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

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) 47259 (Completion Date 09/18/2024) and 38428 (Completion Date 07/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/18/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2371, WAC 388-78A-2600-2-a, WAC 388-78A-2600-2-f, WAC 388-78A-2630-1-a

The Department staff who did the on-site verification:
Karen Glover, Complaint Investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

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
Intake ID: 123164
Compliance Determination #: 38428
Region/Unit #: RCS Region 2 / Unit A
Investigator: Karen Glover
Investigation Date(s): 03/18/2024 through 07/22/2024
Complainant Contact Date(s): 03/15/2024

Allegation(s):

The Named Resident (NR)-
1-was found with various sores and open wounds over their entire body.
2-had not eaten since the day before yesterday.
3-had someone high up attempt to touch their genital area.
4-had to clean the areas they live at the facility.
5-staff do not pay attention to the NR or other residents.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Administration
Record Reviews:	Hospital records Incident investigation Negotiated Service Agreement Medical Provider orders

Investigation Summary:

1. The NR had been treated for the wounds for many months, including 2 hospital admissions for cellulitis. The facility had been in contact with the medical provider and following the medical providers orders. The NR was being followed at the wound care center at the medical providers facility. The facility did not place the NR on alert charting after a hospitalization. Failed practice was found. The facility will be cited for WAC 388-78A-2600 for Policy and Procedures.
2. In an interview the NR stated that you can't believe everything you hear. The NR stated they had eaten at the emergency room and was not hungry by the time they

headed out the next morning to the medical providers office.
3. The NR stated that incident happened years ago and had nothing to do with them, The NR stated they felt safe at the facility and can report any concerns to the nurse. The NR denied being touched inappropriately by anyone. Interview with sampled residents showed no concerns of being inappropriately touched. No failed practice was identified.
4-The NR stated that they like to clean up their room or help with dishes after meal time. The NR stated that is their right to help and they are not being made to clean up. No failed practice was identified.
5-The NR stated that the staff take very good care of them. The NR had no concerns regarding the attention that they receive. Interview of sampled residents showed staff were meeting their needs and had no concerns. No failed practice was 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
Intake ID: 122801
Compliance Determination #: 38428
Region/Unit #: RCS Region 2 / Unit A
Investigator: Karen Glover
Investigation Date(s): 03/18/2024 through 07/22/2024
Complainant Contact Date(s): 07/16/2024

Allegation(s):
The Named Resident (NR) was found with a black eye and injury to the side of their face.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Resident rooms Staff to resident interactions Residents
Interviews:	Hospice staff Nursing staff Residents Family members
Record Reviews:	Incident investigation Progress Notes

Investigation Summary:
The NR was on Hospice services and would be in pain and become agitated at night. Care staff noted the black eye and bruise to the forehead. The facility initiated an investigation and notified the NR's family, Hospice team, and the department's hot line. Review of the NR's progress notes showed the NR had multiple incidents over the last few weeks including a bruise noted on the NR's left hip. Review showed no incident report had been completed for the bruise and no alert charting had been completed for the incidents as directed by facility policy. The facility will be cited for WAC 388-78A-2600 Policy and Procedures, WAC 388-78A-2371 Investigations.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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 03/18/2024 and 06/12/2024 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 123164, 122801

The following sample was selected for review during the unannounced on-site visit: 4 of 47 current residents and 0 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

07/26/2024
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

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

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to investigate, document findings, determine the circumstances of the event, and protect 1 of 3 sampled residents (Resident 1) when staff found a bruise on their left hip. This failure resulted in the ALF not being able to rule out abuse and neglect and placed Resident 1 at risk for future incidents.

Findings included…

Review of the Assisted Living Facility Guidebook Partners in Protection, dated February 2018, contained guidelines intended to assist facilities in developing and implementing policies and procedures to help prevent resident abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation by any person. Chapter 2 and Appendix F showed State law required the assisted living facility to do a thorough investigation when there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident.

Review of the ALF's "General Policy 20-Internal Incident Report and State Incident Report" policy dated 08/10/2021, showed an internal incident report is completed by staff for all unusual occurrences, injury, and incidents. The ALF must:
- investigate and document investigative actions for any accident or incident jeopardizing or affecting a resident's health or life.
-determine the circumstances of the event.

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

Review of Resident 1's progress note dated 03/07/2024, showed Resident 1 had bruising noted on their left hip and the hospice (a program that gives special care to

residents who are near the end of life) team had been notified. There was no evidence of an incident report or investigation being completed.

In an interview on 03/18/2024 at 12:45 PM, Staff B, Health Services Director, stated that they thought since Resident 1 was on hospice services that the bruise did not need to be investigated or reported to the state.

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)_____ .

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

_____ _____
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;

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their policy and place 2 of 4 sampled residents (Resident 1 and 2) on alert charting for multiple falls and a change of condition. This failure resulted in the Residents not being put on alert charting and placed Resident 1 and Resident 2 at risk for unrecognized complications following a fall or change of condition.

Findings included…

Record review of the ALF's policy, "Alert Charting" dated 08/10/2021 showed:
Alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer

monitoring.
1. Alert charting procedures will be initiated if a resident:
a-new to the community
b-exhibits a change in condition
c-is returning from the hospital, ER or urgent care
d-has fallen
2. The alert charting process includes:
a-the resident's name and concern will be placed in a discreet location readily visible to care staff or alert charting reminder is turned on in the service planning program.
b- each resident placed on alert charting will be monitored for at least 48 hours following the initiation of alert charting.

Record review of ALF's policy, "Fall Response Procedures" dated 08/10/2021 showed:
Policy: Should a resident experience a fall, staff will provide immediate care and follow through with Negotiated Service agreement.
Procedure:
For 48 hours after any fall, the Wellness Director or Nurse/Med Tech on each shift will monitor the resident and make a brief narrative charting entry.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

Review of Resident 1's progress notes dated 03/07/2024, 03/09/2024, 03/14/2024 and 03/15/2024 showed only a nursing note had been made on each of those dates identifying a fall had happened with no alert charting noted following the falls.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted].

Review of Resident 2's progress notes dated 02/02/2024 showed Resident 2 returned to the community from a hospital stay. There was no evidence of any alert charting following Resident 2's return to the community from the hospital.

In an interview on 03/18/2024 at 12:56 PM, Staff B, Health Services Director, stated that alert charting had not been completed since last May when they started in the Health Services Director position.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

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 record review and interview the Assisted Living Facility (ALF) failed to report 1 of 3 residents (Resident 1) to the Department's Complaint Resolution Unit (CRU) hotline after a bruise was found on their left hip. This failure resulted in preventing the Department from reviewing the ALF's response to potential abuse and neglect.

Findings included…

Review of General Policy 20-Internal Incident Report and State Incident Report policy dated 08/10/2021, showed all incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the state licensing agency.

Resident 1 was admitted to the ALF on [redacted]/[redacted]/2023 with multiple diagnoses including [redacted].

Review of Resident 1's progress note dated 03/07/2024, showed documentation that Resident 1 had bruising noted on their left hip and the hospice team had been notified.

Review of Resident 1's service plan, dated 03/11/2024 showed Resident 1 had memory loss related to the dementia disease process and was unable to verbalize how the bruising occurred.

In an interview on 03/18/2024 at 12:45 PM, Staff B, Health Services Director, stated that they thought since Resident 1 was on hospice services that the bruise did not need to be reported to the state.

Record review of the Department's Secure Tracking and Reporting System (STARS) showed no report had been made regarding Resident 1's bruise.

Refer to WAC 388-78A-2371(1)(2)(3)(4)

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)_____ .

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

_____ _____

Administrator (or Representative) Date