STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

VILLAGE GREEN OF FEDERAL WAY, A RET
VILLAGE GREEN RETIREMENT CAMPUS
35419 1ST AVE S
FEDERAL WAY, WA 98003

RE: VILLAGE GREEN RETIREMENT CAMPUS License # 1159

Dear Administrator:

This letter addresses Compliance Determination(s) 25003 (Completion Date 06/07/2023) and 21402 (Completion Date 03/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/07/2023 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-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2320-2-b, WAC 388-78A-2320-3-a, WAC 388-78A-2320-3-c

The Department staff who did the on-site verification:
Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

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Statement of Deficiencies	License #: 1159	Compliance Determination # 21402
Plan of Correction	VILLAGE GREEN RETIREMENT CAMPUS	Completion Date
Page 1 of 3	Licensee: VILLAGE GREEN OF FEDERAL WAY, A	03/27/2023

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 the unannounced on-site full inspection on 03/13/2023 and 03/16/2023 of:
VILLAGE GREEN RETIREMENT CAMPUS
35419 1ST AVE S
FEDERAL WAY, WA 98003

The following sample was selected for review during the unannounced on-site visit: 9 of 32 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Residential Care Services

03-31-2023
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.

DSHS/ALTSA
Residential Care Services
APR 10 2023
Received

Administrator (or Representative)

4/3/23
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:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(a) Chapter 18.79 RCW, Nursing care;

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 10 of 10 residents (Resident 1, Resident 3, Resident 4, Resident 8, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, and Resident 16) received medication assistance from staff who were delegated and monitored through the required nurse delegation process. The facility also failed to obtain written consent for 6 of 10 residents (Resident 4, Resident 8, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, and Resident 16) for nurse delegation. These failures placed the residents at risk for medication errors and injury due to medication assistance provided by undelegated staff.

Findings included...

Review of the Washington Administrative Code (WAC) 246-840-930 showed there were guidelines and requirement for nurse delegation services in community-based settings. Subsection 10 (b) showed that written consent for nurse delegation must be obtained. Subsection 12 (b, e, f, g, h, i, j, and k) specified the type of information to be maintained in resident records related to delegation. Subsection 19 specified delegation of insulin injections required at least weekly supervision for the first four weeks and then at least every 90 days after.

Record review of facility records for Resident 4, Resident 8, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, and Resident 16 showed no signed consent for nurse delegation. Review of Resident 3 and Resident 10's delegation records showed no

documentation that there were weekly nurse visits in the first four weeks after staff were delegated for insulin injection assistance. Further review showed the task sheets failed to provide resident specific instructions for the administration of insulin. Additional review of Resident 3 and Resident 10's nurse delegation records showed no documentation that the 12 previously delegated completed the initial caregiver delegation and initial insulin delegation training by the nurse delegator.

During an interview on 03/15/2023 at 1:39 PM, Staff J stated that they last worked as a Registered Nurse – Delegator (RND) in 2019. Staff J stated that on 11/01/2022, they assumed the nurse delegation duties and responsibilities at the facility. Staff J stated that they were unaware that the nurse delegation documentation for residents who received nurse delegation services needed to be maintained at the facility. Staff J also stated that they were unaware the facility had a "Nurse Delegation" book which contained documentation specific to residents that required medication assistance from staff. Staff J reported that they took over the nurse delegation responsibilities, they did not review the facility's nurse delegation documentation.

During an interview on 03/15/2023 at 1:50 PM, Staff J stated that they did not meet individually with the delegated staff to ensure staff understood the required tasks when delegated. Staff J also said they did not verify the competency of the delegated staff. Staff J further stated that they had failed to document nurse delegation task information that included or contained the following resident specific elements: the task was specific to one resident, the condition or purpose requiring delegation, a clear description of the procedure or steps of the task, predictable outcomes and how to deal with them, risks, interactions of prescribed medications, how to observe and report side effects, complications or unexpected outcomes and how to deal with them, and the documentation of teaching done and return demonstration or how competency was verified Staff J also stated that they did not document the four, weekly on-site visits of their direct observation for staff delegated to administer Resident 3 and Resident 10's insulin.

During an interview on 03/14/2023 at 3:15 PM, Staff B, Director of Nursing, stated that Staff J was last in the facility on 02/15/2023. Staff B stated that did not return to the facility to assess, supervise, or evaluate the delegated staff.

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, VILLAGE GREEN RETIREMENT CAMPUS is or will be in compliance with this law and / or regulation on (Date) 4/30/23.

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

4/3/23

Administrator (or Representative) Date