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) 52005 (Completion Date 12/26/2024) and 49474 (Completion Date 11/07/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/26/2024 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-2160

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, 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 #: 49474
Investigator: Melissa Milanez
Investigation Date(s): 10/30/2024 through 11/07/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 150997
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Resident fall with injury.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Outside secured courtyard
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
Observations, interviews and record review showed that the facility did not provide the care and services as agreed upon in the Negotiated Service Agreement (NSA). Failed practice identified. See the Statement of Deficiency dated 11/07/2024 for

implementation of negotiated service agreement, Washington Administrative Code WAC 388-78a-2160.
Observations showed uneven walkways for residents. The facility was aware of safety issues and have started making repairs. Failed practice identified. Consultation was written for WAC 388-78a-2138 (2)(iv)

Conclusion / Action:

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

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License #: 1513 Compliance Determination # 49474
GUARDIAN ANGEL HOMES (THE COTTAGE) Completion Date
Licensee: CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC 11/07/2024

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 10/30/2024 and 10/30/2024 of:

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

This document references the following complaint number(s): 150997, 150444, 153690, 154028

The following sample was selected for review during the unannounced on-site visit: 4 of 67 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.

Laura Williams-Davis
Residential Care Services

11/20/24
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.

Miller
Administrator (or Representative)

11/26/2024
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.

MM 11/26/24

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide the care and services as agreed upon in the negotiated service agreement for 1 of 4 residents (Resident 1). This failure resulted in the resident being unsupervised outdoors after a fall for an extended period of time and placed residents who required supervision at risk of injury and unmet care needs.

Findings included...

Review of the facility's undated disclosure of services, showed the facility's exit doors, excluding main entrances, due to the nature of the care, were delayed egress and if an individual exited out of one of those doors an alarm would sound. The disclosure showed that the doors unlocked upon actuation of the automatic fire detection system or loss of power. The disclosure showed the lock would be deactivated by a keypad code in place that allowed residents to exit.

Review of the facility's undated policy titled, "Negotiated Service Agreement," showed "individual resident service plans are developed through the evaluation process or other identified systems and provide information about resident needs to the care associates. Service assessment tool will be used to evaluate and implement current resident needs."

Review of the facility's undated policy titled, " Dementia Care Homes Policy," showed that staff shall be present at all times to provide care and to supervise residents as cutlined in state regulations and that sufficient staff shall be retained to monitor and care for residents as well as utilizing the wander guard system or similar system to alert staff when a resident exits the community or enclosed outside area.

Resident 1

Review of Resident 1's admission record dated 10/30/2024, showed that the resident

moved into the facility on [redacted]/2017 with multiple medical diagnoses that included [redacted]).

Review of Resident 1's assessment and Negotiated Service Agreement (NSA), dated 08/21/2024, showed that the resident resided in the memory care unit, had memory impairments, a history of exit seeking and wandering that required redirection from staff. The NSA also showed that the resident had a history of falls, required a bed alarm for safety, was unable to leave the facility unsupervised and staff were required to do routine safety checks throughout the day and night.

Review of Resident 1's change in condition assessment and NSA, dated 10/21/2024, showed that the resident was to have a bed alarm and chair alarm (triggers an alert when a resident attempts to get out of bed or chair without assistance, enabling staff to intervene) on at all times for safety.

Review of the facility's "incident log," dated 10/11/2024, showed on 10/11/2024, Resident 1 was found lying outside with their back on a slope, and their head leaned back on a bed of rocks. The incident log showed that staff assisted the resident up and the resident was found with a golf ball size lump to the posterior portion of their head.

Review of Resident 1's progress note, dated 10/21/2024 at 10:22 AM, showed the resident was found by the hospice nurse on one occasion (after the fall incident) in another resident's room. The progress note showed that no bed or chair alarm had been activated. The progress notes further showed that Resident 1's wheelchair and walker were found in the living room away from the resident.

Observation on 10/30/2024 at 11:25 AM, showed Resident 1 laid on the couch in the living room area with their wheelchair beside them. Further observation showed that Resident 1 did not have their pressure alarm underneath them or in their wheelchair.

Interview on 10/30/2024 at 11:33 AM, Staff A, Caregiver, stated that Resident 1 used a wheelchair for mobility, was unsteady on their feet, and required a one person stand by assist with walking short distances. Staff A stated that the resident was to always have a pressure alarm to both the bed and chair to help prevent falls and was not sure why the resident did not have the alarm on that day. Staff A also stated that Resident 1 was a high fall risk, an exit seeker and liked to wander. Staff A stated they were present on the day that Resident 1 had a fall outside. Staff A stated that Resident 1 was not to be outside unsupervised, and that staff needed to always keep an eye on them due to the high fall risk. Staff A stated that there should have been a "dinging sound" when the courtyard door opened to notify staff that there were residents going outside. Staff A stated that all residents in the memory care unit should be checked on hourly and accounted for at the change of shift.

In an interview on 10/30/2024 at 12:04 PM, Collateral Contact 1 (CC1), stated they did

not recall seeing Resident 1 in the house on 10/11/2024 (day of incident). CC1 stated they entered the house at noon and began to assist residents for lunch. CC1 stated that Resident 1 was not present for lunch time. CC1 also stated that they completed rounds at 1:00 PM (a check that is done on all residents) and did not remember seeing Resident 1. CC1 stated that they thought Resident 1 had left on a bus ride.

In an interview on 10/30/2024 at 12:58 PM, Staff B, Nurse, stated that staff were required to do a head count of residents before shift change and two-hour safety checks, but acknowledged that this did not happen. Staff B also stated that the exit door to the secured courtyard should have alarmed to alert staff that someone was coming in or out of the door. Staff B stated Resident 1 was found unsupervised outside without any mobility devices at 3:15 PM, lying with their body on a patch of grass and their head was in the rock bed near the fence. After their investigation, Staff B indicated that the resident could have been outside for about four hours unsupervised. Staff B stated that it was noted in the care plan that Resident 1 was a high fall risk, was not to be outside unsupervised, needed to have a pressure alarm while in bed, and required safety checks. Staff B acknowledged this did not happen

This is a recurring deficiency previously cited on 07/18/2023.

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) 12/10/24

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

Administrator (or Representative) — Date 11/26/24

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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) # 1513

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 11/07/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Laura Williams-Davis, Field Manager
Residential Care Services

Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in (e) of this subsection, the facility must provide an outdoor area for residents that:

(iv) Has walking surfaces that are firm, slip-resistant and free from abrupt changes, and suitable for individuals using wheelchairs and walkers;

The Assisted Living Facility failed to provide safe outdoor paths, that were firm, slip resistant and free from abrupt edges. The facility was aware of the safety issues and had started working on making repairs.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration

Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

WAC 388-78A2160

STEP ONE; How the facility will protect the other residents for each numbered resident.
-Dead bolt doors will be installed to the exterior doors in the resident's room.
-Staff education regarding NSA's-specifically resident safety and who needs to be monitored outside. The nursing team is working on the verbiage of the care plans.

STEP TWO; how the facility will protect other residents in similar situations.
-Snapshot report from NSA posted in the resident's rooms on the inside of the closet.
-Educate all houses about the safety of the residents and who can be outside unattended.
-Deadbolt locks on all resident exterior doors that lead to the courtyard.

STEP THREE; Measures the facility will take or the systems it will change to ensure the problem does not recur.
-Caregiver education to all houses.

STEP FOUR; How the facility plans to monitor its ongoing performance to sustain compliance.
-The maintenance team will do weekly checks on all egress doors to ensure they are functioning properly.

STEP FIVE; Dates corrective action will be completed
12-10-2024