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 99354

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

Dear Administrator:

This letter addresses Compliance Determination(s) 44462 (Completion Date 07/23/2024) and 42779 (Completion Date 06/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/23/2024 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-2930-1-b-i

The Department staff who did the on-site verification:
Elaine Lopez, Licensor

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit G
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: GUARDIAN ANGEL HOMES (THE COTTAGE)
License/Cert.#: 1513
Compliance Determination #: 42779
Investigator: Melissa Milanez
Investigation Date(s): 06/17/2024 through 06/25/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 132832
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Fall with a fracture.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Resident to resident interactions Call light system Call light response times
Interviews:	Nursing staff Residents Family members Maintenance staff
Record Reviews:	State reporting log Incident investigation Facility policies Staff patterns

Investigation Summary:
Interviews and record review showed that an identified resident had an unwitnessed fall that resulted in rib fractures. Interview with the identified resident showed that they were unable to call for assistance after the fall. Interviews with staff showed that the call light system was not utilized in the memory care unit due to residents not being able to operate it effectively. Failed practice identified. WAC 388-78A-2930(1) (b)(i)

Conclusion / Action:

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

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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.

The department completed data collection for an unannounced on-site complaint investigation on 06/17/2024 and 06/17/2024 of:

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

This document references the following complaint number(s): 132559, 132832, 133565

The following sample was selected for review during the unannounced on-site visit: 6 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

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.

Michelle Closner
Residential Care Services

06/27/2024
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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Miller
Administrator (or Representative)

07/02/2024
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure that the communication system worked consistently and performed reliably for 3 of 6 residents (Residents 1, 2 and 3). This failure resulted in the communication system not functioning and placed residents at risk of their health, safety, and care needs not being met.

Findings included...

Resident 1

Record review showed Resident 1 was admitted to the facility on [redacted]/2021 with diagnosis of [redacted] and required one person assistance with transfers due to high fall risk.

In an interview on 06/17/2024 at 1:58 PM, Resident 1 stated they sustained a fall and was not able to call for help while on the floor. Resident 1 stated they did not think the call button worked since the staff did not come when they pushed it.

On 06/17/2024 at 2:07 PM, Resident 1 pressed the call button with the department licensor present. Staff did not respond.

In an interview on 06/17/2024 at 2:17 PM, Staff A, Caregiver, stated that they were not aware that Resident 1 had pressed their call light. Staff A stated that most residents in memory care are not able to use the call light, so they don't carry the phone.

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Observation on 06/17/2024 at 2:18 PM, Staff B, an unidentified staff walked over to a kitchen drawer and pulled out the phone. The phone was not charged and was off.

In an interview on 06/17/2024 at 2:20 PM, Staff C, Caregiver, stated usually there is a phone that they carry around or leave on the medication cart. The phone is used to notify staff when a call light is pressed and when a resident needs assistance. Staff C stated that they had worked in the memory care unit for over a month and had not seen the phone.

Resident 2

Record review showed Resident 2 was admitted to the facility on [redacted]/2024 with diagnosis of [redacted], [redacted], [redacted] and [redacted]. Resident 2 required one person assistance with transfers and all cares due to high fall risk.

In an interview on 06/17/2024 at 2:37 PM, Resident 2 stated they pressed their call button/pendent the other day and staff took a long time to come.

On 06/17/2024 at 2:39 PM, Resident 2 pressed their pendent with the department licensor present. Resident 2 also pressed their pull cord button at 2:45 PM with the department licensor present. Staff did not show up for 15 minutes.

In an interview on 06/17/2024 at 2:57 PM, Staff D, Medication Technician (MT), stated that the communication system did not show the resident had called for assistance.

Resident 3

Record review showed Resident 3 was admitted to the facility on [redacted]/2022 with diagnosis of [redacted], [redacted], [redacted], and [redacted]. Resident 3 required one person assistance with transfers and all cares sue to high fall risk.

In an interview on 06/17/2024 at 3:49 PM, Resident 3 stated they pressed their call button/pendent, and staff took a "very long time" to come. Resident 3 stated that there had been times where they had to wait over 30 minutes for staff to respond. Resident 3 also stated that they have had the urge to have a bowel movement and has had accidents due to waiting a long time to receive assistance from staff.

In an interview on 06/17/2024 at 3:26 PM, Staff E, Caregiver, stated Resident 3's pendent

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had not been reset and was on for 7 hours and 2 minutes. Staff E stated that if Resident 3 attempted to push the pendant again, they would not be able to receive an alert due to the pendent not being reset. Caregiver E also stated that sometimes the phones would lose connection.

In an interview on 06/24/2024 at 4:19 PM, Collateral Contact 1 (CC1), Resident Representative, stated that they had concerns regarding the delay in responding to call lights. CC1 stated they had brought up the concerns to staff and have been told that staff often forgot to reset with pendent, or that staff only have one magnet available to reset the pendants, and that at times the magnet is not available. CC1 stated this has been a long-term issue.

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) 07/02/2024 .

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

Administrator (or Representative) — Date: 07/02/2024

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