated to a hospital or other health care facility; or

(c) The resident dies.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to notify Home and Community Services (HCS) Case Manager, resident representatives, and the medical provider when 4 of 8 sampled residents (Resident 1, Resident 3, Resident 4, and Resident 6) had a significant change in condition and residents were sent to the hospital. This failure resulted in the HCS Case Manager from ensuring payment and changes in services were completed for Resident 1, resident representatives from providing medical decisions while residents were at the hospital for Residents 3 and 4 and medical provider to provide care for Resident 6 which resulted in hospitalization.

Findings included...

In an interview on 10/04/2023 at 11:30AM, Staff B, Nurse Director, stated that guardians and families are called before residents are sent out to the hospital.

Resident 1
Resident 1 was admitted to the ALF on [redacted]2018 with multiple diagnoses including [redacted]

In an interview on 07/06/2023 at 9:33 AM, Collateral Contact 5 (CC5), HCS case manager, stated that they had not been notified by the facility regarding Resident 1's hospitalization on 06/14/2023.

Resident 3
Resident 3 was admitted to the ALF on [redacted]2014 with multiple diagnoses including [redacted]

Record review of Resident 3's face sheet had a cell number and office number listed for the guardian.

In an interview on 07/10/2023 at 8:58 AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 3 was sent to the hospital on 06/18/2023 and they found out Resident 3 was in the hospital when they got a call from the registration department at the hospital. CC1 stated they have an emergency pager for after hour calls.

Resident 4
Resident 4 was admitted to the ALF on [redacted]2021 with multiple diagnoses including [redacted]

Record review of Resident 4's face sheet had a cell number and office number listed for the guardian.

In an interview on 06/29/2023 at 2:10 PM, Collateral Contact 2 (CC2), Resident Representative, stated that their office never received notification Resident 4 was sent to the hospital on 06/18/2023.

In an interview on 09/21/2023 at 2:15 PM, CC2 stated that Resident 4 was sent to the hospital for a decrease in mental status on 09/18/2023. CC2 stated that their office has an emergency pager in place for facilities to use when residents get sent to the hospital after hours. CC2 was notified on 09/19/2023 Resident 4 had been sent to the hospital. CC2 stated that they need to be involved with the resident's hospital stay to help guide care and services.

In an interview on 10/04/2023 at 11:30 AM, Staff B, Nurse Director, stated that the guardian office had made changes to their emergency numbers. They are now listed on the face sheet. Staff B stated they had left a message on the office phone and did not realize the guardian wanted a page after hours. Staff B stated that this was just a miscommunication.

Resident 6
Resident 6 was admitted to the ALF on [redacted]2023 with multiple diagnosis including [redacted] and [redacted] Resident 6 was admitted to the ALF after a 3 month stay at the hospital.

Record review of Resident 6's face sheet showed the in house medical provider as the primary medical provider for Resident 6 and the office number was listed.

Review of the progress notes for Resident 6 showed at least 6 days of diarrhea. A late entry was made on 04/08/2023 for 04/04/2023 stating that the MiraLAX (laxative) was held per verbal order from medical provider. No evidence of which medical provider provided the verbal order. No evidence of a medical provider being notified of Resident 6's hospitalization on 04/13/2023.

In an interview on 10/06/2023 at 12:08 PM, Collateral Contact 7 (CC 7), medical provider, stated that Resident 6 had not been seen by CC7 yet. Resident 6 was scheduled to be seen the week following the hospitalization. CC7 stated their office had no contact regarding this resident. CC7 stated that their office policy is to not give verbal orders, we always send a fax.

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) 12/5/23 .

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

Administrator (or Representative) Date 11/16/23

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the

resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on record review, observation and interview the Assisted Living Facility (ALF) failed to keep 1 of 8 sampled residents (Resident 8) safe in the secured memory care unit. This failure resulted in Resident 8 leaving the ALF from an unsecured door and ambulating 2 miles from the ALF and put 18 other residents at risk for leaving the facility.

Findings included...

Review of the ALF's Disclosure of Services dated 08/09/2022 showed the ALF will have the following security services to help protect the residents with cognitive impairments and wandering behaviors:
-Restricted use of exit doors in a designated portion of the building designed to serve residents with dementia.
-Restricted use of exit doors throughout the building.
-Secured front doors.

Resident 8
Resident 8 was admitted to the ALF on [redacted]2022 with multiple diagnosis including [redacted]Review of Resident 8's Home and Community Services (HCS) assessment dated 08/11/2023 showed Resident 8's behaviors included wandering and exit seeking. A secured dementia unit was required to keep safe.

Review of Resident 8's negotiated service agreement (NSA), undated, showed Resident 8 had memory loss/dementia and their goal was to live in a safe, nurturing and stimulating environment. Handwritten note on page 12 dated 09/28/2023 showed staff to take Resident 8 outside, up the elevator, to the courtyard, this makes Resident 8 happy and can help with not having them focus on eloping. Float caregiver can make sure Resident 8 gets to go outside. Review of the NSA showed no evidence of interventions put in place by the ALF for the wandering and eloping behaviors before the 08/27/2023 incident.

Review of Resident 8's Occurrence Report dated 08/27/2023 at 3:30 PM, showed Resident 8 went missing from the ALF when staff noticed Resident 8 was missing from the dining room. The Occurrence Report showed Resident 8 had left the ALF once before the prior year.

On 09/20/2023 at 12:17 PM it was observed the back door (southwest corner of the basement floor) was unlocked and the outside gate at the top of the ramp was closed but unlocked with access to the alley.

On 09/20/2023 at 12:30 PM it was observed the kitchen door that goes to the outside sidewalk, along the building, was a screen door with a chain that latched door closed. The outside gate was observed to be locked from the alley side of the gate.

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In an interview on 09/20/2023 at 12:45 PM, Staff A, Executive Director, stated that staff were using the southwest corner door as an entrance. Staff A stated they would immediately put-up emergency exit only signs and change the gate code. Staff A also stated they would get a temporary alarm on the door today and put in a work request to get an actual alarm placed on the door. Staff A also stated they are getting cameras for the back door.

In an interview on 9/20/2023 at 10:40 AM, Staff C, medication technician (med tech), stated that Resident 8 was exit seeking the day before and was easily re-directed. Staff C stated staff were doing 30-minute checks on Resident 8 since the Resident left the ALF.

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) 12/15/23 .

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

Administrator (or Representative) 11/16/23 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:

(e) When a resident does not have a personal physician or health care provider;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have a policy in place to guide staff when a resident does not have an established primary care physician (PCP) for 1 of 8 sampled residents (Resident 6) when no PCP was established and Resident 6 ran out of medication. This failure resulted in Resident 6 not receiving medications for 5 days and being hospitalized after multiple days of untreated diarrhea and placed all residents without a PCP at risk of unmet care needs.

Resident 6
Resident 6 was admitted to the assisted living facility (ALF) on [redacted] 2023 with multiple diagnoses including [redacted] and [redacted] Resident 6 was admitted to the ALF after a 3 month stay at the hospital.

Record review of Resident 6's pre-admission assessment completed by Staff G, former

Nurse Director, dated 03/27/2023 showed Resident 6 was independent with ambulation and transfers, no history of falls, regular diet with no problems with chewing, swallowing, or pocketing food. No wandering, or behaviors. Resident 6 would need assistance with medications.

Record review of Resident 6's hospital discharge summary dated [redacted]2023 showed Resident 6 was a high fall risk and had two falls during the hospitalization. Resident 6 had a room close to the nurse's station with a 1:1 sitter to manage wandering and behaviors. Resident 6 was on a dysphagia mechanical soft diet, 1:1 feeds and aspiration precautions. Resident 6 needed stand by assist due to the high fall risk.

Record review of Resident 6's Nurses Admission Assessment dated 03/31/2023 completed by Staff G showed Resident 6 was on a regular diet, independent in ambulation, incontinent of bowel and bladder with a large normal bowel movement noted 03/30/2023 and no recent falls reported.

Record review of the Patient Medication Information dated 03/28/23, from the hospital, showed Resident 6 was to receive the following scheduled medications:
-Amlodipine 10 mg (high blood pressure) one table by mouth every day
-Atorvastatin Calcium 20mg (reduce cholesterol) one tablet by mouth every day
-Cholecalcif 25mcg (Vitamin D supplement) one tablet by mouth every day
-Melatonin 3 mg (Sleep) two tablets by mouth every evening
-Memantine HCL 10mg (memory) one tablet by mouth twice a day
-Polyethylene Glycol 3350 oral powder (constipation) one capful in one cup of water and drink by mouth every day
-Prazosin HCL 1 mg (anxiety) one capsule by mouth every night at bedtime
-Sertraline HCL100mg (depression) one tablet by mouth everyday

Record review of the medication administration record (MAR) for Resident 6 dated April 2023 showed the following scheduled medications that had missing doses:
-Amlodipine 10 mg, 5 missed doses
-Atorvastatin Calcium 20 mg, 4 missed doses
-Cholecalcif 25mcg, 5 missed doses
-Melatonin 3 mg, 2 missed doses
-Memantine HCL 10mg, 9 missed doses
-Prazosin HCL 1 mg, 4 missed doses
-Sertraline HCL 100mg, 5 missed doses
Missed doses on the April MAR were coded: see progress note or medication not available.

Record review of Resident 6's progress notes showed documentation from the medication technician of missing medications with no documentation of re-ordering or notifying the nurse or family representative of the missing medications.

In an email dated 09/27/2023 at 2:51 PM Staff B, Nurse Director, stated that Resident 6 was between providers and Staff G (former Nurse Director) was trying to get refills for medications they were missing for Resident 6. Staff B stated that Resident 6 was to be seen by the in-house medical provider on 04/19/2023.

In an interview on 10/04/2023 at 11:08 AM, Staff C, med tech, stated that the process is to notify the nurse of medications that need to be ordered, the nurse either faxes or calls the

medical provider for the medication refill. Staff C stated she documented on Resident 6's MAR of the missing medication and talked with Staff G.

In an interview on 10/04/2023 at 2:24 PM, Staff H, med tech, stated that the process when a resident needs a refill of medications is to alert the nurse. Staff H stated they write down a list of the medications that need refilled and give the list to the nurse.

Record review of Resident 6's late entry progress note created on 04/08/2023 for 04/04/2023 made by Staff G stated that Resident 6 had loose stools multiple times, MiraLAX was held per verbal order from physician. Late entry progress note created on 04/14/2023 for 04/06/2023 made by Staff G stated that diarrhea had ceased per caregivers. Will continue to monitor. MiraLAX continues to be on hold. Late entry created on 04/14/2023 for 04/09/2023 made by Staff G stated diarrhea has started again, spouse notified, and will bring in over the counter Imodium and will give to Resident 6. Per staff, 5-6 loose stools per day. Fluids continue to be encouraged. Note dated 04/11/2023 made by Staff G, diarrhea continues, wife aware and is communicating with medical provider for prescription for Imodium or appointment. Note on 04/13/2023 made by Staff G stated diarrhea has not ceased and family wishes Resident 6 to be transported to the Emergency room for evaluation. EMS was called and Resident 6 was transported for increased weakness and diarrhea.

In an interview on 10/03/2023 at 4:32 PM, Collateral Contact (CC4), family representative, stated that the facility called on the day Resident 6 was transferred to the hospital, to bring in some Imodium (over the counter medication to treat diarrhea) for the diarrhea. CC4 stated that the Imodium was never given to Resident 6. CC4 stated the family was never notified regarding medications being out or asking them to call the medical provider at the Veteran's Administration (VA) clinic regarding the medications or the diarrhea.

In an interview on 10/25/2023 at 2:50 PM, Staff A, Executive Director, stated that they did not have a policy regarding residents not having a PCP.

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) 12/5/23.

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

Statement of Deficiencies	License #: 2612	Compliance Determination # 26242
Plan of Correction	Everett Heritage Court	Completion Date
Page of 14	Licensee: Greenlake Management Everett, LLC	10/31/2023

Administrator (or Representative) 11/14/23 Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure a complete and accurate pre-admission assessment was completed for 1 of 8 sampled residents (Resident 6) before admission to the ALF. This failure resulted in the ALF staff not being aware of Resident 6's care needs and placed Resident 6 at risk of staff not being prepared to provided the appropriate care.

Findings included...

Resident 6 was admitted to the ALF on [redacted]2023 with multiple diagnosis including [redacted] and [redacted] Resident 6 was admitted to the ALF after a 3 month stay at the hospital.

Record review of Resident 6's pre-admission assessment completed by Staff G, former Nurse Director, dated 03/27/2023 showed Resident 6 was independent with ambulation and transfers, no history of falls, regular diet with no problems with chewing, swallowing, or pocketing food. Resident 6 was identified as having no wandering, or behaviors. Resident 6 would need assistance with medications. The pre-admission assessment did not identify a medical history, medications, health professional diagnosis, significant or known behaviors, activities, preferences to food or daily routine.

Record review of Resident 6's hospital discharge summary dated [redacted]2023 showed

Resident 6 was a high fall risk and had two falls during the hospitalization. Resident 6 had a room close to the nurse's station with a 1:1 sitter to manage wandering and behaviors. Resident 6 was on a dysphagia mechanical soft diet, 1:1 feeds and aspiration precautions. Resident 6 needed stand by assist due to the high fall risk. None of these issues had been addressed in the pre admission assessment.

In an interview on 08/09/2023 at 1:00 PM, Staff A, Executive Director, stated that Staff G, the former Nurse director had completed that pre admission assessment on Resident 6 and could not state why it was not accurate.

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) 12/5/23.

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

Administrator (or Representative) — Date: 11/16/23