STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 45819, Olympia, WA 98504

December 5, 2019

Highland Court Operating Company LLC
Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

RE: Highland Court Memory Care License #2378

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on December 3, 2019 for the deficiency or deficiencies cited in the report/s dated October 10, 2019 and found no deficiencies.

The Department staff who did the follow-up inspection:
Phan Pham, Nurse Surveyor

If you have any questions please, contact me at (360) 664-8421.

Sincerely,

Chris Cornell, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: Highland Court Memory Care (985892)
Intake ID(s): 3671783
License/Cert. #: AL2378
Investigator: Pham, Phan
Region/Unit: RCS Region 3/Unit D
Investigation Date(s): 10/10/2019 through 10/10/2019
Complainant Contact Date(s):

Allegations:

The facility did not administer the resident antibiotic, quality of care.

Investigation Methods:

☒ **Sample:**	Named resident and four current sampled residents.	☒ **Observations:**	Named resident, residents, resident to resident interactions, environment, staff interactions with residents, staff members providing care and services and safety measures.
☒ **Interviews:**	Named resident, residents, staff members, administrative and a member not associated with the facility.	☒ **Record Reviews:**	Sampled residents and incident reports.

Allegation Summary:

An on-site investigation was conducted and the allegation identified in the intake related to medication services, quality of care and treatment were reviewed and failed facility practice was identified. Additional residents reviewed for care, services and safety had no concerns.

Unalleged Violation(s): ☐ **Yes** ☒ **No**

Conclusion / Action:	☒ **Failed Provider Practice Identified / Citation(s) Written**	☐ **Failed Provider Practice Not Identified / No Citation Written**

The facility failed to ensure staff members administered antibiotic as ordered for one resident and also failed to ensure insulin pens were dated when they were opened.

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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.

This document references the following complaint numbers: 3671570 , 3671783 , 3672207 , 3672262
The department has completed data collection for the unannounced on-site complaint investigation on 10/10/2019 of:

Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

The following sample was selected for review during the unannounced on-site complaint investigation : 9 of 37 current residents and 0 former residents.

The department staff that inspected and investigated the assisted living facility:

Phan Pham, RN, Nurse Surveyor

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit D
PO Box 45819
Olympia, WA 98504
(360)664-8421

As a result of the on-site complaint investigation 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 I must be in compliance with all the licensing laws and regulations at all times.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.
(1) An assisted living facility providing medication service, either directly or indirectly, must:
(b) Develop and implement systems that support and promote safe medication service for each resident.
(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :
(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and
(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:
Based on observation, interview and record review, the Assisted Living Facility failed to ensure staff members administered an antibiotic as ordered for 1 of 5 current sampled residents (Resident # 1) reviewed for medication services. This failure caused harm to Resident # 1 who was admitted to the hospital with sepsis (severe infection that has spread via the blood stream). The facility also failed to ensure staff members dated the insulin when they opened the kwikpens and discarded expired insulin for four insulin dependent residents (Residents #2, #7, #8, and #9). This failure placed residents at risk for experiencing abnormal blood sugar from receiving expired insulin.

Findings included...

Keflex

Review of the resident admission record showed Resident # 1 (R#1)admitted to the facility on [redacted]/19 with diagnoses including [redacted] The service plan dated 10/10/19 showed R#1 required assistance with medication services and the facility was responsible for ensuring R#1 received medications as prescribed.

On 10/10/19 at 11:30 AM a Collateral Contact was interviewed and stated R#1 required assistance with medication administration and staff members assisted the resident. The Collateral Contact stated he usually picked up the resident's medications from the pharmacy and delivered it to the facility. He added R#1 was recently hospitalized for a lung infection.

At 1:20 PM the resident was sitting in a chair in the dining room and neatly groomed. The resident was not able to provide additional information related to medication services.

Review of the physician orders dated 09/30/19 showed an order for Keflex (antibiotic) 500 milligrams to be administered twice daily for seven days for a urinary tract infection.

Progress note dated 09/30/19 at 12:46 PM showed the Resident Care Manager (RCM) documented a new order for Keflex was received. The Collateral Contact had picked up the prescription and the first dose was to be started that day.

Resident's Medication Administration Record dated Spetember and October 2019 showed the facility did not administer the antibiotic to R#1 on 09/30/19 and 10/01/19.

Progress note dated [redacted]/19 at 9:24 PM showed staff members did not administer the first two doses of the Keflex and R#1 was found non responsive and with an elevated temperature. R#1 was transported to the hospital and admitted. The resident was diagnosed with [redacted] and a [redacted]

Review of a fax dated 10/01/19 showed the RCM notified the resident's physician that the facility did not administer the Keflex to R#1 on 9/30/19. The Collateral Contact had picked up the medication from the pharmacy and delivered to the facility on the morning of 09/30/19. R#1 had a temperature of 101 Fahrenheit on [redacted]/19 and admitted to the hospital.

On 10/10/19 at 12:30 PM Medication Tech (MT) A stated the physician's office normally faxed the residents' orders directly to the pharmacy. The pharmacy then delivers the medications and staff are to review the orders and medications to ensure they were correct. MT A stated she would contact the resident's physician if she had questions about the orders. MT A stated she had been trained by the facility Licensed Nurse and was approved to perform medication administration independently.

Insulin:

On 10/10/19 at 11:55 AM MT A was observed administering 10 units of Humalog to Resident #7 and at 12:03 PM, MT A administered 15 units of Novolog to Resident #2. Resident #2 and Resident #7 were interviewed and they were not able to provide information related to medication services.

At 12:07 PM review of the medication cart with MT A showed the following: residents had insulin pens that were opened and not dated. Resident #2 had a Novolog and a Lantus, Resident #7 had a Lantus and a Humulin, Resident #8 had a Lantus, and Resident #9 had a Lantus. The medication cart also contained a pen of Lispro insulin that had been opened without a name and was not dated after it was opened.

At 12:30 PM MT A was interviewed and stated she had been trained to date the insulin pens when she opened them. MT A stated the MTs who opened the pens were responsible for dating and reviewing the pens when administering the insulin to ensure they were not expired.

At 2:23 PM the Executive Director stated the MTs were responsible for dating the insulin pens and the insulin was good for 30 days after they had been opened. The Executive Director stated the MTs had completed the nurse delegation course, were trained to administer medications and observed for safe medication administration prior to being on the medication cart independently. The MTs were responsible for administering the medications as ordered and they had been instructed to call the Licensed Nurse if they had questions with an order or a medication. The RCM reviewed the medication cart and did monthly audits to ensure insulin pens were dated, expired medications were discarded and medications were being administered.

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, Highland Court Memory Care 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.

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.

_____ _____

Administrator (or Representative) Date