STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
316 W Boone Ave., Suite 170, Spokane, WA 99201

September 11, 2018

LIBERTY DEVELOPMENT CO LLC
THE COURTYARD AT COLFAX
300 S Main St
Colfax, WA 99111

RE: THE COURTYARD AT COLFAX License #1624

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on September 10, 2018 for the deficiency or deficiencies cited in the report/s dated May 1, 2018 and found no deficiencies.

The Department staff who did the follow-up inspection:
Susan Tansy, Licensor

If you have any questions please, contact me at (509) 323-7324.

Sincerely,

Susan Bergeron, Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
316 W Boone Ave., Suite 170, Spokane, WA 99201

Statement of Deficiencies	License #: 1624	Completion Date
Plan of Correction	THE COURTYARD AT COLFAX	May 1, 2018
Page 1 of 5	Licensee: LIBERTY DEVELOPMENT CO LLC	

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 has completed data collection for the unannounced on-site full inspection on 4/26/2018, 4/27/2018, 4/30/2018 and 5/1/2018 of:
THE COURTYARD AT COLFAX
300 S. Main
Colfax, WA 99111

The following sample was selected for review during the unannounced on-site full inspection : 8 of 42 current residents and 0 former residents.

The department staff that inspected the assisted living facility:
Susan Tansy, RD, Licensor
Mara Ryan, BSW, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1, Unit B
316 W Boone Ave., Suite 170
Spokane, WA 99201
(509)323-7324

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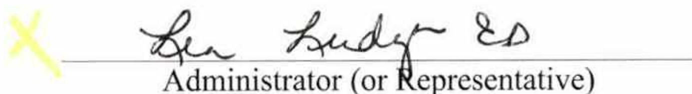
MAY 11 2018
DSHS ADSA RCS
SPOKANE WA

As a result of the on-site full inspection 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: 5/4/18

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.



Administrator (or Representative) — Date: 5-10-18

WAC 388-78A-2305 Food sanitation. The assisted living facility must:
(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:
Based on observation, record review and interview, the facility failed to manage and maintain the on-site food service in compliance with chapter 246-215 WAC related to the cleaning and sanitizing of the ice machine. This placed 42 current residents at potential risk of foodborne illness. Findings included:

Initial rounds were conducted in the kitchen on 04/26/18 at 12:56 PM accompanied by Staff G, Administrator.

Ice is defined as a food and must be handled and cared for in the same manner as food products. Maintainance of ice machines, including any parts which come in contact with water, require cleaning and sanitizing on a routine basis per manufacturers recommendations and to prevent any accumulation of scale, slime and/or mold.

A "Hoshizaki" ice machine with a storage bin was observed in use. During the time of the rounds, Staff F, Cook, stated that he was responsible for the cleaning of the ice machine. He said that every other friday he removed the ice shield from the ice storage bin and ran it through the dishmachine. In addition, the cook stated that the ice was removed from the ice storage bin and the inside of the bin was washed/sanitized with bleach water. Staff F said that he did not complete any other cleaning/sanitizing of the ice machine. He was not aware of the need to run a chemical sanitizer through the inner workings of the ice machine and had not completed that in the past year since being assigned the responsibility of cleaning the ice machine.

On 04/27/18 at 3:00 PM, staff removed the door to the working parts of the ice machine. A significant amount of brown slime/residue was observed around the water pipes and plastic parts inside the door.

Per review of the cleaning and maintenance instructions, the manufacturer recommended the water system of the ice machine to be cleaned and sanitized at least once a year and more frequently, depending on water conditions.

This is a repeat citation from Full Inspection dated 01/23/17.

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, THE COURTYARD AT COLFAX is or will be in compliance with this law and / or regulation on (Date) June 13, 2018. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

Ben Ludington E.D — Administrator (or Representative)

5-10-18 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:
(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :
(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

This requirement was not met as evidenced by:
Based on record review and interview, the facility failed to update the negotiated service agreement for one of seven sample residents (#2) related to blood sugar monitoring and insulin injections. This placed the resident at risk for not receiving needed care and services by the facility. Findings included:

1. Review of Resident #2's medical record showed she had diagnoses including [redacted] Progress Notes, dated 01/11/18 showed the resident received new physician orders for insulin injections and blood sugar monitoring. Per review of medication administration records for April 2018, the resident received an insulin injection every morning, fasting blood sugars (FBS) three times a week Monday/Wednesday/Friday and after dinner fingersticks (blood sugar) three times a week Monday/Wednesday/Friday.

During an interview with the resident on 05/01/18 at 11:15 AM, she stated that recently she had started insulin injections and finger pokes for blood sugar testing. The resident said that the facility staff completed the injections and finger pokes for her.

The resident's current negotiated service agreement (NSA), dated 03/09/18, was reviewed. The NSA did not identify the resident received daily insulin injections, administered by staff. In addition, the NSA did not show the resident had blood sugar monitoring three days per week which were also completed by staff.

During an interview on 05/01/18 at 1:00 PM, Staff G, Administrator, confirmed the resident's NSA had not been updated after the resident started insulin injections and blood sugar

monitoring in January 2018.

Plan/Attestation Statement

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[signature] 5-10-18

Administrator (or Representative) Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:
(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure training of staff and supervision occurred at least weekly for the first four weeks when the nursing task of insulin injections was delegated to caregivers for one of one sample resident (#1) and one supplemental resident (#8). This had the potential for the resident's to receive care from untrained staff. Findings included:

Nurse delegation allows for caregivers to administer insulin under the direction of a registered nurse. The nurse delegator is responsible for assessing the resident's needs, providing specific written instructions to caregivers including how/when to provide insulin, what symptoms/complications to watch for, and who to contact for concerns. The delegated caregiver is required to complete specific training prior to beginning the task.

Chapter 246-840 WAC: Practical and Registerd Nursing
WAC 246-840-930(12)(l) Criteria for delegation requires the documentation of teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every ninety days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.

1. Per review of the medical record, Resident #1 had diagnoses including [redacted] Nurse Delegation records showed Levemir insulin injections, every morning, were delegated to caregivers on 01/11/18. The record did not document teaching was done and/or a return demonstration for verification of competency. In addition, the record did not show weekly

supervisory visits were completed. The record showed the dose of insulin increased from eight units to 10 units on 02/13/18. The delegation record documented no site visit was required for the RN delegator at that time. The record showed the next supervisory visit by the RN delegator occurred on 04/05/18, 11 weeks after the insulin injections were initially delegated.

During an interview on 05/01/18 at 12:45 PM, Staff H, Caregiver, stated that he had previous experience with insulin injections at the time the resident's insulin was delegated to staff. He said that Staff I, RN delegator, watched him give an injection to make sure it was done correctly.

2. Per review of Nurse Delegation records, Resident #8 had diagnoses including [redacted] The record showed on 02/23/18, the nursing task of injecting Lantus insulin every morning was delegated to caregivers. The record did not document teaching was done and/or a return demonstration for verification of competency. In addition, the record did not show weekly supervisory visits were completed. The first registered nurse (RN) delegator visit after the insulin injections were delegated was noted 04/05/18, six weeks later.

During an interview on 05/01/18 at 1:00 PM Staff G, Administrator, confirmed weekly supervisory visits for four weeks by the RN delegator were not completed after insulin injections for Resident #1 and Resident #8 were delegated to staff.

Plan/Attestation Statement

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I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

[signature] 5-10-18

Administrator (or Representative) Date