



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

Tamila Bigun
Cornerstone
10710 NE 86th Circle
Vancouver, WA 98662

RE: Cornerstone # 754527

Dear Provider:

This document references Compliance Determination 35930 (02/21/2024), which included complaint number(s) 112271.

The Department completed a complaint investigation of your Adult Family Home on 02/21/2024 and found that your home does not meet the Adult Family Home Licensing requirements.

The department staff who did the inspection and provided consultation:

Priscilla Changa, Nursing Home Complaint Investigator
Jacob Ubl, ALF NCI CI

A licensor may consult with a provider when a violation of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW) is found, but it is not cited in the Statement of Deficiencies. Violations may not be cited when it is a first-time violation of statute or rule with minimal or no harm to residents. A consult does not require a follow-up visit.

Consultation:

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(10) A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.

Based on interview and record review the home failed to have a hospice care plan for 1 of 2 sampled Residents (Resident 1).

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the home to determine if you have corrected all deficiencies.

You May:

- Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
- Ask questions and provide written information to help clarify or dispute the deficiencies.

- Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:

- Please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit F
Residential Care Services

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:

Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an '**IDR Request Form**' for **each** citation or enforcement you plan to dispute. You can find this form and directions on the IDR Adult Family Home web page at: <https://www.dshs.wa.gov/altsa/idr>

Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your request and supporting documents to the address below or email to rcsidr@dshs.wa.gov:

Adult Family Home IDR Program
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600



Residential Care Services Investigation Summary Report

Provider/Facility: Cornerstone

Provider Type: Adult Family Home

License/Cert.#: 754527

Compliance Determination #: 35930

Intake ID: 112271

Investigator: Priscilla Changa

Region/Unit #: RCS Region 3 / Unit F

Investigation Date(s): 01/29/2024 through 02/21/2024

Complainant Contact Date(s):

Allegation(s):

- 1) Named resident had multiple falls and provider did not seek medical attention
 - 2) Named resident had scars as a result of a shelf falling onto the residents
 - 3) Over prescribed dementia medications resulting into named resident being sedated
 - 4) Named resident did not have activities for meaningful day program and community integration
 - 5) Named resident was kept in their room with blinds shut and was yelling for police
 - 6) Named resident was fed peanut butter and jelly sandwiches and ramen soup
 - 7) Named resident room and medical equipment were unsanitary
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Investigation Methods:

Sample:	Total residents: 4 Resident sample size: 4 Closed records sample size: 1
Observations:	Residents Resident rooms and medical equipment Staff to resident interactions Kitchen/Food Supply Food preparation General environment
Interviews:	Residents Family members Caregivers Hospice Staff Case Manager Provider
Record Reviews:	Medical records Hospital records Incident investigation

Investigation Summary:

- 1) Named resident (NR) was on hospice services and discharged from the home, NR did have non-injury falls and the home logged the incidents, the home coordinated fall prevention plan with hospice team and implemented fall precautions, hospice and

family were notified. The home did not have a hospice care plan in place. Failed practice was identified and a consultation was written under WAC 388-76-10355(10).

2) Interview with staff revealed incident did not occur, NR had a history of skin problem that had resolved. NR did had a skin problem that hospice was aware and had treatment in place. Unable to substantiate failed practice.

3) Named resident was on hospice services, interview and record review showed staff administered medications as ordered, NRs cognitive status fluctuated due to their medical condition. Unable to substantiate failed practice.

4) Interview and record review showed staff provided meaningful day program activities, observed staff providing meaningful day activities to sampled residents. Unable to substantiate failed practice.

5) Named resident discharged from the home, observed the home and residents rooms with adequate artificial and natural lighting, observed residents in living room areas, Interview with staff who stated they honored the residents choices. NR had a decline in medical condition and cognitive status changes, and was under hospice services. Staff responded to residents care needs. Unable to substantiate failed practice.

6) Observed home with variety of food supply in sufficient supply, observed staff preparing nutritious meal, sampled residents had no food concerns, staff reported honored residents choice. Unable to substantiate failed practice.

7) Observed residents rooms and medical equipment clean, staff reported cleaning schedule and as needed. Unable to substantiate failed practice.

Conclusion / Action:

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