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

10/29/2024

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:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 49488 (Completion Date 10/29/2024) and 47450 (Completion Date 09/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/29/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(7) Buildings from which egress is restricted have:

(a) A system in place to inform and permit visitors, staff persons, and appropriate residents freedom of movement; and

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;

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

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

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 (253)234-6020.

Sincerely,

Laurie Anderson

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

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

Statement of Deficiencies	License #: 2230	Compliance Determination # 47450
Plan of Correction	CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY	Completion Date
Page 1 of 7	Licensee: CVC RETIREMENT LLC	09/27/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 09/23/2024 and 09/26/2024 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 76 current residents and 0 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

10/10/2024 — 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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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Residential Care Services

Date

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Administrator (or Representative) 10/14/2024 Date

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(7) Buildings from which egress is restricted have:

(a) A system in place to inform and permit visitors, staff persons, and appropriate residents freedom of movement; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide information regarding how to use 2 of 3 delayed egress fire doors (Exit 4 and Exit 11) within the memory care unit. This failure potentially restricted appropriate residents and visitors from freedom of movement and exit in the event of an emergency.

Findings included...

Observations on 09/23/2024 between 11:57 AM and 12:05 PM, showed the facility used delayed egress doors (a fire exit door with a crossbar that must be depressed and held for 15 seconds to allow the door to open in the event of an emergency) in the secured memory care unit. Observation at 11:57 AM, showed a delayed egress door labeled "#4" covered with wallpaper to look like a bookcase. There was no signage to indicate how to use the exit. Observation at 12:02 PM, showed a delayed egress door labeled "#11" covered with wallpaper to look like a bookcase. There was no signage to indicate how to use the exit.

During an interview on 09/23/2024 at 11:57 AM, Staff G, Director of Environmental Services, stated that the sign for Exit 4 was in the bin next the door under a binder. Staff G stated that the sign for Exit 11 was missing.

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) 10/18/24.

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

Administrator (or Representative) Date

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Administrator (or Representative) 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 maintain 1 of 1 exterior path (Garden) and 1 of 2 common memory care restrooms (Bathroom 2) safe and free of hazards and obstructions. This failure placed all 76 residents at risk of falls or injury from unsafe areas.

Findings included…

PATH
Observation of the exterior path within the garden area on 09/23/2024 at 12:41 PM, showed an unidentified resident sat alone in the garden area. Observation showed a raised and uneven section of the pathway, which created a potential trip hazard for anyone who walked around the garden area.

During an interview on 09/23/2024 at 12:41 PM, Staff G, Director of Environmental Services, stated that they were aware the path needed to be leveled.

MEMORY CARE BATHROOM
Observation of the common bathroom and shower room, across from Room 174, on 09/23/2024 at noon, showed a cabinet that hung on the wall between the toilet and the sink. The cabinet hung approximately four feet above the floor and hung two inches over the left side of the sink. While the department licensor conducted environmental tour, licensor hit their head on the low hanging cabinet.

During an interview on 09/23/2024 at 12:01 PM, Staff G stated that they were aware the placement of the cabinet presented a risk of head injury to anyone who used the bathroom.

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Administrator (or Representative) 10/14/24 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 3 sampled residents (Resident 1) with a medical device was safe and free of entrapment-like qualities. This failure placed Resident 1 at risk for potential entrapment and injury.

Findings included...

BED RAIL
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 Commission (CPSC) issued recalls for three brand-specific quarter- and eighth-length bed rails that are 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.

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)_____ .

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RESIDENT 1
Record review of the facility's Resident Characteristics Roster showed that the facility admitted Resident 1 in [redacted] of 2023. The roster showed Resident 1 used a medical device.

Review of Resident 1's records showed a completed Medical Device Assessment, dated [redacted]2023. The assessment was updated in June 2024. The assessment did not document if the device was safe and free of entrapment-like qualities.

Observation of Resident 1's apartment on 09/25/2024 at 10:39 AM, showed a three-quarter rail attached on both sides of a hospital bed. One side of the bed was pushed up against the wall with a three-quarter rail in the up position. The second three-quarter rail on the opposite side was in the down position. Each railing showed a horizontal gap of six- and one-half inches wide between the posts. Each railing showed a vertical gap of 13 inches from the top portion of the rail to the bed frame. Both gaps were large enough for a limb or other body part to be entrapped in the rail and cause potential injury.

During an interview on 09/25/2024 at 10:11 AM, Collateral Contact 1 (CC 1, Resident 1's representative), stated that the purpose of the three-quarter rails was to "restrain" Resident 1 and prevent them from falling out of the bed. CC1 stated that Resident 1 used the rails to assist the caregivers with bed mobility.

During an interview on 09/26/2024 at 9:30 AM, Staff E, Registered Nurse, Director of Health Services, stated that they "wondered" if the three-quarter bed rail would be a problem.

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) 10/18/24.

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

Administrator (or Representative) 10/14/24 Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(1) Ventilate rooms to:

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Administrator (or Representative) Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to the air flow in for 1 of 5 common assisted living bathrooms (fourth floor common bathroom) and 1 of 1 memory care laundry room (memory care laundry) that provided mechanical ventilation to the outside. This failure placed all 76 residents at risk of poor air quality and a diminished quality of life.

Findings included...

NOTE: Per WAC 388-78A-3030, subsection (2): The assisted living facility must provide each toilet room and bathroom with (e)... mechanical ventilation to the outside.

Per WAC 388-78A-3040, subsection (7): The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is (a) Equipped with (iv) Mechanical ventilation to the outside of the assisted living facility.

Observation on 09/23/2024 at 10:47 AM, showed the air exchange vent in the fourth-floor common bathroom was not functioning to exchange fresh air from inside to the outside of the building.

Observation on 09/23/2024 at 11:47 AM, showed the air exchange vent in the memory care laundry room was not functioning to exchange fresh air from inside to the outside of the building.

During an interview on 09/23/2024 at 10:47 AM and 11:47 AM, Staff G stated that they were aware the vents in the two rooms were not functioning.

Plan/Attestation Statement

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Administrator (or Representative) Date

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10/10/2024

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 09/27/2024 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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

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-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;

The facility failed to provide lockable storage in the rooms for residents within the memory care unit. During the full inspection, the facility provided lockable storage for each resident.

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.

Kent, WA 98032

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Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

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Sincerely,

Laurie Anderson

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

Enclosure

Sincerely,

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

Enclosure