STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 VAN GIESEN ST
RICHLAND, WA 99352

RE: GUARDIAN ANGEL HOMES (THE COTTAGE) License # 1513

Dear Administrator:

This letter addresses Compliance Determination(s) 33283 (Completion Date 12/04/2023) and 30190 (Completion Date 10/12/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/04/2023 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-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2462-3-a, WAC 388-78A-3100-2

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GUARDIAN ANGEL HOMES (THE COTTAGE)
License/Cert.#: 1513
Compliance Determination #: 30190
Investigator: Anna Cairns
Provider Type: Assisted Living Facility
Intake ID: 101500
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/28/2023 through 10/12/2023
Complainant Contact Date(s):

Allegation(s):

1.A non-resident causing disruption to the residents.
2.Staff do not have access to the database that shows care plans for residents that they care for.
3. Staff are being left alone for an entire shift, to care for all residents in their assigned house.
4. There has been resident to resident altercation and neglect by staff that has not been reported.
5. A resident's family member who visits is watching offensive scenes on the television which other residents in the house do not want to watch.
6. A staff person who was hired to be a caregiver was neglecting residents and was moved to float position.
7. Staff providing education do not meet minimum qualifications.

Investigation Methods:

Sample:
Total residents: 70
Resident sample size: 6
Closed records sample size: 0

Observations:
Staff to resident interactions
Resident to resident interactions
Resident rooms
Dining
Residents
Activities
Kitchen
Safety
Cleanliness of residents and environment

Interviews:
Administrator
Residents
Family members
Identified resident

Record Reviews:
Facility policies
Personnel files
Staff training records

Staff patterns
Resident records
Call light response log
Drug and alcohol policy
Oxygen safety policy
Background checks
Administrator qualifications

Investigation Summary:

1.Interview and Record review showed that there were Washington state name and background checks that were expired. Failed practice identified. WAC 388-78A-2462 (3)(a).
2. Staff training included access to Negotiated Service Agreements (NSAs). Record review showed that NSA's for sampled residents did not include required information. Failed practice identified. WAC 388-78A-2140 (2)(a)(b).
3. On-site visit and observation showed that staffing levels were adequate. Record review of staffing schedule showed appropriate staff levels for each shift. No failed practice identified.
4. The facility intervened and provided interventions to protect both residents.
5. Interviews and observations showed there was not inappropriate content that was being shown to residents. No failed practice identified.
6. Record review, observation and interview showed staff to resident interactions were respectful. Residents reported no concerns of staff treatment. The named staff member accused is no longer working at the facility. Interviews showed there had not been any complaints about that staff member neglecting or abusing residents. No failed practice identified.
7. Record review showed staff providing training met requirements. No failed practice identified.
Unalleged intake: onsite visit observation showed unsecured oxygen tanks in the hallway and one unsecured tank in a resident room Failed practice identified. WAC 388-78A-3100 (2)
Reference statement of deficiencies dated 10/12/2023 .

Conclusion / Action:

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

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Statement of Deficiencies	License #: 1513	Compliance Determination # 30190
Plan of Correction	GUARDIAN ANGEL HOMES (THE COTTAGE)	Completion Date
Page 1 of 6	Licensee: CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC	10/12/2023

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 an unannounced on-site complaint investigation on 09/28/2023 and 10/10/2023 of:

GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

This document references the following complaint number(s): 99352, 98779, 101500

The following sample was selected for review during the unannounced on-site visit: 6 of 70 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

10/20/2023
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.

Administrator (or Representative) 10/27/2023 Date

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:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure Negotiated Service Agreements (NSAs) were developed with a documented plan to provide clearly defined roles and responsibilities to meet the assessed needs for 3 of 6 Residents (4, 5, 6) who received hospice services. This failure placed the residents at risk of unmet needs and complications of their chronic health conditions.

Findings included...

Resident 4

Record review of hospice notes dated 10/10/2023 showed that hospice services started on 02/16/2022.

Record review of Resident 4's NSA dated 07/11/2023 showed that the resident had diagnoses which included [redacted] and [redacted] Additionally, the NSA did not address provided hospice services and direction for facility staff.

In an interview on 10/10/2023 at 9:21 AM with Collateral Contact 6 (CC6) they stated that they had been notified by hospice staff of the resident's change of condition.

Resident 5

Record review of hospice notes dated 10/11/2023 showed that hospice services were active on 06/13/2023.

Record review of Resident 5's NSA dated 07/11/2023 showed that the resident had diagnoses which included [redacted] and [redacted] The NSA did not show that Resident 5 received hospice and did not address provided hospice services, including direction for facility staff.

In an interview on 10/10/2023 at 9:30 AM with Collateral Contact 6 (CC6) they stated that their family member began hospice services a few months ago.

Resident 6

Record review of progress notes for September and October 2023 showed six entries that the facility had made, communicating with hospice for a change in condition for Resident 6.

Resident 6's NSA dated 10/05/2023 showed that the resident had diagnoses which included [redacted] and [redacted] The NSA did not show that Resident 6 received hospice and did not address provided hospice services, including direction for facility staff.

In an interview on 10/12/2023 at 1:20 PM with Staff G, Licensed Nurse, stated that Resident 6 had received hospice services and ended last week. They stated that hospice services ended after the most recent NSA dated 10/05/2023. Additionally, they stated the most recent NSA was not updated to reflect end of hospice services.

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date) 10/27/2023.

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

[redacted] 10/27/2023

Administrator (or Representative) Date

WAC 388-78A-2462 Background checks Who is required to have.

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(a) Volunteers who are not residents, and students who may have unsupervised access to residents;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a valid Washington State name and date of birth background check was submitted every two years for 2 of 9 non-residents living at the ALF. This failure left non-residents with unsupervised access to ALF residents.

Findings included...

Record review of Washington state name and date of birth background checks on 10/10/2023 at 9:50 AM with Staff B, Assistant Administrator (AA). They stated the administrative office were responsible for maintaining background checks for all non-residents living at the facility every two years.

Record review for Collateral Contact 4 (CC4) showed that their Washington state name and date of birth background check result dated 06/11/2019, expired on 06/11/2021. CC4's file did not show that a Washington State name and date of birth background check result was maintained every two years as required.

Record review for Collateral Contact 5 (CC5) showed that their Washington state name and date of birth background check result dated 08/27/2018, expired on 08/27/2020. CC5's file did not show that a Washington State name and date of birth background check result was maintained every two years as required.

On 10/10/2023 at 11:30 AM, Staff A, Administrator and Staff B, acknowledged that background checks were expired for non-resident individuals. They stated they needed to implement a system to track and ensure background checks for were completed every two years.

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date) 10/27/2023 .

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Administrator (or Representative) 10/27/2023 Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure safe storage of oxygen tanks for 1 of 1 resident (Resident 5) who utilized therapeutic oxygen. This failure placed the resident, other residents, visitors, and staff at risk of serious injury.

Findings included...

Review of "Oxygen Policy and Procedure" undated, showed that "Tanks must be secured safely at all times i.e., either on a cart holder, wheelchair holder, or to the wall."

During an observation on 10/09/2023 at 5:21 PM, a portable oxygen tank was standing unsecured to the right of the entryway into the resident room. Resident 5 was observed to be receiving oxygen via a concentrator machine.

In an observation on 10/09/2023 at 5:25 PM showed that outside the resident's room were five small portable oxygen tanks and two larger portable oxygen tanks, near the wall. None of the oxygen tanks were secured.

On 10/09/2023 at 6:00 PM Staff F, Personal Care Aide, stated they had only worked at the ALF for one month. Staff F stated they were shown how to manage resident's oxygen. They stated they did not receive training on safe storage.

On 10/09/2023 at 6:05 PM Staff E, Personal Care Aide, stated that they were familiar with the resident and routinely provided care including management of oxygen. Staff E stated that the oxygen tanks "used to come in a crate" and that the oxygen supplier, several months ago, took the crate with the empty oxygen tanks and did not return it. They stated that the tanks were stored in the resident's room. Staff E stated that attempts were made to place them out of the way, against a wall in the resident's room. Further, the oxygen tanks that were observed in the hallway were there waiting for the supplier to remove and replace with filled tanks. Staff E stated they were not aware and had not received training

of handling and safe storage of oxygen.

On 10/09/2023 at 6:19 PM, Staff A, Administrator, stated that they were not familiar with safe storage and handling of oxygen tanks. Staff A observed the placement of the filled oxygen tank in the room and acknowledged it was not secured and it was placed in an area of the entry to the room where it could easily be knocked over.

On 10/09/2023 at 6:37 PM, Staff A, secured the tanks in a wire oxygen holding unit. Staff A stated they were unsure where to place the filled and empty tanks of oxygen and would be seeking more information from the oxygen supplier on safe storage.

During an interview on 10/12/2023 with Collateral Contact 3 (CC3), oxygen supply representative stated that their company provided oxygen tanks for Resident 5's supply needs. They stated that all oxygen tanks should be secured in approved devices. CC3 stated that unsecured oxygen tanks created a risk of the tank falling over, potentially causing the top valve to bust off. If this were to occur, the tank would be like "a missile" due to the rapid release of pressure and could cause significant damage and potential injuries if an individual were struck by the tank.

On 10/10/2023 at 11:55 AM, Staff A acknowledged the failure to store oxygen tanks per their oxygen policy guidelines, which placed the residents, staff and visitors at risk of injury.

Plan/Attestation Statement

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

[signature] 10|27|2023

Administrator (or Representative) Date