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

01/13/2025

Sequim SCC LLC
Cottages of Sequim
408 W Washington St
Sequim, WA 98382

RE: Cottages of Sequim # 2699

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 53137 (Completion Date 01/13/2025) and 44743 (Completion Date 09/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/13/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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:

(f) In response to medical emergencies;

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

The Department staff who did the On Site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,
Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Sequim
Provider Type: Assisted Living Facility
License/Cert.#: 2699
Compliance Determination #: 44743
Intake ID: 138866
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 07/26/2024 through 09/11/2024
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Report of resident being left in saturated brief and resident not receiving pain medication.
2. Dietary Services: Report of resident not receiving meals to room or being escorted to dining room.
3. Restraints/Seclusion -General: Report of residents door being locked resulting in resident being locked in and out of room.

Investigation Methods:

Sample:
Total residents: 42
Resident sample size: 3
Closed records sample size: 1

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Executive Director

Record Reviews:
State reporting log
Incident investigation
Facility policies
Care Plans
Progress Notes
Incident Log
MAR
Face Sheet

Investigation Summary:

1. Sampled resident observed to be in wet brief for extended period of time. Interview with resident confirmed this happens often. Failed practice identified.
2. Facility staff interviewed confirmed bringing meal to resident in room and assisting resident down to meal service. No failed practice identified.
3. Facility staff able to unlock door from the outside. Resident not locked in bedroom and able to exit at anytime. 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: Cottages of Sequim
Provider Type: Assisted Living Facility
License/Cert.#: 2699
Compliance Determination #: 44743
Intake ID: 139509
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 07/26/2024 through 09/11/2024
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/treatment: Report of resident not receiving prescribed medications.
2. Resident/Patient/Client Neglect: Report of POA for resident not being notified when resident had a fall at the community.

Investigation Methods:

Sample:
Total residents: 42
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Executive Director

Record Reviews:
State reporting log
Incident investigation
Facility policies
Care Plans
Progress Notes
Incident Log
MAR
Face Sheet

Investigation Summary:

1. Facility received a cancel order for one of the medications in question. The other medication was not listed on admission orders for the facility. No failed practice identified.

2. Facility staff failed to follow process and make proper notifications when resident had a fall in the community. Failed practice identified.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2699	Compliance Determination # 44743
Plan of Correction	Cottages of Sequim	Completion Date
Page 1 of 6	Licensee: Sequim SCC LLC	09/11/2024

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 07/26/2024 and 09/13/2024 of:

Cottages of Sequim
408 W Washington St
Sequim, WA 98382

This document references the following complaint number(s): 138866, 139509

The following sample was selected for review during the unannounced on-site visit: 3 of 42 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Cory Cisneros
Residential Care Services

09/19/2024
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 9/26/24

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:

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff implemented their incident reporting policy and procedure for 1 of 3 residents (Resident 1 [R1]) when a staff member found a resident on the floor. This failure placed 42 out of 42 residents at risk for unmet care needs.

Findings included...

Record review of a facility policy, procedure, and training document, titled, "Incident Reporting," undated, showed, "All incident reporting needs to be done in the PCC [Point Click Care, medical records system] system under the incidents tab. All care staff have been trained in how to complete this report. The first person to discover the incident needs to put in the incident report into the system. Med techs [Medication Technician] need to be made aware that an incident has taken place so that they can place that resident on alert and start the progress note inside the incident report...Med techs need to notify PCP [Primary Care Physician] and family members of the incident as soon as possible...All care staff need to notify the RCC [Resident Care Coordinator] and the Executive Director of every incident report at the time of occurrence."

Review of R1's face sheet, dated 07/26/2024, showed that R1 was admitted to the facility on [redacted]/2024.

Record review of a report to the department, dated 07/22/2024, showed, R1 was taken out of the facility by family when bruising was discovered on R1's tailbone and down their left leg. R1 remembered falling in the bathroom at the facility. R1 was taken to a hospital for evaluation where a compression fracture was discovered. The report showed R1's representative was not notified of the fall. Further review of department records showed no facility report of this incident.

Record review of R1's MAR (Medication Administration Record), dated 05/01/2024 – 07/31/2024, showed R1 was prescribed Eliquis (a blood thinner medicine that reduces blood clotting and can cause bleeding).

In an interview on 08/16/2024 at 11:00 AM, Staff A, Executive Director, was asked if there was a policy on who staff were to notify when a resident had a fall. Staff A stated there wasn't a policy. Staff A stated that whoever finds the resident was supposed to do an incident report and notify the med tech. The med tech would then notify the doctor and the POA (Power of Attorney) and call 911 if they needed to.

In an interview on 07/26/2024 at 11:10 AM, Staff B, Medication Technician/Caregiver, was asked what the process was when a resident had a fall, they stated they would call a code "timber", the med tech will come down to assess the resident. Staff B stated they will make sure the resident was safe. After the resident had been assessed, the Resident Care Coordinator, Executive Director and the Patient Representative or POA were notified. Staff B stated they would fax the doctor. Staff B was asked when they would contact the POA, they stated as soon as we can.

In an interview on 07/26/24 at 2:27 PM, Staff A, was asked what the expectation was of staff when a resident had a fall, they stated, they were to assess them, do an incident report and notify the med tech. The med tech would put the resident on alert to monitor for pain or behaviors. If they had pain or discomfort the med tech would call EMS (Emergency Medical Services) and EMS would decide to take the resident to the hospital for further evaluation. Staff A stated the med tech would then notify the resident representative and the PCP. Staff A was asked when those notifications to the representative and the PCP were made, they stated if the incident happened at night, we make the notifications the next morning. If was during the day, we make them immediately after the resident was cared for. Staff A was asked if there was a special process for residents who were on blood thinners and had a fall, they stated, if they were on blood thinners we will call EMS, otherwise monitor for latent bruising and swelling. Staff A was asked what happened regarding R1's fall, they stated Staff C, Caregiver, went into R1's room where R1 was found on the floor. Staff A was asked if they were made aware of the fall when it happened, they stated no, they were made aware of it eight days later when R1's representative called the facility regarding the fall they were unaware of. Staff A stated the caregiver [Staff C] who found R1 on the floor didn't report it or enter it into the system. They didn't follow the protocol for falls.

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, Cottages of Sequim is or will be in compliance with this law and / or regulation on (Date) ~~11/01/2024~~ 10/26/24.

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

Statement of Deficiencies	License #: 2699	Compliance Determination # 44743
Plan of Correction	Cottages of Sequim	Completion Date
Page 4 of 6	Licensee: Sequim SCC LLC	09/11/2024

Administrator (or Representative) 9/26/24 Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure that care and services provided to residents maintained or enhanced each resident's dignity for 2 of 3 residents reviewed (Resident 2 [R2] and Resident 3 [R3]). This failure resulted in R2 and R3 at risk for developing skin issues, unmet care needs, and decreased quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights.(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Record review of a report to the department, dated 07/16/2024, showed a report of a resident being left where the person, the clothing, and the bedding were all saturated with urine several times throughout the week.

<R2>

Record review of R2's face sheet, dated 07/26/2024, showed that R2 was admitted to the facility on [redacted]/2024.

Record review of R2's care plan, creation date 03/13/2024, showed, "Toileting: Maintain resident dignity...maintain skin integrity...maximum Assist 3-4x/shift...Resident requires maximum staff assistance for toileting 3-4x/shift." Under "Diagnosis," listed [redacted]

In an interview on 07/26/2024 at 9:49 AM, Staff B, Caregiver, was asked, if they had ever come in for their shift and residents were soaked in urine, they stated yes, it happened quite often. Staff B was asked if they had reported it, they stated they had reported it to management. Staff B stated they believed the caregivers at night were not physically able to lift and roll people. Staff B stated R2 was difficult, but they were "literally soaked up their back, brief, pants, shirt, pad, sheets and down to the

mattress."

In an observation on 07/26/2024 at 10:08 AM, room [redacted] had a smell of urine upon entry into the room.

In an interview on 07/26/2024 at 10:08 AM, R2 was asked if anyone had come in to change their brief yet, R2 stated, no, "I'm nice and wet."

In an observation on 07/26/2024 at 10:08 AM, R2's pajama pants were visibly saturated around the waist of the pants.

In an interview on 07/26/2024 at 10:08 AM, Staff B stated, R2's brief was normally dripping with urine.

In an interview on 07/26/2024 at 10:13 AM, R2 was asked if staff come in to change their brief at night, they stated, "I don't think so, I am wet all night long."

In an observation on 07/26/2024 at 10:13 AM, Staff B opened R2's closet door and a strong odor of urine was noted.

<R3>

Record review of R3's face sheet, dated 09/11/2024, showed that R3 was admitted to the facility on [redacted]/2024.

Record review of R3's care plan, creation date 04/04/2024, showed under "Toileting Assistance", "Resident requires maximum Staff assistance for toileting 3-4x/shift."

In an interview on 07/26/2024 at 2:05 PM, Collateral Contact 1 (CC1), R3's Representative, was asked if R3 has had any issues not getting their brief changed, CC1 came in one morning and noticed that the crotch of R3's pants were wet. CC1 stated the caregiver was pushing R3 in the wheelchair and told CC1 it was water. CC1 stated they looked in the brief 2 hours later and R3's brief was soaked with urine, the sweatpants were soaked, the pad on the wheelchair was soaked. CC1 stated they went to R3's room and the pad on the bed was full of fecal matter.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2699	Compliance Determination # 44743
Plan of Correction	Cottages of Sequim	Completion Date
Page 6 of 6	Licensee: Sequim SCC LLC	09/11/2024

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

Administrator (or Representative) — Date: 9/24/24