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

CVC RETIREMENT LLC
CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY
4450 Davis Ave S
Renton, WA 98055

RE: CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY License # 2230

Dear Administrator:

This letter addresses Compliance Determination(s) 26838 (Completion Date 07/19/2023) and 22973 (Completion Date 04/24/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/19/2023 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-2700-1-e-ii, WAC 388-78A-2700-1-e-iii, WAC 388-78A-2700-1-f-iv, WAC 388-78A-3010-8-e, WAC 388-78A-2305-1, WAC 246-215-03525-1-b, WAC 388-78A-2381-2-d-i, WAC 388-78A-2381-2-d-ii, WAC 388-78A-2381-2-d-iii, WAC 388-78A-2381-2-d, WAC 388-78A-2400-6, WAC 388-78A-2950-6, WAC 388-78A-3100-2, WAC 388-78A-3100-3

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

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

Sincerely,

Laurie Anderson, Field Manager
Region 2, Unit D

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

Residential Care Services

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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 04/10/2023, 04/10/2023, 04/12/2023, 04/13/2023 and 04/13/2023 of:
CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY
4450 Davis Ave S
Renton, WA 98055

The following sample was selected for review during the unannounced on-site visit: 9 of 79 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, 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.

Residential Care Services

04-26-2023
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.

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Administrator (or Representative)

05/22/23
Date

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

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(ii) Clearly marked;

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

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

(iv) The response time of emergency medical services.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 4 of 4 first-aid supply kits were clearly identified and easily accessible. This failure placed all residents at risk of delayed care in an emergency.

Findings included...

Observation on 04/10/2023, during the environmental tour between 9:28 AM - 2:00 PM, showed four first-aid kits within the facility that were not easily accessible. Each kit was mounted on a wall in different areas of the facility. One kit was inside the copy room behind the Concierge's desk, the second kit was located inside the Nurse's Station on the second floor, the third kit was in the main kitchen, and the fourth kit was in the Memory Care office on the first floor. Further observation on 04/13/2023 at 9:45 AM showed another compact green first-aid kit located on a bottom shelf behind the Concierge desk. There were no signs anywhere in the facility that identified the locations of any of the kits.

During an interview on 04/10/2023 at 10:30 AM, Staff G, Lead Maintenance, stated that the first-aid kits were affixed to the wall in each department. Staff G stated that the kits were not movable.

During an interview on 4/12/2023 at 10:00 AM, Staff H, Assisted Living Nurse Manager, stated that there was a first-aid kit in the locked Community Center office. Staff H stated that they were unable to open the office where the kits were stored. Staff H confirmed that there were no first-aid kits located on the third and fourth floors.

Plan/Attestation Statement

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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, CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/31/2023.

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

Administrator (or Representative) — Date: 05/22/2023

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation, and interview, the facility failed to ensure 13 of 13 residents were provided lockable space for personal items. This failure placed the residents at risk for theft and personal property loss.

Findings included...

Observations on 4/11/2023 at 9:59 AM and on 04/12/2023 10:35 AM showed apartments 447, 431, 430, 429, 421, 348, 333, 331, 326, 305, 246, 226, and 218 did not have any secure or lockable storage for residents' small valuables.

During an interview on 4/10/2023 at 11:30 AM, Staff G, Lead Maintenance, stated that the facility did not provide the residents with a locked drawer, cupboard, or space to secure their personal valuables.

During an interview on 4/12/2023 at 10:00 AM, Staff H, Assisted Living Nurse Manager, stated that residents brought their own safe for their valuables. Staff H stated that they were unaware that the facility was required to provide lockable storage.

During an interview on 4/12/2023 at 10:29 AM, Staff I, Memory Care Nurse Manager confirmed that residents living in Memory Care did not have lockable storage.

During an interview on 4/12/2023 at 1:54 PM, Resident 10, stated that when they moved in, their apartment was not equipped with any locked storage.

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During an interview on 4/13/2023 at 11:16 AM, Staff A, Executive Director, stated that they were unaware that the facility must provide a lockable storage or space for added safety of the resident's valuables.

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Administrator (or Representative) — Date: 05/22/2023

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530 , and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(b) At 41 F (5 C) or less.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 2 of 2 food service trays (tray 1 and tray 2) containing milk held the milk at or less than 41° degrees Fahrenheit (F) prior to leaving the commercial kitchen for delivery. This failure placed residents with tray service at risk of contracting foodborne illness.

Findings included...

Review of the Food and Drug Administration (FDA) website on 04/18/2023, defined potentially hazardous food as "as any perishable food which consists in whole or in part of milk or milk products, eggs, meat, poultry, rice, fish, shellfish..." Further review showed groups more likely to contract foodborne illnesses included older adults over age 65 and people with immune systems weakened from medical conditions, such as diabetes, liver disease, kidney disease, organ transplants, or from receiving chemotherapy or radiation treatment.

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Record review of the facility's undated policy titled, "Food Service Policies and Procedures" showed, "During serving, procedures are followed to maintain food at proper temperatures" and "Keep all foods at a temperature of 41° F or below or 135° F or above."

Observation of the facility's commercial kitchen on 04/10/2023 at 7:40 AM, showed milk in take-out cups on two food trays with individually packaged cold cereal. Further observation showed the trays sat on the counter with no method to keep the milk chilled. Observation on 04/10/2023 at 8:07 AM, showed Staff Q, Server, loaded an open delivery cart with the trays. Upon request, Staff Q checked the temperature of the milk in the two cups. On tray 1, the milk's temperature measured 58.9° F. On tray 2, the milk's temperature measured 57.8° F. Observation showed that Staff Q delivered tray 1 to the resident's apartment at 8:14 AM and tray 2 to another resident's apartment at 8:20 AM.

Observation of the commercial kitchen on 04/13/2023 at 7:25 AM, showed milk in take-out cups on two food trays with individually packaged cold cereal. Further observation showed the trays sat on the counter with no method to keep the milk chilled. Observation on 04/13/2023 at 8:19 AM, showed Staff R, Server, loaded an open delivery cart with the trays. Upon request to take the milks' temperatures, Staff R asked Staff O, Vice President of Culinary Services, checked the temperature of the milk in the two cups. On tray 1, the milk temperature measured 59.3° F and on tray 2 the milk measured at 56.6° F. Further observation showed Staff O instructed Staff R to throw out the milk on the trays and replace them with milk from the refrigerator.

During an interview on 04/10/2023 at 8:07 AM, Staff Q stated that they did not take food temperatures prior to delivering the trays to the residents.

During an interview on 04/10/2023 at 8:42 AM, Staff P, Culinary Services Director, reported that the milk delivered to the residents in their apartments was stored in the refrigerator until it was time for delivery. Staff P stated that staff did not measure the temperature of the milk since it was kept in the refrigerator until it was taken for delivery. Staff P further stated that staff was therefore delivering the milk to the residents at "about 34 - 35° (F)".

During an interview on 04/13/2023 at 8:24 AM, Staff O explained that the staff took the milk out of the refrigerator too soon before setting up the cart for delivery which caused the milk to become warm.

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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.

(d) The required outdoor area must be accessible to residents with minimal staff assistance in a manner consistent with the residents' individual negotiated service agreement, except where pursuant to a facility policy, and consistent with WAC 388-78A-2600 , the facility administrator or other appropriate staff reasonably believe that the health or safety may be at risk, including, but not limited to, instances of:

(i) Inclement weather;

(ii) Dangerous construction or maintenance activities; or

(iii) Other temporary environmental factors that create an unsafe environment.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 20 of 20 memory care residents had access to the outside courtyard, offered opportunity for social interaction, and had a safe pathway free of trip hazards. This failure placed residents at risk of fall and a diminished quality of life.

Findings included...
Courtyard Access
Record review showed the facility had no policy related to memory care residents' access to the secured outdoor courtyard.

Record review of the facility's undated document titled, "Resident Characteristic Roster" showed the facility provided care and services to 20 residents within its secured memory care unit.

Record review of the Negotiated Service Agreements (NSAs) for Resident 1, Resident 2, Resident 3, and Resident 4, who resided in the facility's memory care unit, showed the facility failed to address how the residents would access the outdoor courtyard with minimal staff assistance.

Observation on 04/10/2023 at 12:19 PM, showed the door to the outdoor courtyard was locked and alarmed. Further observation on 04/11/2023 at 12:51 PM, showed the door to

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MAY 24 2023
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the outdoor courtyard was locked and alarmed. Observation during both instances, showed the weather was sunny to partially sunny.

During an interview on 04/10/2023 at 12:19 PM, Staff G, Maintenance Lead, stated that the courtyard door always remained locked. During an interview on 04/11/2023 at 12:51 PM, Staff N, Memory Care Caregiver, stated that they always kept the courtyard door locked because they had a resident who liked to wander.

During an interview on 04/12/2023 at 10:40 AM, Staff I, Memory Care Nurse Manager, stated that the door to the courtyard was to be kept open during the day to allow for resident use.

During an interview on 04/15/2023 at 10:00 AM, Staff I confirmed the facility had no policy related to when the memory care courtyard should be open and available to residents. Staff I further stated that the facility had not indicated in the residents' NSAs how the residents could access the secured courtyard with minimal staff assistance.

Follow up observation on 04/15/2023 at 9:56 AM, showed when the courtyard was accessible, Resident 10 roamed around the courtyard.

Courtyard Safety and Promotion of Use
Observation on 04/10/2023 at 12:19 PM, through the locked glass memory courtyard door, showed a ripped plastic garbage bag filled with garbage.

Observation of the Memory Care courtyard on 04/12/2023 at 10:44 AM, showed an electrical cord across the pathway, piles of leaves and other debris such as a broken hummingbird feeder and crumpled single-use cup on the patio surface. Observation showed two patio chairs and sofa. Further observation showed the surface of the chair seats were covered with cushions, and access to the couch-seating was blocked by a long coffee table pushed up against the couch. Observation showed a patio dining table stacked on top of a second patio dining table. Further observation showed debris such as old and soiled decorations on the stacked tables. Observation also showed a ripped plastic garbage bag filled with garbage resembling the garbage bag observed on 04/10/2023.

During an interview on 04/12/2023 at 10:44 AM, Staff I stated that the cord across the walkway was from holiday lights. Staff I acknowledged the cord was a trip hazard. Staff I further seated that the cushions covering the chair and the coffee table blocking access to the sofa were obstructions and posed a safety risk. Staff I that if the residents attempted to sit, they would likely forget to remove the pillows and could become injured. Staff I further stated that the bag of garbage, leaves, and other debris should not be there and did not make the space inviting or safe.

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

Administrator (or Representative) — Date: 05/22/2023

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(6) Maintain ownership and control of resident records, except that resident records may be transferred to a subsequent person licensed by the department to operate the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 59 of 59 Assisted Living residents (Resident 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 61, 62, 63, and 64) records were protected for privacy. This failure placed the residents at risk of having their confidential records exposed to unauthorized persons.

Findings included...

Record review of the facility's undated policy titled, "Confidentiality of Resident Information" showed, "[Facility name] maintains resident information in individual files. The files are kept in the file storage office... and in the Assistant Living Director's office, both areas are locked and secured. The resident information is not available to other residents and unauthorized individuals."

Observation on 04/10/2023 at 10:50 AM, showed the Assisted Living Nurse Manager's office door open with no staff inside. Observation showed two lockable cabinets with multiple shelves. Each shelf had a door that could be pulled down and locked. Further observation showed that the cabinet doors were unlocked and in the open position. All the resident files on the shelves were visible from the hallway, with each resident's name clearly indicated on the spine of each file. All the files were accessible to anyone who walked by the office. Further observation on 04/10/2023 at 11:30 AM, showed the office and the filing cabinets remained unlocked, visible from the hallway, and accessible. Observation on 04/11/2023 at 10:27 AM, again showed the Assisted Living Nurse Manager's office door was unlocked, the cabinets were unlocked, and the resident files were visible. Further observation showed no staff were in the office. Observations during the full inspection from 04/10/2023 – 04/13/2023, showed residents, visitors, and staff passed by the Nurse Manager's office.

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MAY 24 2023
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During an interview on 04/18/2023 at 11:00 AM, Staff S, Health Services Director, stated that staff were expected to follow the facility's policy related to confidentiality of resident records. Staff S further stated that when the Assisted Living Nurse Manager's office did not have staff inside, either the office door or the cabinets containing resident records needed to be locked.

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, CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 05/31/2023 .

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

Administrator (or Representative) — Date: 05/22/2023

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the water temperature in 13 of 13 sampled northside apartments (Apartments 130, 131, 133, 145, 148, 233, 248, 333, 348, 430, 431, 433, and 447), 3 of 3 northside resident laundry rooms (second floor north, third floor north and fourth floor north), 1 of 1 northside common bathrooms (first floor), and 2 of 2 locker rooms (men's locker room north and women's locker room north) maintained safe water temperatures between 105° Fahrenheit (F) and 120° F. This failure placed all residents at risk for injury.

Findings included...

Record review of a facility document titled, "Water Temperature Log", dated January 2023 – March 2023, showed each month the facility tested the water temperature in one resident apartment on each floor, one resident laundry room on each floor, and one common restroom per floor within the five-story, 122,950 square foot facility. Review of the log also showed the facility sampled two common spaces each month.

Observations throughout the full inspection from 04/10/2023 – 04/13/2023, showed the water temperature measurements were above 120° F on the Northside of the building only. On 04/10/2023 at 9:35 AM, the fourth floor North resident laundry room water

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Residential Care Services
MAY 24 2023
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temperature measured 125.8° F; 04/10/2023 at 9:59 AM, the third floor North resident laundry room water temperature measured 127.2° F; on 04/10/2023 at 11:13 AM, the second floor North resident laundry room water temperature measured 123.3° F; on 04/10/2023 at 11:22 AM, the first floor North common restroom water temperature measured 124.3° F; on 04/10/2023 at 11:26 AM, in Apartment 148, the water temperature measured 126.0° F; on 04/10/2023 at 11:29 AM, in Apartment 133, the water temperature measured 123.4° F; on 04/10/2023 at 11:31 AM, in Apartment 145, the water temperature measured 125.1° F; on 04/10/2023 at 11:36 AM, in Apartment 130, the water temperature measured 125.1° F; on 04/10/2023 at 1:20 PM, the basement North men's locker room water temperature measured 122.4° F; on 04/10/2023 at 1:22 PM, the basement North women's locker room water temperature measured 122.5° F; on 04/11/2023 at 9:55 AM, the first floor North common restroom water temperature measured 128.5° F; on 04/11/2023 at 9:59 AM, in Apartment 131, the water temperature measured 125.6° F; on 04/11/2023 at 10:05 AM, in Apartment 447, the water temperature measured 125.2° F; on 04/11/2023 at 10:12 AM, the third floor North resident laundry room water temperature measured 126.0° F; on 04/11/2023 at 10:15 AM, the second floor North resident laundry room water temperature measured 123.3° F; on 04/11/2023 at 10:35 AM, in Apartment 248, the water temperature measured 125.8° F; on 04/11/2023 at 10:38 AM, in Apartment 233, the water temperature measured 124.2° F; on 04/12/2023 at 10:34 AM, in Apartment 348, the water temperature measured 124.7° F; on 04/12/2023 at 1:28 PM, the fourth floor North resident laundry room water temperature measured 120.6° F; on 04/12/2023 at 1:31 PM, in Apartment 433, the water temperature measured 122.5° F; on 04/12/2023 at 1:38 PM, in Apartment 430, the water temperature measured 123.4° F; on 04/12/2023 at 1:44 PM, in Apartment 431, the water temperature measured 124.0° F; on 04/12/2023 at 1:56 PM, the third floor North resident laundry room water temperature measured 126.0° F; on 04/12/2023 at 2:00 PM, in Apartment 333, the water temperature measured 123.4° F; on 04/13/2023 at 8:55 AM, the fourth floor North resident laundry room water temperature measured 122.6° F.

During an interview on 04/11/2023 at 10:34 AM, Resident 3 stated that they thought the water in their apartment was hotter than it needed to be. During an interview on 04/12/2023 at 1:44 PM, Resident 10 stated that they thought the water in their apartment was warmer than it needed to be.

During the environmental tour on 04/10/2023 between 9:28 AM and 2:00 PM, Staff G, Maintenance Lead, acknowledged that the water temperatures above 120° F were above the maximum allowed temperature. Staff G stated that once a month, Maintenance staff sampled the water temperatures throughout the facility. On 04/13/2023 at 9:40 AM, Staff G further stated that the high water temperature issue, identified on the northside of the building, was related to the mixing valve that needed an adjustment. Staff G stated that the facility did not have a water temperature policy with temperature guidelines. Staff G stated that they relied on the state's regulation to determine the water temperatures.

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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, CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 06/10/2023.

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

Administrator (or Representative) — Date: 05/22/2023

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;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure hazardous cleaning chemicals in 1 of 1 Community Center and 1 of 1 common second floor bathroom. This failure placed residents at risk of harm due to eye, skin, or lungs, if hazardous chemicals were accessed, ingested, or inhaled.

Findings included...

Record review of the facility's document titled, "Featured Events", dated April 2023, showed the facility held up to four resident activities per day in the Community Center.

Observations on 04/10/2023 – 04/13/2023, during the full inspection, showed residents independently used the Community Center, a common resident gathering room. Observation also showed residents were present in the Community Center during structured activities.

Observation of the Community Center on 04/10/2023 at 11:05 AM showed a kitchenette with lockable cabinets. Further observation showed the cabinet located below the sink was unlocked. The unlocked cabinet contained several chemical cleaning products: a product used for urine removal, a product for disinfecting surfaces, and an aerosol can of furniture polish. The cabinet also held several cans of spray paint. All the products showed hazardous warning labels. The warning labels stated, "Danger: extremely flammable liquid, vapor harmful. Health hazards: May cause acute/chronic eye irritation, skin irritation, nasal

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and respiratory irritation. Inhalation - drowsiness, staggering, confusion, unconsciousness, coma, or death."; "Warning: Keep out of reach of children. Eye irritant"; "Hazardous to humans and domestic animals. Harmful if absorbed through skin. Avoid contact with eyes, skin, clothing... Avoid breathing mist."; and "Caution: Eye irritant. Do not get in eyes. If swallowed... call a poison control center... Keep out of reach of children."

Observation on 04/13/2023 at 9:45 AM of the second-floor common restroom, showed a container of cleaning chemicals next to the side of the toilet. The hazardous warning labels included, "Avoid contact with eye, skin or clothing. Harmful if swallowed or inhaled. Avoid breathing vapor."; and "Causes severe eye irritation or damage to eyes and skin... Harmful if swallowed."

During an interview on 04/10/2023 at 11:10 AM, Staff G, Maintenance Lead, confirmed that hazardous chemical products required locked storage for resident safety. Staff G was unaware the staff left the hazardous products unsecured.

During an interview on 04/24/2023, Staff T, Maintenance Director, confirmed the facility had no policy related to safe storage of potentially hazardous chemicals. Staff T further stated that staff in every department were trained to always lock hazardous chemicals. Staff T stated the chemicals in the Community Center were required to be kept locked. Staff T further stated the chemicals in the common bathroom should not have been left there.

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

04/26/2023

CERTIFIED MAIL

9489 0090 0027 6382 8694 08

CVC RETIREMENT LLC
CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY
4450 Davis Ave S
Renton, WA 98055

RE: CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY # 2230

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/24/2023 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

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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-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

The facility failed to check blood glucose levels from the continuous glucose monitoring device prior to administer insulin injections for 1 of 1 sampled resident (Resident 1) with diabetes mellitus and dementia. The facility's nurse delegation document showed that the facility's registered nurse delegator delegated blood glucose monitoring and insulin administration to medication technicians for Resident 1. Observation showed that Resident 1 used a glucose sensor for continuous glucose monitoring. Observation showed that the medication technician did not check blood glucose reading from the monitoring device in the resident's room, before they administered insulin injections to Resident 1. The facility stated that they were unaware the monitoring device's capability of sensing and displaying the current blood glucose. The facility stated that Resident 1's family had monitored resident's blood glucose remotely outside the facility and that they did not have a system in place to ensure the medication technicians check the blood glucose prior to administer insulin injection. The facility also stated Resident 1's family transmitted blood glucose readings to the physician and communicated concerns with the physician, and that they did not have a system in place to monitor and document blood glucose levels by the facility staff. The facility records did not contain any physician order for blood glucose monitor. The facility corrected the findings identified during the course of the licensing inspection.

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;

The facility failed to ensure the air vents in two common restrooms and one resident's apartment bathroom worked. The facility failed to remove a nonfunctioning washer that sat next to the facility garbage dumpster. The facility failed to repair an uneven walkway to the Love Garden and unleveled top staircase landing. The three air vents were fixed on the last day of inspection. The facility's Lead Maintenance staff reported that the broken washer was scheduled for disposal next week. The facility placed a caution sign on the uneven walkway and staircase landing to alert any residents, staff, and visitors of the potential tripping hazards.

DSHS/ALTSA
Residential Care Services

MAY 24 2023

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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

DSHS, WA.

Enclosure

DSHS/ALTSA
Residential Care Services
MAY 24 2023
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