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

FARRINGTON COURT (WAKFC) LLC
FARRINGTON COURT RETIREMENT COMMUNITY
516 Kenosia Ave S
Kent, WA 98030

RE: FARRINGTON COURT RETIREMENT COMMUNITY License # 2145

Dear Administrator:

This letter addresses Compliance Determination(s) 51670 (Completion Date 12/12/2024) and 48289 (Completion Date 10/17/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/12/2024 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-2270-1, WAC 388-78A-2300-2-a, WAC 388-78A-2300-2-a-i, WAC 388-78A-2300-2-a-ii, WAC 388-78A-2300-2-a-iii, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-2320-3, WAC 388-78A-2320-3-a, WAC 388-78A-2320-3-b, WAC 388-78A-2320-3-c, WAC 388-78A-2320-3-d, WAC 388-78A-2320-3-e, WAC 388-78A-2450-2-e, WAC 388-78A-2450-2-i-i, WAC 246-980-030-1-b, WAC 246-980-030-1-a, WAC 246-980-030-1, WAC 246-980-030-2, WAC 246-980-030, WAC 388-78A-2510, WAC 388-112A-0495-4, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2700-1-a

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Kathy Young, Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley

Kimberley Ripley, Field Manager

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

Region 2, Unit D
Residential Care Services

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

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

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 10/07/2024 and 10/10/2024 of:
FARRINGTON COURT RETIREMENT COMMUNITY
516 Kenosia Ave S
Kent, WA 98030

The following sample was selected for review during the unannounced on-site visit: 10 of 31 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, Licensor

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.

Laurie Anderson
Residential Care Services

10/28/2024
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.

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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516 Kenosia Ave S
Kent, WA 98030

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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 _____ 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.

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

Administrator (or Representative)

11/06/2024
Date

WAC 388-78A-2270 Resident controlled medications.

(1) The assisted living facility must ensure all medications are stored in a manner that prevents each resident from gaining access to another resident's medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 residents, (Resident 6, Resident 9, and Resident 10) kept all their resident-controlled medications in a locked location. This failure placed all 31 residents at risk of compromised health if they accessed and ingested medications prescribed for other residents.

Findings included...

Review of the facility's policy titled, "Medication Policy", dated 05/29/2024, showed if a resident self-administered their medications, they must have a secure location for medication storage, which must be locked from other resident access.

Review of Resident 6's record, showed the facility approved Resident 6 for independent medication administration. Review of Resident 6's progress note, dated 08/14/2024, showed Resident 6 misplaced some medications within their apartment. The progress notes showed Staff H, Licensed Practical Nurse (LPN), located the medications in the apartment, in various unlocked locations.

Observation of Resident 6's apartment on 10/07/2024 at 1:25 PM, showed medications were seen on the floor, the end table, and the kitchen counter. The medications were in weekly AM/PM pill organizers, bubble packs (an entire week's worth of medications sorted into a single dosing periods), and pill bottles. Observation showed a lockbox was available in the apartment, inside the entry closet. The lockbox was too small to lock up all of Resident 6's medications. Observation showed there was no other lockable space available within the apartment. Observations at 1:25 PM and 1:55 PM showed the Resident 6 kept their apartment door unlocked.

During an interview on 10/07/2024 at 1:25 PM, Resident 6 stated that they kept their front door unlocked even when they left their apartment. Resident 6 stated that they were never informed about the facility's medication policy that required residents, who managed their medications independently, needed to keep all medications secured. Resident 6 stated that they were unaware of the lockbox in their closet.

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

Administrator (or Representative) Date

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Findings included…

Review of the facility's policy titled, "Medication Policy", dated 05/29/2024, showed if a resident self-administered their medications, they must have a secure location for medication storage, which must be locked from other resident access.

Review of Resident 6's record, showed the facility approved Resident 6 for independent medication administration. Review of Resident 6's progress note, dated 08/14/2024, showed Resident 6 misplaced some medications within their apartment. The progress notes showed Staff H, Licensed Practical Nurse (LPN), located the medications in the apartment, in various unlocked locations.

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During an interview on 10/07/2024 at 1:25 PM, Resident 6 stated that they kept their front door unlocked even when they left their apartment. Resident 6 stated that they were never informed about the facility's medication policy that required residents, who managed their medications independently, needed to keep all medications secured. Resident 6 stated that they were unaware of the lockbox in their closet.

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During an interview on 10/08/2024 at 10:17 AM, Resident 9 stated that independently managed their own medications. Resident 9 stated that they kept their medications in an unlocked kitchen drawer. Resident 9 stated that they were never told of the facility's medication policy that required residents, who managed their medications independently, needed to keep all medications secured.

During an interview on 10/08/2024 at 10:27 AM, Resident 10 stated that they were independent with administering their own medications. Resident 10 stated that they kept their pill boxes in an unlocked drawer and only sometimes locked their front door when they left the apartment. Resident 10 stated that they were never told of the facility's medication policy that required residents, who managed their medications independently, needed to keep all medications secured.

During an interview on 10/08/2024 at 10:35 AM, Staff G, Health and Wellness Director, identified Staff H as the staff who completed resident independent medication assessment and added the information to the resident care plan.

During an interview on 10/08/2024 at 11:12 AM, Staff H stated they were unaware of any facility policies that required residents, who independently administered their own medications, needed to keep their medications secured.

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, FARRINGTON COURT RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) ~~12/08/2024~~ 12/01/2024

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

Administrator (or Representative) 11/06/2024 Date

WAC 388-78A-2300 Food and nutrition services.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

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During an interview on 10/09/2024 at 10:17 AM, Resident 9 stated that independently managed their own medications. Resident 9 stated that they kept their medications in an unlocked kitchen drawer. Resident 9 stated that they were never told of the facility's medication policy that required residents, who managed their medications independently, needed to keep all medications secured.

During an interview on 10/09/2024 at 10:27 AM, Resident 10 stated that they were independent with administering their own medications. Resident 10 stated that they kept their pill boxes in an unlocked drawer and only sometimes locked their front door when they left the apartment. Resident 10 stated that they were never told of the facility's medication policy that required residents, who managed their medications independently, needed to keep all medications secured.

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(iii) Reviewed and updated as necessary or at least every five years.

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain 1 of 1 current dietary manual (dietary manual 1) and make available to food preparation staff for residents with special dietary needs. This failure placed all 31 residents at risk of not having their nutritional needs adequately met.

Findings included...

Review of the facility's Disclosure of Services showed the facility provided prescribed low sodium diets, general diabetic diets, mechanical soft diets, and pureed diets.

Observation of the commercial kitchen and residents' dining room on 10/08/2024 between 8:17 AM and 9:34 AM, showed there was no current dietary manual available to the food preparation staff..

During an interview on 10/08/2024 at 9:08 AM, Staff K, Cook, stated that there were residents with specialized dietary needs who resided in the facility. Staff K stated that they were unaware of any dietary manual.

During an interview on 10/08/2024 at 10:48 AM, Staff J, Executive Chef, stated that the facility switched to a different dietary consulting company. Staff J stated that the facility never received a dietary manual from the new dietary consulting company currently used. Staff J stated that they informed management. Staff J stated that there was an outdated manual, with a copyright date of 2017, from the previous dietary consulting company.

During an interview on 10/08/2024 at 12:38 PM, Staff A, Executive Director, stated that the facility started with the current dietary consulting company around the beginning of 2023. Staff A stated that they were aware there was no current dietary manual available. Staff A stated that they informed corporate management they were not getting what they needed from the dietary consulting company.

Plan/Attestation Statement

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During an interview on 10/08/2024 at 10:48 AM, Staff J, Executive Chef, stated that the facility switched to a different dietary consulting company. Staff J stated that the facility never received a dietary manual from the new dietary consulting company currently used. Staff J stated that they informed management. Staff J stated that there was an outdated manual, with a copyright date of 2017, from the previous dietary consulting company.

During an interview on 10/08/2024 at 12:38 PM, Staff A, Executive Director, stated that the facility started with the current dietary consulting company around the beginning of 2023. Staff A stated that they were aware there was no current dietary manual available. Staff A stated that they informed corporate management they were not getting what they needed from the dietary consulting company.

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Statement of Deficiencies	License #: 2145	Compliance Determination # 48289
Plan of Correction	FARRINGTON COURT RETIREMENT COMMUNITY	Completion Date
Page 5 of 13	Licensee: FARRINGTON COURT (WAKFC) LLC	10/17/2024

Administrator (or Representative) 11/06/2024 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 1 of 2 courtyards (back courtyard) was free of potential fall hazards. These failures placed all 31 residents at risk of injury and a diminished quality of life.

Findings included...

Observation of the back courtyard near Building C on 10/07/2024 at 11:22 AM, showed a cracked and uneven path. Observation showed a wooden ramp leading to Building C had wet leaves and plant debris scattered across it.

Observation on 10/07/2024 at 11:24 AM, showed an unidentified resident walked their dog in the back courtyard.

During an interview on 10/07/2024 at 11:26 AM, Staff I, Maintenance Director, stated that the sidewalk needed to be leveled. Staff I stated that the leaves and debris needed to be cleared from the walkway to Building C.

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, FARRINGTON COURT RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) ~~12/08/2024~~ 12/01/2024

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

Administrator (or Representative) 11/06/2024 Date

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Administrator (or Representative) Date

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Findings included…

Observation of the back courtyard near Building C on 10/07/2024 at 11:22 AM, showed a cracked and uneven path. Observation showed a wooden ramp leading to Building C had wet leaves and plant debris scattered across it.

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Administrator (or Representative) Date

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

WAC 388-78A-2320 Intermittent nursing services systems.

(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;

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure that 2 of 2 residents (Resident 8 and Resident 4) received nurse delegation services from qualified, Registered Nurse delegated staff. This failure placed Resident 8 and Resident 4 at risk for improper insulin administration and a potential for compromised health.

Findings included…

Review of the facility's Assisted Living Resident Characteristics Roster showed that the facility admitted Resident 8 in [redacted] 2020 and Resident 4 in [redacted] 2018. The document showed Resident 8, and Resident 4 were insulin dependent diabetics.

During an interview on 10/07/2024 at 9:30 AM, Staff A, Executive Director, stated that the facility was aware there were two Residents who required nurse delegation. Staff A identified the two residents as Resident 8 and Resident 4. Both residents were in the hospital at the time of the Department's full inspection. Staff A stated that they were aware staff were required to be delegated by a Registered Nurse for insulin administration. Staff A stated that the facility hired an outside delegation company to provide nurse delegation. Staff A stated that they were unaware the Medication Technicians (Med Techs- unlicensed staff who dispense and administer medications under nurse delegation) administered insulin to Resident 8 and Resident 4.

During an interview on 10/09/2024 at 12:08 PM, Staff A, stated that they were unable to find a nurse delegation binder and were unsure if there was a binder.

RESIDENT 4
Review of Resident 4's eMAR from August 2024 to October 2024 showed Resident 4 received insulin (medication used to treat diabetes, a disease where the body does not produce enough insulin to regulate blood sugar), 70 units at bedtime. A second order showed Resident 4 received sliding scale insulin (progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges) before meals.

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

During an interview on 10/08/2024 at 11:10 AM, Staff L, stated that they did not administer Resident 4's insulin even though Resident 4 was adamant that the staff should inject their insulin for them. Staff L stated that they explained to Resident 4 that they could inject the insulin themselves. Staff L didn't know if other Med Techs administered Resident 4's insulin.

During an interview on 10/10/2024 at 8:30 AM, Staff A stated that an outside company was scheduled to start nurse delegation the following day. Staff A acknowledged that the facility was required to provide nurse delegation for the Med Techs who administered insulin for residents.

At the time of the full inspection, Resident 4 was in hospital and was not able to be interviewed.

RESIDENT 8
Review of Resident 8's electronic Medication Administration Record (eMAR) from August 2024 to October 2024 showed Resident 8's blood sugar was checked four times a day. The eMARs showed Resident 8 received Lantus Solostar (long-acting insulin), 52 units to be injected at 8:00 PM every day.

During an interview on 10/08/2024 at 11:10 AM, Staff L, Med Tech, stated that they checked Resident 8's blood sugar. Staff L stated that Resident 8's hands were shaky which required staff to administer the insulin.

During an interview on 10/17/2024 at 3:50 PM, Collateral Contact 1 (CC1- Resident 8's Representative) stated that staff administered Resident 8's insulin when Resident 8's hands were too shaky or Resident 8 refused to self-inject.

At the time of the full inspection, Resident 8 was in hospital and was available to be interviewed.

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, FARRINGTON COURT RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) ~~12/08/2024~~ 12/01/2024

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

Administrator (or Representative)

11/06/2024
Date

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During an interview on 10/10/2024 at 9:30 AM, Staff A stated that an outside company was scheduled to start nurse delegation the following day. Staff A acknowledged that the facility was required to provide nurse delegation for the Med Techs who administered insulin for residents.

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_____ _____
Administrator (or Representative) Date

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WAC 246-980-030 Can a nonexempt long-term care worker work before obtaining certification as a home care aide?

(1) A nonexempt long-term care worker may provide care before receiving certification as a home care aide if all the following conditions are met:

(a) Before providing care, the long-term care worker must complete the training required by RCW 74.39A.074 (1)(d)(i)(A) and (B).

(b) The long-term care worker must submit an application for home care aide certification to the department within fourteen calendar days of hire. An application is considered to be submitted on the date it is post-marked or, for applications submitted in person or online, the date it is accepted by the department.

(2) The long-term care worker may not work for more than two hundred calendar days from their date of hire without obtaining certification.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

(i) Develop and implement a process to ensure caregivers:

(i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to ensure that 1 of 4 sampled staff (Staff B) was qualified to work with vulnerable residents. This failure placed all 31 residents at risk for receiving care from an unqualified staff.

Findings included…

Review of the facility's Assisted Living Resident Assistants job description showed that Resident assistants provided actives of daily living and instrumental activities of daily living services to resident according to their care plans. The job description showed that a valid unrestricted certification was preferred, and a Certified Nursing Assistant certification was desired.
Review of the staff roster showed the facility hired Staff B on 02/23/2024 as a Assisted Living Resident Assistant.

On 10/08/2024, review of the Department of Health (DOH) Credentialing website showed no record that Staff B applied for a Health Care Aide (HCA) or Nursing Assistant Certified (NA-C) certification. Review of the DOH credentialing website showed there was no credential pending. Review of the DOH website showed an active Nursing Assistant Registration credential for Staff B.

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

During an interview on 10/09/2024 at 2:43 PM, Staff A, Executive Director, stated that they were fairly confident that Staff B applied for their DOH Nursing Assistant Certified credential and that it was in pending status. Staff A stated that DOH just had not posted Staff B's license or posted that it was pending.

During an interview on 10/10/2024 at 9:30 AM, Staff A stated that Staff B should have some type of record that showed they submitted the application to DOH, whether it was a copy of an email or some other type of documentation. Staff A stated that they were unable to obtain this record of verification.

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Administrator (or Representative) — Date: 11/06/2024

WAC 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities?

(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training.

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff C) received Specialty Training for Dementia within 120 days of hire. This failure placed all 31 residents at risk for receiving care from an unqualified staff.

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

During an interview on 10/09/2024 at 2:43 PM, Staff A, Executive Director, stated that they were fairly confident that Staff B applied for their DOH Nursing Assistant Certified credential and that it was in pending status. Staff A stated that DOH just had not posted Staff B's license or posted that it was pending.

During an interview on 10/10/2024 at 9:30 AM, Staff A stated that Staff B should have some type of record that showed they submitted the application to DOH, whether it was a copy of an email or some other type of documentation. Staff A stated that they were unable to obtain this record of verification.

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, FARRINGTON COURT RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities?

(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training.

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff C) received Specialty Training for Dementia within 120 days of hire. This failure placed all 31 residents at risk for receiving care from an unqualified staff.

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

Findings included...

Review of the facility's characteristics roster showed that 31 residents resided in the facility. The characteristics roster identified 14 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment.

Review of the facility's employee roster showed the facility hired Staff C, Assisted Living Assistant, on 03/18/2024 as a caregiver.

Review of the facility's staff weekly schedule for September 2024 and October 2024 showed Staff C worked a total of five shifts.

Review of Staff C's personnel records found no documentation that Staff C completed Specialty Training for Dementia, as required.

During an interview on 10/09/2024 at 2:43 PM, Staff A, Executive Director, stated that they were certain Staff C completed the Specialty Training for Dementia at a previous job. Staff A stated that they would ask Staff C to obtain the certificates from their other job.

During an interview on 10/10/2024 at 9:30 AM, Staff A stated that Staff C was unable to provide a certificate for specialty training for dementia.

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, FARRINGTON COURT RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) ~~12/08/2024~~ 12/01/2024 DSA

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

Administrator (or Representative) 11/06/2024 Date

WAC 388-78A-2484 Tuberculosis. Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

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

Findings included…

Review of the facility's characteristics roster showed that 31 residents resided in the facility. The characteristics roster identified 14 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment.

Review of the facility's employee roster showed the facility hired Staff C, Assisted Living Assistant, on 03/18/2024 as a caregiver.

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Review of Staff C's personnel records found no documentation that Staff C completed Specialty Training for Dementia, as required.

During an interview on 10/09/2024 at 2:43 PM, Staff A, Executive Director, stated that they were certain Staff C completed the Specialty Training for Dementia at a previous job. Staff A stated that they would ask Staff C to obtain the certificates from their other job.

During an interview on 10/10/2024 at 9:30 AM, Staff A stated that Staff C was unable to provide a certificate for specialty training for dementia.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 2 of 2 sampled staff (Staff B and Staff D) for tuberculosis. This failure placed all 31 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the Department of Social and Health Services “Dear Provider letter”, amended 05/26/2022, showed that the Department reinstated the TB requirements on 07/01/2022.

Review of the facility’s document titled, “Tuberculosis Screening Policy”, dated 2014, showed that the facility followed the Center for Disease Control (CDC) recommendations. The policy showed that any voluntary, part time, temporary contract or full-time health care workers who have face-to-face contact with residents should be included in TB screening programs. The policy showed that any employee or volunteer must submit documentation for the following on or before their first day of employment: a. Documentation of a negative Tuberculin skin test, the date and the type of test, administered within six months before the starting date of employment or volunteer service. In Washington, a two-step skin test is required. The first before employment and the second within one to three weeks after first test, unless documentation of previous skin or blood test in previous 12 months in which case only one skin test is required: b. or a statement written and dated by a physician, physician assistant, or registered nurse practitioner within six months before the starting date of employment or volunteer service, that the staff member or volunteer is free from infectious pulmonary tuberculosis.

STAFF B
Review of the facility's Employee Roster showed that the facility hired Staff B, Assisted Living Resident Assistant, on 02/23/2024. Review of the facility’s Care Staff Schedule showed that Staff B worked in September 2024 and October 2024. Review of Staff B’s employee record showed no documentation that a one-step was done with three days of hire. There was no record of two-step TB test. The records showed no documentation that Staff B completed any TB test.

STAFF D
Review of the facility's Employee Roster showed that the facility hired Staff D, Assisted Living Resident Assistant/Medication Technician (unlicensed staff who dispenses and/or administer medications under nurse delegation), on 09/24/2024. Review of the facility’s Care Staff Schedule showed that Staff D worked in September of 2024 and October of 2024. Review of Staff D’s employee record showed no documentation that Staff D completed any TB test within three days of hire.

During an interview on 10/09/2024 at 12:08 PM, Staff A, Administrator, stated that they could not find any TB documentation for Staff B. Staff A stated that they were certain

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

Staff B received a one-step and two-step TB test. Staff A stated that TB testing for Staff D may have been missed.

During an interview on 10/10/2024 at 8:30 AM, Staff A, Administrator, stated they believed the TB tests were either done or were missed. Staff A confirmed that there was no documentation to show Staff B received a TB test. Staff A stated that the facility missed doing a TB test for Staff D.

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, FARRINGTON COURT RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 12/06/2024 12/01/2024

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

Administrator (or Representative) 11/06/2024 Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents (Resident 11) medical device was secured and safely installed for use. This failure placed Resident 11 at risk for potential entrapment and injury.

Findings included...

BED ENABLER
Review of the Department of Health and Social Services (DSHS) document titled "Dear Assisted Living Facility Administrator", dated 05/15/2013, showed Assisted Living Facility Providers were issued this letter related to the safety risks associated with the use of all medical devices. The letter listed some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted.

Review of the Department of Health and Social Services (DSHS) document titled Dear Assisted Living Facility Administrator/Provider, dated 02/25/2022, showed Assisted Living Facility Providers were issued this letter related recall of certain bed rails. The letter showed that in December 2021, the United States Consumer Product Safety

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Staff B received a one-step and two-step TB test. Staff A stated that TB testing for Staff D may have been missed.

During an interview on 10/10/2024 at 9:30 AM, Staff A, Administrator, stated they believed the TB tests were either done or were missed. Staff A confirmed that there was no documentation to show Staff B received a TB test. Staff A stated that the facility missed doing a TB test for Staff D.

Plan/Attestation Statement

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Commission (CPSC) issued recalls for three brand-specific quarter- and eighth-length bed rails that were commonly used to assist with transferring and positioning. The letter showed that CPSC found these devices can lead to consumer injury or death due to entrapment and asphyxiation. The letter showed that an occupational therapist/physical therapist may be able to find an alternative for transferring and positioning for those who need it.

RESIDENT 11
Review of the facility's Resident Characteristics Roster showed that the facility admitted Resident 11 in [redacted] 2024. The Characteristics Roster did not document Resident 11 used a medical device (bed enabler)

Observation of Resident 11's apartment on 10/09/2024 at 11:19 AM, showed a U-shaped half rail, 5 inches wide and 14 inches long, with two poles that slid under the mattress of the bed. The bed enabler was not attached or secured to the bed frame. Observation showed there no mesh or other type of cover over the gap of the rail bars to prevent entrapment. Observation showed the side rail was able to slide out from under the mattress without resistance.

During an interview on 10/09/2024 at 2:43 PM, Staff G, Wellness Director, and Staff M, Regional Resource Registered Nurse, stated that they were not aware the bed rail was not fastened to the bed frame and that there were large gaps that allowed the bed rail to have entrapment-like qualities. Staff G stated they did not have a current system in place to ensure the bed rails were safe and secure.

Plan/Attestation Statement

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

Administrator (or Representative) — Date 11/06/2024

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Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

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

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

10/25/2024

FARRINGTON COURT (WAKFC) LLC
FARRINGTON COURT RETIREMENT COMMUNITY
516 Kenosia Ave S
Kent, WA 98030

RE: FARRINGTON COURT RETIREMENT COMMUNITY # 2145

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/17/2024 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 many deficiency listed on the enclosed report; and
- May inspect your program 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 Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

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

Kent, WA 98032

• 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-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:

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

The facility failed to ensure its Resident Abuse Prevention policy was consistent with the Revised Code of Washington (RCW) 74.34 related to mandated reporting of abuse, exploitation, and neglect of residents. During the full inspection, the facility corrected its policy to meet to the reporting requirements of RCW 74.34.

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

(iii) Able to be moved to the location where needed; and

(f) Make sure first-aid supplies are appropriate for:

(i) The size of the assisted living facility;

(ii) The services provided;

(iii) The residents served; and

(iv) The response time of emergency medical services.

The facility failed to ensure first aid kits were clearly marked and readily available. During the full inspection, the facility made clearly marked first aid kits available, per the regulation.

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

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

(ii) The name, address and telephone number of:

(A) The department;

(B) Appropriate resident advocacy groups; and

(C) The state and local long-term care ombuds with a brief description of ombuds services.

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

The facility failed to ensure it posted its most recent full inspection report and failed to post information regarding long-term care ombuds program in a conspicuous location within the facility. During the full inspection, the facility made the inspection report available and posted the ombuds program information in conspicuous locations.

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

The facility failed to accurately document in each residents' service plans the level of assistance each resident required with medications. The facility used standard language in the service plan that included nurse delegation for residents who did not need this assistance. The facility failed to document the side effects of medications for the residents. During the full inspection, the facility updated the service plans to accurately reflect the needs of each resident.

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

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

The facility failed to ensure that the Medicaid disclosure document was written on a separate page apart from other documents and typed in 14-point font. During the full inspection, the facility corrected the issue and created a separate page in 14-point font. The facility obtained resident or resident representatives' signatures.

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 (253)234-6020.

Sincerely,

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

Enclosure

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

Plan of Correction

Agency Name	Citation Date
Department of Social & Health Services	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: (list WAC) WAC 388-78A-2270 Resident Controlled Medications	
What *initial or immediate actions* were taken to address concerns affecting clients?	Facility's Maintenance Director immediately installed a lock on cupboards In sample resident units. Health & Wellness Director and Nurse advised residents. On medication policy and reminded residents to lock their unit door and to ensure medications are appropriately stored. Staff H was educated about Medication policy and that residents that self-administer medications are required to keep their medications secured.
How will you apply the correction to all clients you support?	Facility conducting audit of resident rooms to ensure all residents have Access to lockbox or locked space specifically for medications. Executive Director to address at resident meeting as well as to provide written information to residents & their responsible parties.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Dominique Allen, Executive Director will oversee procedural changes and Corrections.
Date by which lasting correction will be achieved	~~12/8/2024~~ 12/01/2024 Dal
Additional Information	Enter any additional information you believe is pertinent such as if you intend to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Laurie Anderson, Field Manager
Residential Care Services
20425 72nd Avenue S, Suite 400
Kent, WA 98032
Fax: (360) 725-3208

Send copy to DDA Resource Manager or Residential Program Specialist for your region.

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

Plan of Correction

Agency Name	Citation Date
Washington State Department of Social and Health Services	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-2300 Food & Nutrition Services	
What *initial or immediate actions* were taken to address concerns affecting clients?	Executive Director obtained the current, certified dietary manual and Replaced the expired manual, ensuring it is located in plain view and accessible to all employees.
How will you apply the correction to all clients you support?	Executive Director to review dietary manual with Executive Chef on an Annual basis to ensure book is certified, current and located in plain view and is accessible to all employees.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Chef to oversee manual and procedure to ensure compliance.
Date by which lasting correction will be achieved	~~12/8/2024~~ 12/01/2024
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Laurie Anderson, Field Manager
Residential Care Services
20425 72nd Ave S., Suite 400
Kent, WA 98032
Fax: (360) 725-3208

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Plan of Correction

Agency Name	Citation Date
Washington Department of Social & Health Services	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-3090 Maintenance & Housekeeping	
What *initial or immediate actions* were taken to address concerns affecting clients?	Yellow cones have been placed at the section of pavement that is cracked To warn residents of risk. Maintenance Director cleaned leaves/debris from ramp in back courtyard.
How will you apply the correction to all clients you support?	Farrington Court is hiring a company to level the pathway in the back courtyard and to re-pave surface of cracked concrete. Daily tasks have been implemented into the maintenance schedule to ensure no leaves or debris are located in areas that would pose fall risk for residents.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director to oversee repairs in pavement. Maintenance Director to oversee daily tasks ensuring all leaves/debris are removed daily.
Date by which lasting correction will be achieved	~~12/8/2024~~ 12/01/2024
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

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Residential Care Services
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Kent, WA 98032
Fax: (360) 725-3208

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Plan of Correction

Agency Name	Citation Date
Farrington Court	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-2320 Intermittent Nursing Services	
What *initial or immediate actions* were taken to address concerns affecting clients?	Executive Director became aware for need of delegation with residents and implemented Nursing Delegation Services in 09/2024. Licensed Registered Nurse began delegating on 10/11/2024.
How will you apply the correction to all clients you support?	All residents in need of a service that requires delegation will be delegated to. All Employees that will be providing delegated service will be delegated to.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Health & Wellness Director to oversee delegation services, ensuring residents and staff are delegated to in accordance with Washington State Regulations. Health & Wellness Director as well as Executive Director to maintain delegation documentation in binder.
Date by which lasting correction will be achieved	~~12/08/2024~~ 12/01/2024 DT
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

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20425 72nd Ave S., Suite 400
Kent, WA 98032
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Plan of Correction

Agency Name	Citation Date
Washington Department of Social and Health Services	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 246-980-030 / WAC 388-78A-2450	
What *initial or immediate actions* were taken to address concerns affecting clients?	The employee was removed from caregiving duties until NAC certification is obtained.
How will you apply the correction to all clients you support?	Executive Director has conducted an internal audit of all caregivers credentials at Farrington Court to ensure compliance. Staff B was removed from caregiving duties pending NAC license. Business Office Manager to review all new hire credentials with Executive Director prior to hire date. Caregivers that do not hold a current HCA or NAC license will not be hired.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Business Office Manager is responsible for ensuring all new hires have the appropriate credentials prior to official hire.
Date by which lasting correction will be achieved	~~12/8/2024~~ 12/01/2024
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

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Plan of Correction

Agency Name	Citation Date
Farrington Court	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-112A-0495 / WAC 388-78A-2510	
What *initial or immediate actions* were taken to address concerns affecting clients?	Caregiver (Staff C) has been enrolled in Specialty Dementia Training Class To obtain her certification
How will you apply the correction to all clients you support?	Executive Director has conducted an internal audit to ensure all employees are compliant. Farrington Court has applied to DSHS to certify a Facility Trainer for future trainings/certifications. Business Office Manager has developed a tracking tool to ensure that new hires obtain their certifications within the timeframe as allotted by Washington State Regulations.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	The Business Office Manager will oversee employee compliance with regards to Specialty Training certifications for caregivers. Executive Director to Assist when Business Office Manager not available.
Date by which lasting correction will be achieved	~~12/8/2024~~ 12/01/2024 DA
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

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Plan of Correction

Agency Name	Citation Date
Washington Department of Social & Health Services	10/25/2024
Submitted by	**Date of POC Submission**
Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-2484	
What *initial or immediate actions* were taken to address concerns affecting clients?	Staff B & Staff D were removed from providing caregiving services effective immediately until TB testing was completed and documented.
How will you apply the correction to all clients you support?	Executive Director has performed an internal audit to ensure all employees have been tested for Tuberculosis. Business Office Manager to implement procedure to ensure all staff complete full TB testing cycles within 3 days and 3 weeks of hire.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Business Office Manager to oversee TB testing compliance for newly hired staff. The Executive Director to manage this process in the absence of the Business Office Manager.
Date by which lasting correction will be achieved	~~12/08/2024~~ 12/01/2024
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Laurie Anderson, Field Manager
Residential Care Services
20425 72nd Ave S., Suite 400
Kent, WA 98032
Fax: (360) 725-3208

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Plan of Correction

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Washington Department of Social & Health Services	10/25/2024
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Dominique Allen	11/06/2024
☐ **Complaint Citation** ☒ **Certification Citation**	

Citation: WAC 388-78A-2700	
What *initial or immediate actions* were taken to address concerns affecting clients?	Health & Wellness Director immediately contacted responsible party for resident and advised that the bedrail currently in resident's room was not safe. The bedrail was removed and Health & Wellness Director offered the responsible party safe, alternative options and a new, approved bedrail was installed. Bed mobility device was added to Resident 11's characteristic roster, mobility device safety assessment completed and bed cane daily check by staff was added to resident 11's care plan.
How will you apply the correction to all clients you support?	Health & Wellness Director and/or Licensed Practical Nurse to advise all residents and/or responsible parties regarding approved assistance devices. Facility must approve any bed cane/rails to be used or installed by residents. Nursing team to perform audit and identify all residents who have a bed mobility device and educate residents about the use of approved assistance devices. Work with any residents or families that need to have a device replaced. Ensure staff is trained and understand what to look for and report when doing daily bed cane checks.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Health & Wellness Director in conjunction with Licensed Practical Nurse to oversee corrections.
Date by which lasting correction will be achieved	~~12/8/2024~~ 12/01/2024
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

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