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

01/09/2025

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

RE: Everett Heritage Court # 2612

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 52847 (Completion Date 01/09/2025) and 45128 (Completion Date 08/15/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/09/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

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;

The Department staff who did the On Site verification:
Wesler Dumecquias, Community 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: 141151
Compliance Determination #: 45128
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 08/02/2024 through 08/15/2024
Complainant Contact Date(s): 08/02/2024

Allegation(s):

1. The Named Resident was roughly handled by the RN and caregiver.
2. The NR was not properly cleaned after bowel movements and fecal matter was getting into the sacral wound.
3. The NR's wound dressing was not always off or the wound dressing was removed despite the ALF staff being educated to maintain wound dressing.
4. The NR's sacral wound became bigger due to the poor care from the Assisted Living Facility staff.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 4 Closed records sample size: 1
Observations:	Residents Resident rooms Resident care equipment Staff to resident interactions Resident to resident interactions Delivery of care, transfer
Interviews:	Nursing staff Residents Family members Housekeeping staff
Record Reviews:	Facility policies Care plans PCP treatment orders Outside providers notes Medical records Assessments progress notes

Investigation Summary:

1. The NR passed away on [redacted]/2024, a day before the Department's visit on

[redacted]/2024. Interview indicated that the NR needed two person assist with transfers. Observation showed the ALF care staff were careful and respectful in providing care to sampled residents.
2. Interview showed the NR needed two person to assist them with their Activities of daily living due to their agitation and refusal with care sometimes. Observation of sampled residents (SR) did not indicate any concerns with the staff in providing care to the residents. Interview with a SRs showed they did not have concerns and were satisfied with their care. The ALF staff were following the care plans.
3. Interview showed the ALF caregivers would report to their Med Tech and the Licensed Nurse if they observed a wound dressing coming off. The Med Tech would reinforce and inform the License nurse who would do the wound dressing as needed. There was no similar cases observed from the sampled residents. Interview and records review showed the ALF's License Nurse failed to ensure a weekly assessment, follow up, and documentation was done for the NR's wound. Failed practice was identified and a citation was issued for non compliance with WAC 388-78A-2410(9) Content of resident records.
4. Observation showed the ALF care staff were repositioning a sampled resident (SR) at least every two hours by putting and tucking pillows on the SR's back. Interview and record review showed the ALF License Nurse were to do weekly assessment, monitor food intake and placed on weekly weights residents identified with skin issues. The License Nurse stated that they were informed verbally by the Home Health about the worsened pressure ulcer and the development of a new pressure ulcer on the same area. The ALF's License Nurse failed to ensure a weekly assessment, follow up and documentation was done for the NR. Failed practice was identified and a citation was issued for non compliance with WAC 388-78A-2410(9) Content of resident records and WAC 388-78A-2600(1)(b). 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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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 08/02/2024 and 08/02/2024 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 141151

The following sample was selected for review during the unannounced on-site visit: 4 of 45 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community 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.

Residential Care Services

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-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

This requirement was not met as evidenced by:

Based on the interview and records review, the Assisted Living Facility (ALF) failed to document in the Residents' records observations and assessments for 2 of 2 Residents (Resident 1 and 2) with skin issues. These failures resulted in the ALF not being able to show that they were monitoring and assessing the Residents' skin issues in order to determine and timely address potential complications or worsening of the skin issues. These failures placed Residents 1 and 2 at risks of developing increased skin complications.

Findings included…

A review of the ALF's "Skin Care Management" policy dated 02/15/2024 showed the Health Services Director (HSD) would ensure that they would complete documentation of the appropriate interventions, follow-up, Service Plan updates, and progress notes. The policy showed the HSD would at least do a weekly assessment and documentation in Resident 1's progress note until the skin problem was resolved. The policy showed the ALF staff would monitor the food intake and place the residents on weekly weights. The Community nursing staff would continue to monitor and document the progress of the wound, even if an outside agency were providing the treatment.

Resident 1

Resident 1 was admitted on [redacted]/2024 with multiple diagnoses, including [redacted].

A review of an undated Care Plan (CP) showed Resident 1 had a stage 2 sacral pressure ulcer related to immobility. The CP showed that a care manager (CM) would do weekly treatment documentation to include measurements for each area of skin breakdown, including width, length, depth, type of tissue and exudate (a fluid released through

pores or a wound), and any other notable changes or observations.

A review of the ALF's Weekly Wound Care Report dated 07/19/2024 showed on 07/18/2024 the ALF identified Resident 1's Stage 2 pressure ulcer on their sacral area on [redacted]/2024 and an outside home health provider would perform the wound care. The Report showed that an assessment should be documented in the residents' health records each week. The documentation should include a brief description of the wound, including current treatment, how the resident tolerated the healing process, and any concerns. No other entries were entered on the Weekly Wound Report.

On 08/07/2024 at 9:47 AM, Staff B, HSD, stated that the Home Health (HH) was doing the wound care, and they were not in charge. Staff B said they would not do anything about the wound. Staff B stated that they do not do weekly weights. Staff B stated that HH informed them that the wound deteriorated, and a new pressure wound developed. Staff B stated that right after HH informed them of the deteriorating wound and newly discovered wound, they put Resident 1 in hospice.

A review of the home health's Outside Provider's outcome of the visit dated 07/30/2024 showed Resident 1's wound deteriorated, and a new wound formed above the original wound. The latest wound measured 0.4x1x0.1 cm (centimeters).

A review of Progress notes from Resident 1's admission date of [redacted]/2024 to [redacted]/2024 showed no documentation of a weekly assessment, including measurements for each area of skin breakdown, width, length, depth, type of tissue and exudate, and any other notable changes or observations. There was no documentation in the progress notes showing a brief description of the wound, including current treatment, how the resident tolerated the healing process or any concerns.

Resident 2

Resident 2 was admitted into the ALF on [redacted]/2024 with multiple diagnoses, including [redacted]

A review of the CP dated 07/16/2024 showed Resident 2 could get redness on their buttocks and peri area. Resident 2 had potential impairment to skin integrity related to fragile skin and dementia.

On 08/02/2024 at 3:20 PM, Staff F, Caregiver, stated that Resident 2 had a skin irritation in their private area. Staff F stated Resident 2 stays mostly in their bed and needed two-person assist.

On 08/02/2024 at 3:23 PM, Staff G, Caregiver, stated that Resident 2 had sensitive skin

and mostly slept on their back. Staff G stated that Resident 2 had skin irritation and a small scratch on their vaginal area. Staff G stated they would turn Resident 2 at least every two hours and apply a barrier cream.

On 08/02/2024 at 3:29 PM, Staff E, Med Tech, stated that Resident 2 had rashes in their private area and bottom. Staff E described Resident 2's skin issue in their private area and bottom as a bedsore (Pressure ulcer). Staff E stated they knew of the skin problem when changing Resident 2's brief and was applying barrier cream. Staff E stated they had informed the HSD of the pressure ulcer.

A review of progress notes dated 06/18/2024 and 06/19/2024 showed Resident 2 developed a rash on their bottom and needed the application of a barrier cream, and nystatin powder was being applied. There were no documentation showing weekly assessments and monitoring of the skin issue from 06/25/2024 to 08/02/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, 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.

(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;

This requirement was not met as evidenced by:

Based on the interview and records review, the Assisted Living Facility (ALF) failed to follow and implement their policy when it did not monitor the food intake and place on weekly weights 1 of 1 Resident (Resident 1) with a stage 3 pressure ulcer (an injury in the outer surface or more profound layer of the skin with a red or pink wound bed) of the sacral region (the portion of your spine between your lower back and tailbone). The failure resulted in the ALF not having documentation to provide the primary care physician (PCP) and consider dietary and physical therapy consults. This failure placed Resident 1 at risk of worsening pressure wounds or developing skin complications.

Findings included…

A review of the ALF's "Skin Care Management" policy (Policy) dated 02/15/2024 showed the ALF staff would monitor the food intake and place residents on weekly weights if they have stage 1, 2, 3, or 4 pressure wounds. Residents at risk for skin breakdown due to immobility, excessively dry skin, diabetes, or other medical conditions would be considered for dietary and physical therapy consults. The Community nursing staff would continue to monitor and document the progress of the wound, even if an outside agency was providing the treatment.

Resident 1 was admitted with multiple diagnoses, including [redacted].

A review of an incompletely signed and undated Care Plan (CP) showed Resident 1 had a stage 2 sacral pressure ulcer related to immobility. The CP showed Resident 1 had a potential nutritional problem related to impaired cognitive function.

Review of visit notes by the primary care physician dated 07/31/2024 showed Resident 1 had a sacral stage 3 ulcer.

On 08/07/2024 at 9:47 AM, Staff B, Health and Services Director, stated that they did not obtain weekly weights for Resident 1 because they only do weekly weights if they have an order. Staff B said they had a log of Resident 1's food intake.

On 08/07/2024 at 10:04 AM, Staff A, Executive Director, stated that they do not do meal monitoring, so they do not have a meal log for Resident 1. Staff A stated that they do not do weekly weights, but they do it monthly. Staff A said there was something wrong with their policy and that they would speak with their corporate about it.

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