STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

This document was prepared by Residential Care Services for the Locator website.

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

RE: THE COURTYARD AT COLFAX License # 1624

Dear Administrator:

This letter addresses Compliance Determination(s) 39155 (Completion Date 05/03/2024) and 35267 (Completion Date 03/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/03/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2600-1-c, WAC 388-78A-2600-2-i, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2160

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COURTYARD AT COLFAX
License/Cert.#: 1624
Compliance Determination #: 35267
Investigator: Amy Wright
Investigation Date(s): 01/16/2024 through 03/01/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 114377
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):

[redacted] resulting in death.

Investigation Methods:

Sample:
Total residents: 46
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Executive Director
Residents
Certified Nursing Assistant
Caregivers
Alleged Victim's Representative
Director of Nursing
Maintenance Staff

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Nurse Evaluation/Baseline Assessment
Side Rail Policy
Medical Device Assessment Forms
Restraint Policy
Incident Investigation
Progress notes
Resident Death Protocol-Unexpected Death Policy
Resident POLST form
Staff training records

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Investigation Summary:

The Alleged Victim's negotiated service agreement did not indicate they used a bedrail. Interviews with staff showed the resident was not checked on by staff at the frequency noted in their service agreement. The facility failed to ensure the bedrails were maintained by staff who were knowledgeable about the use and risks of bedrails. Failed facility practice was cited under WAC 388-78A-2600 Policies and Procedures, WAC 388-78A-2160 Implementation of negotiated service agreement, and WAC 388-78A-2140 Negotiated Service Agreement Contents.

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1624	Compliance Determination # 35267
Plan of Correction	THE COURTYARD AT COLFAX	Completion Date
Page 1 of 7	Licensee: LIBERTY DEVELOPMENT CO LLC	03/01/2024

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 01/16/2024, 01/16/2024 and 01/16/2024 of:

THE COURTYARD AT COLFAX
300 S Main St
Colfax, WA 99111

This document references the following complaint number(s): 114377

The following sample was selected for review during the unannounced on-site visit: 2 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S.M. (signature) — Residential Care Services

03/13/2024 — 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.

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Administrator (or Representative) Jennifer Broeckel Date 03/18/24

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:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop and implement a policy that defined the manner and frequency of staff monitoring for 3 of 3 residents (Resident 1, Resident 2, and Resident 3) who used medical devices with known safety risks. The facility's policy failed to identify which staff were responsible for monitoring residents with medical devices, the frequency of bedrail checks, and how to assess the resident's ability to safely use the device. These failures resulted in Resident 1 becoming [redacted], contributed to Resident 1's death by inadequately addressing in a policy, the measures that should be taken to prevent entrapment or death for residents who used bedrails and placed all residents who used bedrails at increased risk for entrapment or death.

Findings included...

The facility's policy, titled, "5.16 Side Rails"," dated 01/16/2023, stated that staff were to determine if the side rails in use were safe. The policy showed that "safe" implied that the side rails were installed securely and maintained in good operating condition. The policy showed that the space between the side of a resident's mattress and the side of their bedrail was not to exceed 4.75 inches, in order to reduce the risk of entrapment. Further review of the policy showed that it failed to indicate which staff were responsible for determining the safety of the side rails, how the staff were to determine their safety, or how frequently the side rails' safety was to be determined.

Review of a facility investigation, dated 01/16/2024, showed that on [redacted]/2024,

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Resident 1 was found deceased in their bed after [redacted].
The investigation showed that the coroner believed the resident's death was caused by [redacted] [redacted].

In an interview on 01/16/2024 at 12:39 PM, Staff A, Executive Director, stated that bedrails were not routinely checked on by maintenance.

An observation of Resident 2's bedrail on 01/16/2024 at 1:18 PM, showed a sticker on the side stating, "Incorrect mounting may cause injury or death." Further observation of the bedrail knob showed that when turned, the bedrail was brought closer to the bed, minimizing the gap between the mattress and the bedrail.

In an interview on 01/16/2024 at 1:58 PM, Staff B, Certified Nursing Assistant, stated the facility bedrails had not routinely been checked for function. Staff B stated they had worked at the facility for three years and had never received specific training on bedrail use and did not check bedrails routinely.

In an interview on 01/16/2024 at 2:07 PM, Resident 3 stated that Staff F, Maintenance Staff, installed the bedrail on their bed.

An observation of Resident 3's bedrail on 01/16/2024 at 2:08 PM, showed it had been installed so the end of the bedrail at the head of the bed extended well beyond the mattress toward the wall, and did not appear to be installed correctly.

In an interview on 01/16/2024 at 2:42 PM, Staff A stated that facility bedrails were not routinely tightened. Staff A stated that staff were trained on bedrail use individually by other caregivers during floor orientation, though the facility had no formal bedrail education.

In an interview on 02/15/2024 at 9:48 AM, Staff C, Caregiver, stated they were unsure if maintenance routinely checked on the residents' bedrails. Staff C stated they had never received facility training on bedrail use or the risks of using them. Staff C stated that residents tried to remove their bedrails themselves at times, especially if staff left them in the wrong position. Staff C further stated that it was impossible to eliminate the gaps between bedrails and mattresses.

In an interview on 02/16/2024 at 2:30 PM, Staff D, Advanced Caregiver, stated that when they found Resident 1 the day of their death, their bottom and legs were swung off the side of the bed, their head and left shoulder were on the bed, their left arm was above their head and stuck in between the vertical bars on the bedrail, their ribs and hips were between the mattress and the bedrail, and their right arm was stuck between their chest and the bedrail. Staff D stated that the bedrail appeared to be pressing into Resident 1's sternum. Staff D stated they had not made a point to check the residents' bedrails when

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providing them care, and that they didn't think maintenance or anyone else routinely checked on the function or safety of the bedrails in the facility either. Staff D further stated that they remembered Resident 1's bedrail being loose one time, and that it may have been further away from the bed than it should have been. Staff D stated they hadn't reported it to anyone because it had not been loose enough to report. Staff D stated they had worked at the facility for seven years and they were unsure if training on bedrail use was part of the facility's education. Staff D was unable to recall if the facility ever educated them on the risks of bedrail use, and they were unable to recall how to tighten facility bedrails.

In an interview on 02/20/2024 at 9:06 AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1's bedrail had been loose about a month before the resident died, and that they saw gaps between Resident 1's mattress and bedrail when the bedrail was loose. CC1 stated they were unaware if routine bedrail checks were being done by the facility.

In an interview on 02/20/2024 at 9:56 AM, Staff E, Director of Nursing, stated that no one at the facility had been checking on the bedrails aside from during the annual assessments. Staff E stated that bedrails and other durable medical equipment were items that were used daily. Staff E stated there was a gap of four to six inches between the side of Resident 1's mattress and the side of their bedrail.

In an interview of 02/20/2024 at 4:32 PM, Staff F, Maintenance Staff, stated they had worked at the facility for about 16 years and had never received facility training on bedrail installation. Staff F stated they did not check bedrail function for safety due to their understanding that the bedrails needs to checked by someone more qualified.

In an interview on 03/01/2024 at 9:52 AM, Staff A stated that bedrail checks were only documented annually. Staff A stated that devices were to function per manufacturer directions. Staff A further stated they did not have the manufacturer directions.

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) 03/18/2024.

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

Jennifer Broeckel
Administrator (or Representative) Date 3/18/24

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WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that medical devices identified as an assessed resident need were included in the resident's negotiated service agreement for 1 of 3 residents (Resident 1), reviewed for medical device use. This failure contributed to the death of Resident 1 as facility staff were not instructed on medical device usage, frequency of medical device checks, and safety risks associated with bedrail use and placed residents who used medical devices at increased risk for injury or death.

Findings included...

In an interview on 01/16/2024 at 12:39 PM, Staff A, Executive Director, stated that on [redacted]/2024, Resident 1 was found deceased after [redacted]

Review of Resident 1's medical device assessment form, dated 12/14/2023 and completed by Staff E, Director of Nursing, showed that bilateral bedrails were recommended for the resident.

In an interview on 02/15/2024 at 9:48 AM, Staff C, Caregiver, stated that Resident 1 had a bedrail on at least one side of their bed.

In an interview on 02/16/2024 at 2:30 PM, Staff D, Advanced Caregiver, stated that Resident 1 had a bedrail on the left side of their bed.

In an interview on 02/20/2024 at 9:06 AM, Collateral Contact 1 (CC1) stated that Resident 1 had an alternating airflow mattress and that it had been somewhat "unstable".

Review of Resident 1's negotiated service agreement (NSA), last updated 12/08/2023, showed that neither bedrails nor an air mattress were listed as medical devices that the resident used. Further review of the NSA showed no instructions for monitoring the resident with bedrails, the frequency of bedrail checks or how to assess the safety of the resident using bedrails.

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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) 03/18/2024.

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

[signature] 03/18/24

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide resident checks at the frequency indicated by the negotiated service agreement for 1 of 3 residents (Resident 1) reviewed for supervision by staff. This facility failure contributed to the death of Resident 1 and placed residents at increased risk for harm or injury due to a lack of supervision by staff.

Findings included:

Review of Resident 1's assessment, dated 12/07/2023, showed that Resident 1 was diagnosed with [redacted] and [redacted] Further review of the assessment showed that staff were to check on Resident 1 every two hours at night.

Review of Resident 1's negotiated service agreement (NSA), last updated 12/08/2023, showed that Resident 1 was to be checked every two hours, including at night, though staff did not need to wake them up. Further review of the NSA showed that Resident 1 had difficulty calling for help at times.

In an interview on 01/16/2024 at 12:39 PM, Staff A, Executive Director, stated that Resident 1 passed away on [redacted]/2024 after [redacted]

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[redacted]. Staff A stated that Staff C, Caregiver, checked on Resident 1 at about 2:00 AM the morning before they died. Staff A stated that Resident 1 was not found deceased until about 7:20 AM, when Staff D, Advanced Caregiver, came around to do morning cares.

Review of a facility investigation, dated 01/16/2024, showed that, "[Resident 1] had last been checked on at 2:00 AM even though [Resident 1] was scheduled for overnight checks." Further review of the investigation showed that the coroner approximated Resident 1's time of death as being 3:00 AM.

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) 03/18/2024.

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

[signature] 03/18/24
Administrator (or Representative) Date

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