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

Renton Special Care Community LLC
The Cottages of Renton
17033 108th Ave SE
Renton, WA 98055

RE: The Cottages of Renton License # 2496

Dear Administrator:

This letter addresses Compliance Determination(s) 38910 (Completion Date 03/27/2024) and 34657 (Completion Date 01/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/27/2024 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-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2610-1, WAC 388-78A-24681-1, WAC 388-78A-24681-2, WAC 388-78A-24681, WAC 388-78A-24701-1, WAC 388-78A-2468-1, WAC 388-78A-2466-1, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-2500-1, WAC 388-78A-2500-2, WAC 388-78A-2500-2-a, WAC 388-78A-2500-2-b, WAC 388-78A-2500-2-c, WAC 388-78A-2500-2-d, WAC 388-78A-2500, WAC 388-112A-0400-3-c, WAC 388-78A-2510, WAC 388-112A-0495-4, WAC 388-78A-2450-2-h, WAC 388-78A-2450-2-h-i, WAC 388-78A-2450-2-h-ii, WAC 388-78A-2450-2-h-iii, WAC 388-78A-2450-2-h-iv, WAC 388-78A-2450-2-h-v, WAC 388-78A-2450-2-h-vi, WAC 388-78A-2450-2-h-vii, WAC 388-78A-2450-3-d-i-A, WAC 388-112A-0611-1-a-i, WAC 388-112A-0611-1-a-ii, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0720-2-a, WAC 388-112A-0200, WAC 388-112A-0200-1, WAC 388-112A-0200-2, WAC 388-112A-0200-2-a, WAC 388-112A-0200-2-b, WAC 388-112A-0200-2-c, WAC 388-112A-0200-2-d, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2483-2, WAC 388-78A-2483-1, WAC 388-78A-2483, WAC 388-78A-2484-1, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2160

The Department staff who did the on-site verification:
Steven Garrett, LTC Licensor
Thomas Forkgen, ALF Licensor
Jane Hermano, NCI

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 #: 2496	Compliance Determination # 34657
Plan of Correction	The Cottages of Renton	Completion Date
Page 1 of 34	Licensee: Renton Special Care Community LLC	01/29/2024

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 01/03/2024 and 01/09/2024 of:
The Cottages of Renton
17033 108th Ave SE
Renton, WA 98055

The following sample was selected for review during the unannounced on-site visit: 9 of 56 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Steven Garrett, LTC Licensor
Jane Hermano, NCI

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

01/30/2024 — 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.

Fiz Stepnowski, BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document a plan to monitor and address interventions required to meet the current clinical needs for 2 of 2 residents (Resident 7 and Resident 22). This failure placed the resident at risk for unmet care needs and potential harm.

Resident 7
Review of the facility's move in record showed that the facility admitted Resident 7 on [redacted]2022 with multiple diagnoses which included [redacted] with [redacted]. Review of Resident 7's October 2023, November 2023, December 2023, and January 2024 electronic medication administration record (eMAR) showed the resident received administration assistance with medication management that included an anti-seizure medication Lacosamide 100 milligrams (mg), by mouth, two times a day.

Review of the Resident 7's assessment, dated 10/04/2023, showed Resident 7 had history of seizures. Review of Resident 7's service plan, dated 06/16/2023, did not document the signs and symptoms of seizures. The service plan provided no staff instructions to follow if Resident 7 experienced a seizure.

Interview on 01/05/2024 at 1:59 PM, Staff B, Director of Nursing (DON), stated that the staff were trained to call the Medication Technician when a resident has a seizure episode. Staff B stated the facility did not have a seizure protocol. Staff B was aware Resident 7's service plan had no seizure interventions or safety plan written on it.

Interview on 01/08/2024 at 8:55 AM, Staff U and Staff X did not know that Resident 7 had

a seizure disorder. Staff U and Staff X stated they were instructed by nursing to call the Medication Technician in the case that any resident had a seizure.

Resident 22
Review of the facility's move in record showed that the facility admitted Resident 22 on [redacted]2020 with multiple diagnoses including [redacted].
Review of Resident 22's December 2023 and January 2024 eMAR showed Resident 22 received convulsion medication Levetiracetam 500 mg, to give 0.5 tablet, by mouth, two times a day.

Review of the Resident 22's undated service plan did not document the signs and symptoms of convulsions. The service plan provided no staff instructions or a safety plan to implement if Resident 22 experienced convulsions.

Interview on 01/09/2024 at 10:39 AM, Staff B stated that Resident 22 had a history of convulsion. Staff B stated that they were aware Resident 22's service plan had no convulsion interventions or safety plan written on it.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 3/14.

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

Fiz Stepnowski, BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

This requirement was not met as evidenced by:

Based on observation, interview and record review, 1 of 1 staff (Staff J) failed to implement infection control practices related to proper hand washing hygiene when providing medication administration assistance to 56 of 56 residents (Resident 1 to Resident 56). This failure placed all 56 residents at risk of illness from possible infections and a decreased quality of life due to potential medical emergency from possible cross contamination of medications.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for infection prevention and control practices for healthcare settings. Review of CDC's "Health Care Providers: Hand Hygiene", showed that hand hygiene reduced the incidents of infections.

Review of the facility's policy titled, "Infection Control", revised 03/28/2023, showed the importance of handwashing and required new employees complete an in-service training for hand washing and universal precautions. The policy showed employee hands should be washed before and after touching a resident.

Review of the facility's policy titled, "Delegation of Nursing Tasks", revised 04/01/2021, showed step-by-step instructions for the administration of medications. The instructions included hand washing before and after staff provided medication administration assistance for the residents.

During an interview on 01/03/2023 at 9:15 AM, Staff A, Executive Director, stated that there were three memory care cottages on the campus. Staff A stated that all residents were diagnosed with [redacted], [redacted] or [redacted]. Staff A stated that staff provided medication assistance or administration services to all residents.

BIRCH COTTAGE
Observation in the common dining area on 01/04/2024 between 7:45 AM and 8:36 AM showed Staff J, Medication Technician/Caregiver, administered medications to Resident 15, Resident 16, Resident 18, Resident 19, and Resident 20. Between each resident medication assistance, Staff J used their bare hands to handle the keys to lock and unlock the medication cart and retrieved the medication cards that contained the residents' medications in unit-of-use packaging. Observation showed Staff J pushed out each medication from the cards into plastic medication cups. After each resident medication administration assistance provided, Staff J touched the laptop and documented the activity in the electronic medication administration record (eMAR) system. Observation showed that Staff J did not wash their hands or use hand sanitizer before or after they provided each resident with medication administration assistance.

Observation on 01/04/2024 at 8:29 AM showed Staff J pulled out a lidocaine transdermal patch (medication for pain) from the medication cart. Staff J put on gloves and removed the patch's protective liner. Observation showed Staff J approached Resident 19, raised their shirt, and applied the patch to their lower back. Observation showed Staff J removed their gloves and washed their hands. Observation showed that Staff J did not sanitize or wash their hands before they applied the patch.

CEDAR COTTAGE

Observation in common dining/living room areas and residents' apartments on 01/04/2024 between 8:48 AM and 10:00 AM showed Staff J assisted and administered medications to 17 unidentified residents. Between each medication assistance provided, Staff J used their bare hands to handle the keys to unlock the medication cart. Staff J opened the medication drawers, pulled out the medication cards that contained the residents' medications in unit-of-use packaging. Staff J pushed the oral medications from the cards into plastic medication cups. Observation showed Staff J then touched the laptop computer and mouse to enter and document in the eMAR system each medication assistance provided. Observation showed that Staff J touched several walkers, residents' chairs, and the residents as they assisted each resident with medication administration. Observation showed that Staff J did not wash their hands or perform any hand hygiene before or after they provided each resident with medication administration assistance.

Observation on 01/04/2024 at 9:25 AM showed Staff J prepared a topical medication to administer to an unidentified resident. Observation showed Staff J put on gloves and approached the unidentified resident who sat in common living room area. Staff J applied the topical medication to the resident's leg. Observation showed Staff J removed their gloves following the application of the topical medication. Staff J then began preparation for the next resident medication administration assistance. Observation showed Staff J did not wash their hands after gloves were removed.

During an interview on 01/04/2024 at 10:45 AM, Staff B, Director of Nursing, stated that the facility provided infection control training for new staff. Staff B stated that the training included proper hand hygiene which included medication administration hygiene practice. Staff B stated that they expected the Medication Technicians to follow proper hygiene practices, as required.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 (14) .

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

F.L. Stegmaier, BSW — Administrator (or Representative)

1/31/2024 — Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 22 sampled long-long term care staff (Staff A, Staff B, Staff H, Staff K, and Staff O) completed a national fingerprint check within 120 days of hire. This failure placed all the residents at risk for abuse and neglect from caregivers with unknown backgrounds.

Findings included...

Review of the Department of Social and Health Services Administrator/Provider letter, dated 04/30/2021, showed that the Governor's Proclamation 20-18 issued on 03/18/2020 which suspended fingerprint background check requirements for long-term care facilities, was no longer in effect. The letter showed that Administrators/Providers were asked to resume the fingerprint background checks for current employees.

STAFF A
Review of the facility's Employee Information roster showed Staff A, Executive Director, was hired on 12/19/2022. Review of Staff A's records showed a national fingerprint background check was completed on 08/03/2023, 228 days after the date Staff A started work.

STAFF B
Review of the facility's Employee Information roster showed Staff B, Licensed Practical Nurse, Director of Nurses, was hired on 07/05/2022. Review of Staff B's records showed a national fingerprint background check was completed on 07/18/2023, one year and 13 days after the date Staff B started work.

STAFF H
Review of the facility's Employee Information roster showed Staff H, Resident Care Director, was hired on 05/09/2022. Review of Staff H's records showed a national fingerprint background check was completed on 07/18/2023, one year and 71 days after the date Staff H started work.

STAFF K
Review of the facility's Employee Information roster showed Staff K, Medication Technician/Caregiver (unlicensed staff who dispenses and administers medications) was hired on 08/24/2022. Review of Staff K's records showed a national fingerprint background check was completed on 08/20/2023, 360 days after the date Staff K started work.

STAFF O
Review of the facility's Employee Information roster showed Staff O, Medication Technician/Caregiver, was hired on 07/17/2022. Review of Staff O's records showed a national fingerprint background check was completed on 07/21/2023, one year and three days after the date Staff O started work.

During an interview on 01/04/2023 at 4:30 PM, Staff A stated they were aware that staff background checks and fingerprints were not done during the previous administration. Staff A stated that the facility completed an audit of all staff for completed name and date of birth and fingerprint background checks. The audit showed Staff A, Staff B, Staff H, Staff K, and Staff O were out of compliance. At that time, the required background checks were processed.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 (14) FTR.

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

FIR Alexander BSW — Administrator (or Representative)

1/31/2024 — Date

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a character, competence, and suitability (CCS) review to determine if 1 of 2 sampled staff (Staff F) was appropriate to work with vulnerable adults. This failure placed all the memory care residents at risk for abuse and neglect.

Staff F
Review of the facility's Employee Information roster showed that the facility hired Staff F on 10/12/2019 as a Dietary worker. Review of Staff F's employee records showed that on 10/15/2019, the facility completed a Washington State name and date of birth background check (BGI). The BGI results showed a review was required for a past criminal conviction in

December 1987. Review of Staff F's record showed a fingerprint final report was completed on 08/08/2023. The fingerprint background check report showed a review was required for a criminal conviction in November of 2021.

Review of Staff F's records showed no character, competence, and suitability review was completed to determine if Staff F was suitable to work with vulnerable adults in long-term care.

During an interview on 01/04/2023 at 4:30 PM, Staff A, Executive Director, stated that they were aware Staff F's BGI completed on 10/15/2019 required a review. Staff A stated that they read the criminal conviction. Staff A stated that Staff F was hired prior to Staff A's start of employment at the facility and that the previous administration did not conduct a review, as required. Staff A stated that they were unaware of the fingerprint record completed on 08/08/2023 which required a review. Staff A stated that they were not aware of the new criminal conviction. Staff A stated that a CCS was not completed for the fingerprint record.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 1/31/2024.

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

FIZ Hernandez-BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to submit background checks within one business day after hire for 8 of 22 sampled staff (Staff E, Staff F, Staff G, Staff I, Staff K, Staff O, Staff Q and Staff T). This failure placed all residents as risk for abuse and neglect from caregivers with unknown backgrounds.

Findings included...

Staff E
Review of the facility's Employee Information roster showed that the facility hired Staff E on 10/07/2021 as a Medication Technician/Caregiver (unlicensed staff who dispenses and administers medications). Review of Staff E's employee records showed a Washington State name and date of birth background check (BGI) was submitted and completed on 10/21/2021, 14 days after Staff E started work.

Staff F
Review of the facility's Employee Information roster showed that the facility hired Staff F on 10/12/2019 as a Dietary worker. Review of Staff F's employee records showed the facility submitted and completed a Washington State name and date of birth BGI on 10/15/2019, two business days after Staff F started work.

Staff G
Review of the facility's Employee Information roster showed that the facility hired Staff G on 07/18/2022 as the Business Office Manager. Review of Staff G's employee record showed the facility submitted and completed a Washington State name and date of birth BGI on 07/07/2023, 354 days after Staff G started work.

Staff I
Review of the facility's Employee Information roster showed that the facility hired Staff I on 05/22/2023 as the Dietary Manager. Review of Staff I's employee record showed the facility submitted and completed a Washington State name and date of birth BGI on 05/25/2023, three business days after Staff G started work.

Staff K
Review of the facility's Employee Information roster showed that the facility hired Staff K on 08/24/2022 as a Medication Technician/Caregiver. Review of Staff K's employee record showed the facility submitted and competed a Washington State name and date of birth BGI check on 07/10/2023, 321 days after Staff K started work.

Staff O
Review of the facility's Employee Information roster showed that the facility hired Staff O on 07/17/2022 as Medication Technician/Caregiver. Review of Staff O's employee record showed the facility submitted and competed a Washington State name and date of birth BGI on 07/07/2023, 354 days after Staff O started work.

Staff Q
Review of the facility's Employee Information roster showed that the facility hired Staff Q on 11/01/2023 as a Medication Technician/Caregiver. Review of Staff Q's employee record showed the facility submitted and competed a Washington State name and date of birth BGI on 11/07/2023, four business days after Staff Q started work.

Staff V
Review of the facility's Employee Information roster showed that the facility hired Staff V on 12/27/2023 as a Medication Technician/Caregiver. Review of Staff V's employee record showed the facility submitted and competed a Washington State name and date of birth BGI on 01/05/2024, six business days after Staff V started work.

During an interview on 01/05/2024 at 10:00 AM, Staff A, Executive Director, stated that they were aware background checks were not done on-time and that the facility was out of compliance with the Washington State Administrative Codes for Assisted Living Facilities. Staff A stated that the facility conducted an audit last summer and discovered several staff background checks were out of compliance. Staff A stated that at that time, the facility completed background checks and fingerprints for the identified staff.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 FDR 14

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

FR Stagnaro BSU
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State name and date of birth background check (BGI) every two years for 5 of 22 sampled staff (Staff E, Staff F, Staff J, Staff M, and Staff N). This failure placed all residents at risk of abuse, neglect, or exploitation from caregivers with unknown backgrounds.

Findings included...

STAFF E
Review of the facility's Employee Information roster showed the facility hired Staff E on 10/07/2021 as a Medication Technician/Caregiver (unlicensed staff who dispenses and administers medications). Review of Staff E's employee records showed their Washington state name and date of birth BGI expired on 10/21/2023. The records showed that on 10/08/2023 a BGI application was filled out. There was no record to show the application was ever submitted. Review of the records found no completed BGI.

STAFF F
Review of the facility's Employee Information roster showed the facility hired Staff F on 10/12/2019 as a Dietary worker. Review of Staff F's employee records showed their Washington state name and date of birth BGI expired on 10/15/2021. There was no documentation that showed the facility completed a new BGI, as required.

STAFF J
Review of the facility's Employee Information roster showed the facility hired Staff J on 05/25/2020 as Medication Technician/Caregiver. Review of Staff J's employee records showed their Washington state name and date of birth BGI expired on 05/18/2022. The records showed a new BGI was completed on 06/14/2023, one year and 27 days after the initial BGI expired.

STAFF M
Review of the facility's Employee Information roster showed the facility hired Staff M on 10/27/2020 as a Medication Technician/Caregiver. Review of the records showed their Washington state name and date of birth BGI expired on 10/14/2022. The records showed a new BGI was completed on 06/14/2023, 243 days after the initial BGI expired.

STAFF N
Review of the facility's Employee Information roster showed the facility hired Staff N on 01/12/2021 as a Medication Technician/Caregiver. Review of Staff N's employee records showed their Washington state name and date of birth BGI expired on 01/07/2023. The records showed a new BGI was completed on 06/14/2023, 153 days after the initial BGI expired.

During an interview on 01/05/2023 at 10:00 AM, Staff G, Business Office Manager, stated that they were responsible for completion of the staff background checks for all employees. Staff G stated that they were aware staff BGIs had were not done or had expired and were not renewed on time.

During an interview on 01/30/2024 at 11:09 AM, Staff G stated that Staff E left for a period of time between 10/07/2021 and 10/08/2023. Staff E returned to the facility on 10/08/2023. The facility decided to retro Staff E's date of hire to their original date of hire of 10/07/2021. Staff G stated that was the reason why the BGI application was never submitted to the DSHS background unit. Staff G stated that they did not know at the time a BGI needed to be done every two years.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024. FR 3/14

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

FR Stepnowski BSW
Administrator (or Representative)

1/31/2024
Date

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:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to secure the hazardous chemicals in 1 of 3 utility rooms (Dogwood Cottage utility room 1). This failure placed all 56 residents at risk for harm and injury had they accessed and ingested the hazardous chemicals.

Findings included...

Note: The facility design consisted of four separate buildings, contiguous (shared the same common border) with each other and connected by a secured outdoor courtyard.

Observation on 01/03/2024 at 9:00 AM, showed three of the buildings were identified as "cottages", each with separate name (Dogwood, Cedar, and Birch). Each cottage had capacity for 20 residents. Each cottage was rectangular shaped with a continuous pathway that started and ended at the common area/dining room. The facility was designated as a secured memory care facility that provided services for residents with a primary diagnosis of [redacted], and/or [redacted].

DOGWOOD COTTAGE
Observation on 01/03/2024 at 12:58 PM, showed an unlocked door to the utility room used for soiled products. Observation found the utility room contained several cleaning products: a bottle of tub tile cleaner, a bottle of floor cleaner, a bottle of detergent disinfectant, and other cleaning products, a hazardous waste disposal container and soiled

linen.

During an interview on 01/03/2024 at 1:08 PM, Staff V, Medication Technician/Caregiver, stated that the door to the soiled utility should always remain locked. Staff V locked the door to the soiled utility room.

Observation on 01/04/2024 at 11:00 AM, showed Resident 23 enter the unlocked soiled utility room with their walker. Resident 23 was observed rummaging around in the room until staff were alerted. Staff C, Medication Technician/Caregiver, (unlicensed staff who dispense and administer medications) removed Resident 23 from the utility room.

Observation on 01/04/2024 at 12:41 PM, showed the Dogwood Cottage solid utility room, with cleaning chemicals inside, was unlocked and accessible to the residents. Observation showed multiple residents wandering back and forth along the hallway, past the unlocked soiled utility room. During an interview on 01/04/2024 at 12:45 PM, Staff W, Maintenance Director, stated that the soiled utility room was to always remain locked. Staff W locked the door to the soiled utility room.

Observation on 01/04/024 at 1:30 PM showed that the soiled utility room was unlocked and the cleaning chemicals inside were accessible to multiple residents observed walking past the room.

Observation on 01/08/2024 at 7:20 AM, showed the soiled utility room was unlocked and the cleaning chemicals were accessible in the room. Observation at 7:25 AM, showed Staff W check the soiled utility room doorknob, discovered it was unlocked, and locked the door, securing the cleaning chemicals inside.

During an interview on 01/25/2024 at 2:06 PM, Staff H, Resident Care Director, stated that they were unaware the door to the soiled utility did not automatically lock when closed. Staff H stated that in the other two cottages, soiled utility room doors automatically locked when the door was closed.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/14/2024.

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

FR Stepanek - BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 2 of 19 sampled staff (Staff B and Staff O) received Mental Health specialty training within 120 days of hire. This failure placed all the memory care residents at risk of receiving care from unqualified staff.
Findings included...

Observation on 01/03/2024 at 9:00 AM showed the campus consisted of four buildings. Three of the buildings were for residents, each with a capacity to house 20 residents. The fourth building was used for the administration offices and the main kitchen. Observation showed that the facility was exclusively a memory care facility that provided care for residents with diagnoses of [redacted] and/or [redacted].

Review of the facility's characteristics roster showed that 56 residents resided in the facility. The characteristics roster identified all 56 residents with behavior/psychosocial

issues, dementia, Alzheimer's, and cognitive impairment. One resident was identified with mental health problems.
Review of the facility's Employee Information roster showed the facility hired Staff B, Licensed Practical Nurse, on 07/05/2022 as the Director of Nurses. The facility hired Staff O on 07/17/2022 as a Medication Technician/Caregiver (unlicensed Staff who dispenses and administers medications).

STAFF B
Observations on 01/03/2024 between 9:00 AM and 3:00 PM, 01/04/2024 between 10:00 AM and 5:00 PM, 01/05/2024 between 7:30 AM and 4:00 PM, 01/08/2024 between 8:00 AM and 4:00 PM, and 01/09/2024 between 9:00 AM and 1:00 PM, showed Staff B interacted with residents in each of the three memory care buildings.

Review of Staff B's personnel records found no documentation that showed Staff B completed Mental Health specialty training, as required.

During an interview on 01/04/2024 at 2:10 PM, Staff B stated that they received Mental Health specialty training several years ago. Staff B stated that the Department of Social and Health Services (DSHS) Mental Health specialty training certificates were at home somewhere.

During an interview on 01/08/2024 at 10:00 AM, Staff B stated that they were unable to produce the certificates for the Mental Health specialty training.

STAFF O
Review of Staff O's personnel records showed that on 07/03/2023, Staff O completed the DSHS Mental Health specialty training, 351 days after hire and 231 days past the 120 days allowed.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 (14). FR

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

FR Administrator 3SW — 1/31/2024

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 observation, interview, and record review, the facility failed to ensure 2 of 19 sampled staff (Staff B and Staff O) received Specialty Training for Dementia within 120 days of hire. This failure placed all the residents at risk for receiving care from unqualified staff.

Findings included...

Observation on 01/03/2024 at 9:00 AM showed the campus consisted of four buildings. Three of the buildings were for residents, each with a capacity to house 20 residents. The fourth building was used for the administration offices and the main kitchen. Observation showed that the facility was exclusively a memory care facility that provided care for residents with diagnoses of [redacted] and/or [redacted].

Review of the facility's characteristics roster showed that 56 residents resided in the facility. The characteristics roster identified all 56 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment. One resident was identified with mental health problems.

Review of the facility's Employee Information roster showed the facility hired Staff B, Licensed Practical Nurse, on 07/05/2022 as the Director of Nurses. The facility hired Staff O on 07/17/2022 as a Medication Technician/Caregiver (unlicensed Staff who dispenses and administers medications).

STAFF B
Observations on 01/03/2024 between 9:00 AM and 3:00 PM, 01/04/2024 between 10:00 AM and 5:00 PM, 01/05/2024 between 7:30 AM and 4:00 PM, 01/08/2024 between 8:00 AM and 4:00 PM, and 01/09/2024 between 9:00 AM and 1:00 PM, showed Staff B interacted with residents in each of the three memory care buildings.

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

During an interview on 01/04/2024 at 2:10 PM, Staff B stated that they received Specialty Training for Dementia several years ago. Staff B stated that the Department of Social and Health Services (DSHS) Specialty Training for Dementia certificates were at home somewhere.

During an interview on 01/08/2024 at 10:00 AM, Staff B stated that they were unable to produce the certificates for their completed Specialty Training for Dementia.

STAFF O
Review of Staff O's personnel records showed that on 07/03/2023, Staff O completed the DSHS Specialty Training for Dementia, 351 days after hire and 231 days past the 120 days allowed for completion.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/18/2024 FTR 3/14.

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

FTR Stephanie BSW — Administrator (or Representative)

1/31/2024 — Date

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

(2) Long-term care worker orientation. Individuals required to complete the seventy-hour long-term care worker basic training must complete long-term care worker orientation, which is two hours of training regarding the long-term care worker's role and applicable terms of employment as described in WAC 388-112A-0210 .

(a) All long-term care workers who are not exempt from certification as described in RCW 18.88B.041 hired on or after January 7, 2012, must complete two hours of long-term care worker orientation training before providing care to residents.

(b) Long-term care worker orientation training must be provided by qualified instructors that meet the requirements in WAC 388-112A-1260 .

(c) The department must approve long-term care worker orientation curricula and instructors.

(d) There is no test for long-term care worker orientation.

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the seventy-hour long-term care worker basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure: 5 of 22 sampled staff (Staff B, Staff C, Staff D, and Staff E, and Staff H) completed facility orientation; 7 of 22 sampled staff (Staff C, Staff D, Staff H, Staff K, Staff O, Staff P, and Staff S) obtained and maintained Cardiopulmonary Resuscitation (CPR) certification and/or first-aid training within thirty days of hire; and 6 of 22 staff (Staff E, Staff J, Staff K, Staff L, Staff M, and Staff N) completed the required continuing education training. This failure placed all the residents at risk of receiving care from unqualified staff.

Findings included...

Review of the facility's Employee Information roster showed the facility hired Staff B on 07/05/2022 as the Director of Nurses, Staff C on 11/30/2023 as a Medication Technician/Caregiver, Staff D on 11/10/2023 as a Medication Technician/Caregiver, Staff E on 10/07/2021 as a Medication Technician/Caregiver, Staff H on 05/09/2022 as the Resident Care Director, Staff J on 05/25/2020 as a Medication Technician/Caregiver, Staff K on 08/24/2022 as a Medication Technician/Caregiver, Staff L on 03/05/2021 as a Medication Technician/Caregiver, Staff M on 10/27/2021 as a Medication Technician/Caregiver, Staff N on 01/12/2021 as a Medication Technician/Caregiver, Staff O on 07/17/2022 as a Medication Technician/Caregiver, Staff P on 11/10/2023 as a Medication Technician/Caregiver. (Unlicensed Staff who dispenses and administers medications), and Staff S on 10/26/2023 as a Medication Technician/Caregiver.

FACILITY ORIENTATION
Review of the facility personnel records showed no documentation that Staff B, Staff C, Staff D, Staff E, and Staff H received facility orientation.

Review of Washington Administrative Code 388-112A-0200 subsection one showed that facility orientation was required before staff interacted routinely with residents.

During an interview on 01/25/2024 at 2:10 PM, Staff H stated that prior to facility orientation, newly hired caregivers initially received "generic training" in the cottages with another staff member who provided care for residents. Staff H stated that facility orientation occurred within 60 days of hire unless there were a lot of new hires, then facility orientation occurred within a month. Staff H stated that facility orientation consisted of: watching videos on blood borne pathogens, infection control, and active shooter; Human Resource policy reviewed with Staff G, Business Office Manager; hot boxes (food warming carts) and kitchen restrictions reviewed with Staff I, Dining Services Manager; fire protocols reviewed with Staff W, Maintenance Director; and the emergency exits process reviewed with Staff H, Resident Care Director. Staff H stated that when they were hired two years ago, facility orientation was not provided. Staff H stated that they were not surprised that other staff were not provided with facility orientation when hired.

CARDIOPULMONARY RESUSCITATION CERTIFICATION/FIRST AID
Review of the facility personnel records showed no documentation that Staff C maintained a valid first aid card; no documentation that Staff D completed first aid training and maintained a valid first aid card; no documentation that Staff H maintained a valid first aid card; no documentation that Staff O completed first aid training and maintained a valid first aid card; no documentation Staff P maintained a valid CPR or first aid card; no documentation Staff S maintained a valid CPR card and no documentation Staff S completed and maintained a valid card for first aid training. The personnel records showed that on 10/12/2023, Staff K completed CPR certification, 415 days after Staff K started work.

CONTINUING EDUCATION
Review of the facility personnel records showed Staff E only completed four hours of continuing education training approved by the Department of Social and Health Services (DSHS); Staff J completed zero hours of continuing education training approved by the DSHS; Staff K completed zero hours of continuing education training approved by the DSHS; Staff L completed zero hours of continuing education training approved by the DSHS; Staff M completed only 4.75 hours of continuing education approved by DSHS; Staff N completed zero hours of continuing education approved by the DSHS.

During an interview on 01/08/2024 at 3:00 PM, Staff A, Executive Director, provided staff training documents for review. Review of the documents showed several staff attendance rosters for several facility in-service trainings. Review of the documents showed that none of the trainings were approved by the DSHS, as required. Staff A confirmed that the staff trainings provided by the facility were not DSHS approved trainings. Staff A stated they understood the required 12 hours of continued education training needed to be approved by DSHS.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 14

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

FR Mcgrouth - BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the service plan for 1 of 9 sampled residents (Resident 6) when there was a change in Resident 6's condition and care needs. This failure placed Resident 6 at risk for unmet care needs.

Review of the facility's Move in Record documentation showed the facility admitted Resident 6 in [redacted] 2023 with a diagnosis of [redacted].

Review of Resident 6's Service Plan, dated 11/09/2023, showed that Resident 6 exhibited wandering behaviors and was independent with ambulation. The plan instructed staff to redirect Resident 6, as necessary, when Resident 6 wandered into other's rooms or into unsafe areas. The plan showed that Resident 6 received a mechanical soft diet (food modified to allow for easier swallowing) and required set-up, cuing, and stand-by assistance from staff for meals. The plan showed that Resident 6 was a moderate risk for falls during transfers and while ambulating. Resident 6 required minimal staff assistance with transfers for safety. The service plan showed Resident 6 needed assistance with dressing and toileting.

Review of a facility incident report dated 12/21/2023, showed an altercation occurred between Resident 6 and three other residents. The incident report showed that Resident 6 became aggressive and had physical behaviors towards others. The report showed 911 was called and Resident 6 was transported to the emergency department and subsequently admitted to the hospital.

Review of Resident 6's hospitalization records, dated 12/21/2023, showed Resident 6 became aggressive, combative, and tried to attack the other residents at the facility. Review of hospital records, dated 12/29/2023, showed that Resident 6 fell at the hospital and hit their head. The records showed Resident 6 was diagnosed with a [redacted] related to the fall. The records showed that prior to their hospitalization, Resident 6 ambulated independently with staff supervision. The records showed that after the fall, Resident 6's condition changed, and Resident 6 was now unable to ambulate independently. The records showed Resident 6 required assistance for most activities of daily living (complete hands-on assistance with tasks for dressing, grooming, and bathing).

Review of Resident 6's facility assessment, dated 12/27/2023, showed that Resident 6 was a "two-person transfer." The assessment showed that while at the hospital, Resident 6 fell, hit their head, and sustained a hematoma. The assessment showed that home health psych and physical therapy were to follow Resident 6 after discharge. The assessment did not show that Resident 6's care needs changed significantly, and Resident 6 now required full

assistance with all aspects of care. There was no documentation that showed Resident 6 was no longer ambulatory and was now required a wheelchair, was unable to independently maneuver the wheelchair and required one-on-one staff assistance with feeding.

During an interview on 01/02/2024 at 12:40 PM, Staff J, Medication Technician, (unlicensed staff who dispenses and administers medication) stated that prior to the last hospitalization, Resident 6 ambulated independently and wandered about the facility and the courtyard without any assistive devices or staff assistance. Staff J stated that after Resident 6's returned to the facility, Resident 6 required a wheelchair, and required staff assistance with transfers and feeding.

Observations on 01/03/2024 between 12:12 PM and 12:58 PM, showed Resident 6 sat in a wheelchair in the common area/dining room of the cottage. Resident 6's verbalization was incomprehensible and was unable to appropriately respond to questions. Resident 6's primary language was not English. Resident 6 was non-ambulatory and showed they were unable to feed themselves. Observation showed staff hand fed Resident 6 lunch and assisted with fluids by holding the cup to Resident 6's mouth.

During an interview on 01/04/2024 at 11:00 AM, Collateral Contact 1, (CC1) Home Health intake nurse, stated that Resident 6 was recently hospitalized for aggressive behavior toward staff and other residents, which included resident to resident altercations. CC1 stated that a change in environment and constipation may have contributed to the aggressive behaviors. CC1 stated that prior to their hospital stay, Resident 6 ambulated independently. CC1 stated that since Resident 6's return to the facility, Resident 6 no longer ambulated independently. CC1 stated that it was unclear as to why Resident 6's ambulatory status changed. CC1 stated that the Home Health physical therapist, occupational therapist and possibly the speech therapist planned to evaluate Resident 6 due to the change in condition.

Observation on 1/04/2024 between 12:30 PM and 12:55 PM showed Resident 6 seated at a dining room table. Observation showed staff fed lunch to Resident 6. Observation showed Resident 6 continued to be non-ambulatory.

During an interview on 01/04/2024 at 12:52 PM, Collateral Contact 2 (CC2), Resident 6's representative, stated that when Resident 6 admitted to the facility, CC2 placed Resident 6's partial denture on the closet shelf. CC2 stated that Resident 6's partial denture went missing the following day. CC2 stated they asked the staff about it and the staff were able to locate the partial denture. CC2 stated that shortly after staff found the partial denture, the partial denture again went missing and had not been found. CC2 stated that Resident 6 used to walk about the facility by themselves and now requires a wheelchair. CC2 stated that Resident 6 needs a pureed (foods that do not need to be chewed) diet because they now have difficulty eating a mechanical soft diet (food that is chopped up).

Observations on 01/05/2024, at breakfast time, 01/08/2024, at lunch time, and 01/09/2024 at breakfast time showed that Resident 6 was non-ambulatory and required a

wheelchair for all mobility. Resident 6 required total staff assistance to eat.

During an interview on 01/05/2024 at 2:23 PM, Staff B, Licensed Practical Nurse, Director of Nurses stated that since Resident 6's return to the facility, they did not have the opportunity to update Resident 6's service plan or initiate a temporary service plan to document the changes in Resident 6's care needs. Staff B confirmed there were significant changes in Resident 6's condition, and Resident 6 now required more staff assistance with care. Staff B stated that until the service plan was updated, staff would observe Resident 6 and determine what type of assistance Resident 6 needed.

During an interview on 01/08/2024 at 9:15 AM, Staff H, Resident Director, stated that when Resident 6 moved into the facility, CC2 never informed the staff that Resident 6 wore a partial denture. Staff H stated the staff were not informed the CC2 placed the partial denture on a closet shelf. Staff H stated that when CC2 informed the staff that the partial denture was missing, the staff were able to locate it. Staff H stated that the staff made sure Resident 6 wore the partial denture at mealtimes. Staff H stated that unfortunately the partial denture was lost and has not been found. Staff H stated that Director of Nurses was responsible for updating the service plan. Staff H stated they only assisted with the service plans.

During an interview on 01/08/2024 at 10:00 AM, Staff B stated that they assessed Resident 6 at the hospital. Staff B stated that they did not have an opportunity to update the service plan to reflect Resident 6 care needs.

During the exit conference on 01/09/2024 at 11:00 AM, Staff B stated that they had not updated Resident 6's service plan. Staff B stated they had not created a temporary service plan to provide staff guidance for Resident 6's change of condition.

On 01/09/2024, review of Resident 6's facility records showed no updated to Resident 6's service plan to show Resident 6's change of condition since their return from the hospital. There was no documentation that showed Resident 6 was no longer ambulatory and required a wheelchair for all mobility. There was no documentation that showed Resident 6 wore a partial denture. There was no documentation that showed Resident 6 required staff hands-on assistance to eat and complete activities of daily living.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 3/14

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

FIZ Stephanie. BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled staff (Staff B, Staff P, and Staff U) were screened for tuberculosis. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's policy titled, "Tuberculosis Testing", dated 01/17/2024, showed the facility followed the Washington Administrative Code (WAC) on tuberculosis testing (TB) requirements. The policy showed the assisted living community only required staff to complete a one-step test if the person had a documented negative test result from a one-step skin test or a blood test in the previous twelve months.

STAFF B
Review of the facility's Employee Information roster showed the facility hired Staff B on 07/05/2022 as the Director of Nurses. Review of Staff B's personnel records showed documentation that on 04/06/2022, Staff B took an Interferon Gamma Release Assays [IGRA (blood test for TB)] with negative results. The records showed no documentation that staff B completed a one-step TB skin test within three days of hire, as required.

STAFF P
Review of the facility's Employee Information roster showed the facility hired Staff P on 11/10/2023 as Medication Technician/Caregiver (unlicensed staff who dispense and administer medications). Review of Staff P's personnel file showed that on 09/05/2023, Staff P took an IGRA test, two months prior to Staff P's hire date, with negative results. Staff P's records showed no documentation that Staff P completed a one-step TB test within three days of hire, as required.

STAFF U
Review of the facility's Employee Information roster showed the facility hired Staff U on

12/06/2023 as Medication Technician/Caregiver. Review of Staff U's personnel file showed that on 01/11/2023, Staff U took an IGRA test with negative results. The records showed no documentation that Staff U completed a one-step TB test within three days of hire, as required.

During an interview on 01/05/2024 2:23 PM, Staff B stated that they had an IGRA done on a yearly basis and believed they met the TB requirements. Staff B stated they did not realize a one-step TB test was required since their IGRA was done within 12 months of hire and prior to their date of hire.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/18/2024 (14). JM

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

F.Z. Stepanek, BSW
Administrator (or Representative)

1/31/2024
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

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to implement a system to screen and test 6 of 22 sampled staff (Staff C, Staff E, Staff H, Staff J, Staff O, and Staff Q) for Tuberculosis (TB) as required. This failure placed all residents in the memory care facility at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of a Department of Social and Health Services (DSHS) "Dear Administrator/Provider" letter, dated 05/17/2022, showed that Washington state experienced a significant increase in the number of TB cases. The letter stated that to reduce the risk of illness to the vulnerable people served, TB testing was reinstated on July 1, 2022. The letter stated that Residential Care Services encouraged facilities and providers to immediately begin staff TB testing. This would allow facilities time to meet the TB testing requirements on 07/01/2022.

Review of the facility's policy titled "Tuberculosis Testing", dated 01/17/2024, showed that the facility followed the Washington Administrative Code (WAC) on tuberculosis testing (TB) requirements. The document showed that it was the policy of the assisted living facility to test or verify compliance of staff persons within three days of hire. The facility ensured that all tuberculosis testing was done through Intradermal [(Intradermal injections are administered into the second layer of skin called the dermis, just below the first layer of skin called the epidermis.) Mantoux tuberculin skin test, also known as TST] administration with test results read by a trained professional within forty-eight to seventy-two hours of the test or through a blood test for tuberculosis called interferon-gamma release assay (IGRA).

ONE STEP TB TEST

STAFF C
Review of the facility's Employee Information roster showed that the facility hired Staff C on 11/30/2023, as a Medication Technician/Caregiver (unlicensed staff who dispense and administer medications). Staff C's first paid day of work was 12/01/2023.

Review of Staff C's personnel records showed that Staff C received a one-step TB skin test injection on 12/05/2023, five days after first paid day of work.

STAFF E
Review of the facility's Employee Information roster showed that the facility hired Staff E on 10/07/2021, as a Med Tech/Caregiver.

Review of Staff E's personnel records showed that Staff E received a one-step TB skin test injection on 08/25/2023, 421 days after TB testing was reinstated on 07/01/2022.

STAFF H
Review of the facility's Employee Information roster showed that the facility hired Staff H on 05/09/2022, as the Resident Care Director.

Review of Staff H's personnel file showed Staff H received a one-step TB skin test on 08/21/2023, 417 days after TB testing was reinstated.

STAFF J
Review of the facility's Employee Information roster showed that the facility hired Staff J on 05/25/2020, as a Med Tech/Caregiver.

Review of Staff J's personnel file showed Staff J received a one-step TB skin test on 08/22/2023, 418 days after TB testing was reinstated.

STAFF O
Review of the facility's Employee Information roster showed that the facility hired Staff O on 07/17/2022, as a Med Tech/Caregiver.

Review of Staff O's personnel file showed Staff O received a one-step TB skin test on 08/24/2023, 420 days after the date of hire.

STAFF Q
Review of the facility's Employee Information roster showed that the facility hired Staff Q on 11/01/2023, as a Med Tech/Caregiver.

Review of Staff Q's personnel file showed Staff Q received a one-step TB skin test on 11/20/2023, 19 days after date of hire.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 (14). 7pm

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

FR Administrator BSW
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 residents (Resident 4 and Resident 7) received medications as prescribed. This failure placed Resident 4 and Resident 7 at risk for compromised health and not receiving their medications as prescribed.

Findings included...

MEDICATION UNAVAILABLE POLICY
Review of the facility's policy titled, "Medication Unavailable Policy", revised on 06/22/2021, showed the procedure to obtain unavailable medication included repeated contact to the pharmacy and physician, and monitor the resident for any side effects from the missed doses. Review of the policy showed the facility should contact the pharmacy 5-7 days prior to last dose for ongoing routine and as needed (PRN) medications.

MEDICATION SERVICES POLICY
Review of the facility's undated policy titled, "Medication Services", defined medication administration as when a resident is not physically able to ingest or apply medication independently or with assistance, staff legally authorized to administer medications provided the assistance. The policy showed that nursing services provided by the facility were planned and supervised. The policy showed that staff who provided medication administration assistance were appropriately trained and would document medication name, time, and dosage in resident's record.

RESIDENT 7
Review of Resident 7's Move-In Record showed the facility admitted resident on [redacted] 2022. Review of the record showed that Resident 7 admitted with a diagnosis [redacted].

Review of Resident 7's Assessment, dated 10/04/2023, showed that the facility ordered and maintained Resident 7's medication. Review of Resident 7's assessment showed that the facility provided administration of all medications and treatments to Resident 7.

Review of Resident 7's October 2023, November 2023, December 2023, and January 2024 electronic Medication Administration Records (eMAR), showed that Resident 7's prescriptions included Lacosamide (a drug used to treat partial onset seizures), 100 milligrams (mg), by mouth, two times a day, at 8:00 AM and 6:00 PM. Review of November 2023 eMAR showed that the anti-seizure medication was not available for the two doses on 11/02/2023 and the 8:00 AM dose on 11/03/2023.

Interview on 01/05/2024 at 1:59 PM, Staff B, Director of Nursing, stated that the dispensing pharmacy delivered medications to the facility through cycle fill (medications filled on a regular basis). During the interview, Staff B provided three documents that showed the facility's effort to obtain the anti-seizure medication. Review of the first document, dated 11/02/2023, showed the facility notified the pharmacy and the expected delivery of anti-seizure medication "tomorrow". Review of the second document, dated 11/03/2023, showed the anti-seizure medication was not delivered. Review of the third document, dated 11/06/2023 showed Resident 7 missed three doses of anti-seizure medications without adverse reaction. Review of the document showed the physician was notified. Staff B stated that the anti-seizure medication was a controlled substance and was excluded from cycle fill. Staff B stated that they requested the anti-seizure medication

from the pharmacy on the same day they run out of the medication.

RESIDENT 4
Review of Resident 4's Service Plan, dated 01/19/2023, showed a diagnosis of [redacted]. The service plan showed that the facility staff maintained all of Resident 4's medications. The plan showed the facility staff provided assistance with medication administrations and treatments.

Review of Resident 4's January 2024 electronic medication administration record (eMAR) showed an order for Diclofenac 1% gel (topical pain ointment) to be applied topically to both knees for knee pain one time a day, during the "day." A second order showed Diclofenac 1% gel to be applied topically to both knees one time a day, during the "evening." The order did not specify or provide instructions on the dosage/strength or the amount of Diclofenac that was to be administered.

Observation and interview on 01/08/2024 at 1:49 PM, showed Staff K, Medication Technician, (Med Tech; unlicensed staff who dispense and administer medications) reviewed Resident 4's eMAR. Staff K stated that they used the measuring strip that came with the tube of Diclofenac to measure out the correct amount required. The measuring strip was marked with two lengths, one for two grams and another with four grams. Staff K stated that they used the strip to measure out two grams. Staff K demonstrated how they measured out two grams and stated that they applied 50% (one gram) of the gel to each knee. Staff K stated that if Resident 4 complained that one knee was hurting more than the other knee, Staff K would apply the entire 2 grams of Diclofenac to that knee. Staff K stated that the dosage amount was not specified on the eMAR, so they decided how much to apply. Observation of the pharmacy label affixed to the tube of Diclofenac showed that the dosage amount was supposed to be four grams.

Observation and interview on 01/09/2024 at 10:18 AM, showed Staff J, Med Tech, squeeze an unknown amount of Diclofenac from the tube into a clear measured medication cup. Observation showed Staff J applied the Diclofenac to each of Resident 4's knees. When asked how they determined the amount of Diclofenac to be applied, Staff J smiled and stated, "I just put."

During an interview on 01/09/2024 at 11:00 AM, Staff B, Licensed Practical Nurse, Director of Nurses, stated that the pharmacy uploaded the original order form the prescriber into the eMAR system for each resident. Staff B stated that they reviewed the new orders in the eMAR system, made any corrections necessary, then activated the order in the system. Staff B stated that the system would not allow the user to enter the order as twice a day which was why there were two orders, each order for once a day. Review of Resident 4's eMAR showed two other orders, one order for Olanzapine (dementia medication) five mg tab entered in the eMAR as twice a day and another order for Divalproex (dementia medication) entered in the eMAR for three times a day. Staff B acknowledged that the Diclofenac order did not provide instructions for the dosage amount to be applied. Staff B acknowledge the order was not written clearly.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/15/2024 (corrected to 3/14). FIR

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

FIR Administrator - BSN
Administrator (or Representative)

1/31/2024
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility staff failed to provide care and services for 8 of 8 sampled male Residents (Resident 4, Resident 6, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 23) as instructed in each Residents' service plan. This failure placed Resident 4, Resident 6, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 23 at risk for neglect, unmet care needs and a decreased quality of life.

Findings included...

Observation on 01/03/2024 at 9:00 AM showed the campus consisted of four buildings. Three of the buildings were for residents, each with a capacity to house 20 residents. The fourth building was used for the administration offices and the main kitchen. Observation showed that the facility was exclusively a memory care facility that provided care for residents with diagnoses of [redacted] and/or [redacted]

Observation on 01/03/2024 at 12:10 PM, showed Resident 14 wearing a state basketball champions shirt and a pair of trousers that were stained with dirt, food, and unknown substances. Resident 14 was observed to be unshaved.

Observations on 01/03/2024 at 12:40 PM, showed Resident 4, Resident 6, Resident 10, Resident 11, Resident 12, Resident 13, and Resident 23 in the main dining room of the "Dogwood" cottage during lunch time. Observation showed each resident had a small amount of facial hair growth and were unshaven.

Observation on 01/03/2024 at 2:28 PM, showed Resident 14 wearing the same clothing as observed earlier in the day at 12:10 PM. Resident 14 remained unshaved.

Observations on 01/04/2024 at 10:30 AM, showed Resident 4 sat on the couch, Resident 6 sat in a wheelchair at the dining room table, Resident 10 sat in the common room, Resident 11 wandered about the building, Resident 12 was in the common room/dining room area, Resident 13 sat in the common room/dining room, Resident 14 was in the common area, and Resident 23 pushed a walker as they wandered about the common area and halls. Each resident was observed with facial hair growth greater than the day before. Observation showed none of the male residents were shaved from the previous day.

Observation on 01/05/2024 between 7:33 AM and noon, showed Resident 4, Resident 6, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 23 remained unshaven. Each resident showed three days of facial hair growth.

Observation on 01/08/2024 at 11:32 AM Resident 4, Resident 6, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 23 remained unshaven from the previous week. Each resident had several days of facial hair growth, which was greater than what was observed on 01/05/2024.

Observation on 01/09/2024 at 10:00 AM, showed Resident 11 and Resident 23 were shaved. Resident 4, Resident 6, Resident 10, Resident 12, Resident 13, Resident 14 remained unshaved and showed significant facial hair growth.

Review of the facility's "Skin Monitoring: Comprehensive CNA Shower Review" document located in the resident record log, showed no documentation of residents that refused care.

RESIDENT 4
Review of the facility's move in record showed that the facility admitted Resident 4 in [redacted] of 2015 with the diagnoses of [redacted], and [redacted]. Resident 4 resided in the secured memory care unit.

Review of Resident 4's Service Plan, dated 01/19/2023, showed that Resident 4 received hygiene services provided by the facility staff.

RESIDENT 6
Review of the facility's move in record showed the facility admitted Resident 6 in [redacted] 2023 with the diagnoses of [redacted]. Resident 6 resided in the secured memory care unit.

Review of Resident 6's Service Plan, dated 11/09/2023, showed that staff "would need to

help (Resident 6) with all personal hygiene needs. Shaving with showers. Notify MT (Med Tech) of refusals."

RESIDENT 10
Review of Resident 10's Service Plan, dated 12/13/2022, showed that the facility admitted Resident 10 in [redacted] of 2022 with a diagnosis of [redacted]. The service plan showed that Resident 10 required staff assistance with personal hygiene care.

RESIDENT11
Review of Resident 11's Service Plan, dated 08/19/2023, showed that the facility admitted Resident 11 in [redacted] of 2023 with a diagnosis [redacted] and [redacted]. The service plan showed that "due to (Resident 11's) physical and cognitive decline staff will need to help with personal hygiene and shaving."
Review of Resident 11's Activities of Daily Living Care Record, dated January 2024 showed Resident 11 was to receive daily hygiene care which included shaving. The Care Record showed staff initialed the document to show the care was provided daily from January 1, 2024, through January 08, 2024. There was no refusal of care noted.

RESIDENT 12
Review of Resident 12's Service Plan, dated 12/16/2023, showed that the facility admitted Resident 12 in [redacted] of 2021 with a diagnosis [redacted] and [redacted]. The service plan showed that Resident 12 required "total help with personal hygiene... skincare, and shaving. Notify MT of any refusals of care."

Review of Resident 12's Activities of Daily Living Care Record, dated January 2024 showed Resident 12 required staff assistance with daily hygiene care, which included shaving. The Care Record showed staff initialed the document to show the care was provided daily from January 1, 2024, through January 07, 2024. There was no refusal of care noted.

RESIDENT 13
Review of Resident 13's Service Plan, dated 11/04/2023, showed that the facility admitted Resident 13 in [redacted] of 2020 with a diagnosis [redacted] and [redacted]. The service plan showed that staff helped Resident 13 to shave.

Review of Resident 13's Activities of Daily Living Care Record, dated January 2024 showed Resident 13 required staff assistance with daily hygiene care, which included shaving. The Care Record showed staff initialed the document to show the care was provided daily from January 1, 2024, through January 07, 2024. There was no refusal of care noted.

RESIDENT 14
Review of Resident 14's Service Plan, dated 05/26/2023, showed that the facility admitted Resident 14 in [redacted] of 2023 with a diagnosis [redacted]. The service plan showed that staff provided total assistance with personal hygiene, which included shaving.

Review of Resident 14's Activities of Daily Living Care Record, dated January 2024 showed Resident 14 required staff assistance with daily hygiene care, which included shaving. The Care Record showed staff initialed the document to show the care was provided daily from January 1, 2024, through January 07, 2024. There was no refusal of care noted.

RESIDENT 23
Review of the facility's move in record showed the facility admitted Resident 23 in [redacted] of 2021 with a diagnosis of [redacted].

Review of Resident 23's Service Plan, revised on 11/29/2023, showed that the staff provided total assistance with personal hygiene, which included shaving.

Review of Resident 23's Activities of Daily Living Care Record, dated January 2024 showed Resident 23 received daily hygiene care, which included shaving. The Care Record showed staff initialed the document to show the care was provided daily from January 1, 2024, through January 25, 2024. There was no documentation Resident 23 refused care.

During an interview on 01/08/2024 at 8:52 AM, Staff C, Med Tech/Caregiver, stated that the staff were responsible to shave the male residents every day. Staff C confirmed the male residents in The Dogwood Cottage were not shaved for several days.

During an interview on 01/08/2024 at 11:32 AM, Staff X, Med Tech/Caregiver, stated that resident refusals for care were documented on the weekly shower form. Staff X stated that the Med Tech on duty would be notified of any resident that refused care.

During an interview on 01/08/2024 at 1:19 PM, Staff B, Licensed Practical Nurse, Director of Nurses, stated that resident refusals of care would be documented on the weekly shower forms. Staff K, Med Tech, stated that when they were notified a resident refused care, they informed the Director of Nurses and/or Resident Care Director. Staff B, Staff H, Resident Care Director, and Staff K each stated they received no notification of residents who refused care over the weekend or the previous week.

During an interview on 01/09/2024 at 10:15 AM, Staff C stated that all the male residents were shaved prior to the Department's Licensing visit on 01/03/2024. Staff C stated that the eight unshaved male residents did not refuse care. Staff C stated that several male residents were shaved that morning. Staff C stated that they planned to shave the rest of the male residents later that day. Staff C stated that more staff support was needed to complete all the hygiene care the residents required. Staff C stated that it would be helpful if the Med Tech or Resident Care Director reminded the staff to shave the male residents.

Review of an email dated 01/25/2023 at 2:45 PM, from Staff H, showed male residents were shaved two to three times a week, depending on preferences and behaviors. The email showed staff were encouraged to offer and attempt hygiene and shave residents more than three times a week.

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, The Cottages of Renton is or will be in compliance with this law and / or regulation on (Date) 3/14/2025. FIR

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

FIZ Stepnoski BSW
Administrator (or Representative)

1/31/2024
Date

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

01/30/2024

Renton Special Care Community LLC
The Cottages of Renton
17033 108th Ave SE
Renton, WA 98055

RE: The Cottages of Renton # 2496

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 01/29/2024 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

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-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

The on-duty kitchen staff's food handler card expired on 08/27/2023. During the inspection, the on-duty kitchen staff completed the food handler training and presented an active food handler card valid from 01/04/2024 to 01/04/2026, to meet the regulatory requirements.

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;

The location of first aid kit supplies throughout the facility cottages were not identified. The first-aid supplies were not readily available. During the inspection, the facility staff placed several first aid kit supplies throughout the facility cottages with identifier signs posted with each kit.

WAC 388-78A-2732 Liability insurance required Ongoing. The assisted living facility must:

(1) Obtain liability insurance upon licensure and maintain the insurance as required in WAC 388-78A-2733 and 388-78A-2734 ; and

(2) Have evidence of liability insurance coverage available if requested by the department.

The assisted living facility certificate of liability insurance initially presented to the licensors expired on 02/01/2023. During the inspection, facility staff located and presented the active certificate of liability insurance to meet the regulatory requirements.

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

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

Enclosure