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

02/26/2025

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

RE: The Cottages of Renton # 2496

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 55401 (Completion Date 02/26/2025) and 49917 (Completion Date 12/17/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/26/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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;

(iii) When the resident has an injury requiring the intervention of a practitioner.

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(2) The assisted living facility must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

(b) The resident dies.

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted

living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

(4) In case of a resident's death, the assisted living facility must notify the coroner if required by RCW 68.50.010 .

The Department staff who did the On Site verification:
Karri Hernandez, Community Complaint Investigator

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

Sincerely,

Laurie Anderson

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages of Renton
Provider Type: Assisted Living Facility

License/Cert.#: 2496
Intake ID: 152982
Compliance Determination #: 49917
Region/Unit #: RCS Region 2 / Unit D
Investigator: Karri Hernandez
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s): 12/16/2024, 12/18/2024

Allegation(s):
Failure to update service plan and monitoring ongoing needs of resident (s)

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Residents Nursing staff Administrator Case Manager Business Office manager Social Worker Medical Provider
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
Reviewed intake. Reviewed facility records, policies and procedures. Interviewed facility staff, residents. Observed facility common areas, resident areas, resident to resident interactions and resident to staff interactions. Based on interviews, record reviews and observations, facility did not comply with regulatory requirements and

citation issued on intake numbers 153428, 1529882, 157865, 15473, 15851.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages of Renton
Provider Type: Assisted Living Facility

License/Cert.#: 2496
Intake ID: 153428
Compliance Determination #: 49917
Region/Unit #: RCS Region 2 / Unit D
Investigator: Karri Hernandez
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s): 12/18/2024

Allegation(s):

1. Failure to update service plan and monitoring ongoing needs of resident (s)
2. Failure to communicate with and document communication of resident (s) relocation to hospital or death (s) of resident(s) to payor source.

Investigation Methods:

Sample:
Total residents: 58
Resident sample size: 5
Closed records sample size:

Observations:
Identified resident
Residents
Activities
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Identified staff
Residents
Nursing staff
Administrator
Case Manager
Business Office manager
Social Worker
Medical Provider

Record Reviews:
Medical records
Hospital records
State reporting log
Incident investigation
Facility policies

Investigation Summary:

Reviewed intake. Reviewed facility records, policies and procedures. Interviewed facility staff, residents. Observed facility common areas, resident areas, resident to

resident interactions and resident to staff interactions. Based on interviews, record reviews and observations, facility did not comply with regulatory requirements and citation issued on intake numbers 153428, 1529882, 157865, 15473, 15851.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages of Renton
Provider Type: Assisted Living Facility

License/Cert.#: 2496
Intake ID: 155473
Compliance Determination #: 49917
Region/Unit #: RCS Region 2 / Unit D
Investigator: Karri Hernandez
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s):

Allegation(s):
Failure to update service plan and monitoring ongoing needs of resident (s)

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Residents Nursing staff Administrator Case Manager Business Office manager Social Worker Medical Provider
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
Reviewed intake. Reviewed facility records, policies and procedures. Interviewed facility staff, residents. Observed facility common areas, resident areas, resident to resident interactions and resident to staff interactions. Based on interviews, record reviews and observations, facility did not comply with regulatory requirements and

citation issued on intake numbers 153428, 1529882, 157865, 15473, 15851.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages of Renton
Provider Type: Assisted Living Facility

License/Cert.#: 2496
Intake ID: 155851
Compliance Determination #: 49917
Region/Unit #: RCS Region 2 / Unit D
Investigator: Karri Hernandez
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s):

Allegation(s):
Failure to update service plan and monitoring ongoing needs of resident(s)

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Residents Nursing staff Administrator Case Manager Business Office manager Social Worker Medical Provider
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
Reviewed intake. Reviewed facility records, policies and procedures. Interviewed facility staff, residents. Observed facility common areas, resident areas, resident to resident interactions and resident to staff interactions. Based on interviews, record reviews and observations, facility did not comply with regulatory requirements and

citation issued on intake numbers 153428, 1529882, 157865, 15473, 15851.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages of Renton
Provider Type: Assisted Living Facility

License/Cert.#: 2496
Intake ID: 157865
Compliance Determination #: 49917
Region/Unit #: RCS Region 2 / Unit D
Investigator: Karri Hernandez
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s): 12/18/2024

Allegation(s):
Failure to update service plan and monitoring ongoing needs of resident (s)

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Residents Nursing staff Administrator Case Manager Business Office manager Social Worker Medical Provider
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
Reviewed intake. Reviewed facility records, policies and procedures. Interviewed facility staff, residents. Observed facility common areas, resident areas, resident to resident interactions and resident to staff interactions. Based on interviews, record reviews and observations, facility did not comply with regulatory requirements and

citation issued on intake numbers 153428, 1529882, 157865, 15473, 15851.

Conclusion / Action:

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

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 # 49917
Plan of Correction	The Cottages of Renton	Completion Date
Page 1 of 8	Licensee: Renton Special Care Community LLC	12/17/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 11/06/2024, 11/06/2024 and 12/17/2024 of:

The Cottages of Renton
17033 108th Ave SE
Renton, WA 98055

This document references the following complaint number(s): 153428, 152982, 157865, 155473, 155851

The following sample was selected for review during the unannounced on-site visit: 5 of 58 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karri Hernandez, Community Complaint Investigator

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

01/02/2025 — 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.

FR Stepnowski BSW
Administrator (or Representative)

1.3.2025
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;

(iii) When the resident has an injury requiring the intervention of a practitioner

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update 2 of 2 residents (Resident 1 and Resident 2) service plans when there was a change of condition. This failure placed Resident 1 and Resident 2 at risk of a diminished quality of life due to unmet care needs.

Findings included:

RESIDENT 1
Review of facility policy titled, "Fall Prevention and Protocol", dated 10/01/2020, showed all residents receive a fall assessment that is done with each annual assessment and after any subsequent falls

Review of facility policy titled, "Fall with a Potential Head Injury", dated 11/01/2023, showed the facility would initiate a temporary service plan and resident care team would be notified of the change.

Review of the facility's characteristic roster showed the facility admitted Resident 1 in [redacted] 2023.

Observation on 10/23/2024 at 2:45 PM showed Resident 1 sat in a recliner, in the reclined position in the common area of Cottage D. Observation showed no walker or wheelchair near Resident 1

Administrator (or Representative) 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;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update 2 of 2 residents (Resident 1 and Resident 2) service plans when there was a change of condition. This failure placed Resident 1 and Resident 2 at risk of a diminished quality of life due to unmet care needs.

Findings included…

RESIDENT 1
Review of facility policy titled, “Fall Prevention and Protocol”, dated 10/01/2020, showed all residents receive a fall assessment that is done with each annual assessment and after any subsequent falls.

Review of facility policy titled, “Fall with a Potential Head Injury”, dated 11/01/2023, showed the facility would initiate a temporary service plan and resident care team would be notified of the change.

Review of the facility’s characteristic roster showed the facility admitted Resident 1 in [redacted] 2023.

Observation on 10/23/2024 at 2:45 PM showed Resident 1 sat in a recliner, in the reclined position, in the common area of Cottage D. Observation showed no walker or wheelchair near Resident 1.

Review of department intakes showed from 08/23/2024 through 11/14/2024, Resident 1 had eight falls.

Review of Resident 1's records showed on [redacted]/2024, Resident 1 slipped and fell into a pole as they returned to bed. Resident 1 sustained a hip fracture from the fall. The records showed Resident 1 had an unwitnessed fall that resulted in a head injury which required treatment at the hospital.

Review of Resident 1's records showed on [redacted]/2024, Resident 1 had an unwitnessed fall which required hospitalization for treatment of five rib fractures.

Review of facility incident report, dated [redacted]/2024, showed Resident 1 had an unwitnessed fall. The report showed Resident 1 was found on the floor with a head injury. Resident 1 was sent to the hospital for treatment.

Review of the facility incident report, dated [redacted]/2024, showed Resident 1 had an unwitnessed fall. Resident 1 was found on the floor in the common area of Cottage D. The report showed Resident 1 fell as they transferred from a seated to a stand position and the walked away without staff assistance. Resident 1 sustained a head injury during the fall.

Review of facility investigation records, dated 10/30/2024, showed Resident 1 had an unwitnessed, injury fall on [redacted]/2024. Resident 1 sustained a punctured right lung from the fall. Resident 1 was sent to the hospital. Resident 1 developed sepsis (a life-threatening complication of an infection), hemorrhagic shock (shock caused by heavy blood loss), a kidney infection, and fractured their clavicle (collar bone) and eight ribs. Records showed Resident 1 discharged from hospital to skilled nursing facility and passed away on [redacted]/2024.

Review of Resident 1's Service Plan, dated 01/31/2024, showed Resident 1 required staff reminders with dressing tasks and assistance with nail care. The plan, dated 07/31/2024, showed Resident 1 required maximum staff assistance with personal hygiene and was a fall risk when Resident 1 moved from a seated or laying position to a stand position. The plan, dated 09/05/2024, showed Resident 1 required maximum staff assistance with transfers. The service plan, dated 10/03/2024, showed Resident 1 required maximum staff assistance with bed and chair mobility and staff reminders to use their walker when ambulating.

After hospitalizations in [redacted] 2024, and upon Resident 1's return to the facility in [redacted] 2024, there were no service plan updates completed. Review of the hospital discharge notes, dated [redacted]/2024, showed Resident 1 discharged from the hospital with a wheelchair. Review of the notes showed Resident 1 required assistance to propel wheelchair and increased supervision when walker was used. Review of hospital physical therapy (PT) discharge notes, dated [redacted]/2024, showed Resident 1 required a wheelchair or front wheeled walker for mobility with 24-hour continuous staff

assistance. The hospital PT discharge notes showed Resident 1 required maximum staff assistance with upper and lower body dressing, and staff assistance with toileting, grooming, and bathing.

Record review showed there was no documentation that the facility initiated their “Fall Prevention” policy related to Resident 1’s repeated falls. There was no documentation that showed the facility initiated their “Fall with Head Injury” policy. There was no updated service plan, no new assessment completed, and no documentation that showed staff were provided with a temporary service plan to follow related to Resident 1’s change of condition.

During an interview on 10/16/2024 at 1:15 PM, Collateral Contact 1 (CC1- Resident 1 representative) stated that they were concerned about the excessive number of falls by Resident 1. CC1 stated that they never received any updated service plans from the facility staff to show what care plans were changed to try and prevent Resident 1 from falling. CC1 stated that they were concerned about the lack of supervision, monitoring, general resident oversight, and lack of service plan updates related to Resident 1’s change of condition with increased care needs.

During an interview on 10/23/2024 at 1:30 PM, Staff A, Executive Director, stated that Resident 1 had multiple falls while at the facility. Staff A stated that most of the falls were when Resident 1 slipped out of bed to the floor. Staff A stated that the unwitnessed fall on [redacted]/2024 was a result of Resident 1 slipping and hitting on the transfer pole at the bedside. Staff A stated that Resident 1 required staff assistance with transfers out of a chair or their bed. Staff A stated that Resident 1 did not always wait for staff to assist with transfers. Staff A stated that they planned to order a chair alarm to assist staff with alerts when Resident 1 attempted to transfer without staff assistance.

During an interview on 10/23/2024 at 1:30 PM, Staff B, Director of Nursing, stated that on 10/10/2024, the physical therapist released Resident 1 from using a wheelchair and Resident 1 was discharged from any further physical therapy appointments. Staff B stated that Resident 1 was very unsteady on their feet. Staff B stated that Resident 1 was able to independently ambulate with a front wheeled walker. Staff B stated that Resident 1 required maximum assistance with transfers. Staff B stated that Resident 1’s service plan was updated to reflect the increased staff monitoring of Resident 1.

During an interview on 10/23/2024 at 2:50 PM, Staff C, Caregiver, stated that Resident 1 was able to independently walk around the facility and to the bathroom with their walker. Staff C stated that Resident 1 frequently forgot to use their walker.

During an interview on 12/18/2024 at 8:30 AM, Collateral Contact 4, (CC4- Resident 1’s Medical Provider), stated that Resident 1’s multiple falls with injury caused Resident 1 pain and suffering. CC4 stated that they were concerned about the lack of supervision, lack of nursing care, and lack of immediate medical care for Resident 1. CC4 stated that the facility did not provide any supporting documents that showed staff increased

monitoring of Resident 1 that may have helped to intervene or lessen the number and severity of the falls.

RESIDENT 2
Review of the facility's characteristic roster showed the facility admitted Resident 2 in [redacted] 2023.

Review of Resident 2's progress notes, dated 10/10/2024, showed Resident 2 presented with a swollen and tender left knee. The notes showed that the Director of Nursing and the Primary Care Provider (PCP) were informed. Review of Resident 2's PCP note, dated 10/10/2024, showed Resident 2's left knee was swollen, tender, and warm to the touch.

Review of Resident 2's progress notes, dated 10/11/2024, showed Resident 2 was placed on alert charting related to left knee condition. The notes showed Resident 2's primary PCP evaluated the knee and prescribed pain-relieving cream. Progress notes showed Resident 2's anxiety level increased.

Review of Resident 2's progress notes, dated 10/12/2024 through 10/15/2024, showed Resident 2's left knee continued to be swollen with redness of the skin and complaints of pain. Progress notes showed alert charting was discontinued on 10/15/2024.

Review of Resident 2's progress notes, dated 10/17/2024, showed Resident 2's knee remained swollen, red, and tender.

Review of Resident 2's progress notes, dated 10/19/2024, showed Resident 2 expressed signs and symptoms of pain in the left knee when leg was re-positioned.

Review of Resident 2's progress notes, dated 10/25/2024, showed a portable x-ray was brought to the facility. Resident 2's left knee was x-rayed. The x-ray showed a fracture of the left knee. The notes showed Resident 2 was sent to the hospital for treatment of the fracture and returned to the facility with a knee immobilizer.

Review of Resident 2's progress notes, dated 10/25/2024, showed Resident 2 was sent to the hospital for a "spontaneous" fracture of their left knee.

During an interview on 10/25/2024 at 9:53 AM, Collateral Contact 3, CC3- Hospital Social Worker, stated that Resident 2 arrived at the hospital from the facility by Emergency Medical Services (EMS) with a diagnosis of [redacted]. CC3 stated that they were concerned about the significant level of injury that was unwitnessed. CC3 stated that they were concerned about possible abuse of neglect.

During an interview on 11/06/2024 at noon, Staff B stated that Resident 2 showed signs and symptoms of leg pain for a few weeks. Staff B stated that Resident 2's primary care provider prescribed Diclofenac cream for pain. Staff B stated that when the pain cream did not work, the facility provider prescribed an opioid based pain medication. Staff B stated that when this pain medication did not work, the pain medication dosage was increased. Staff B stated that the increase of medication no longer worked, and an x-ray was ordered. The x-ray determined Resident 2 had an acute impacted fracture of the lower leg.

Review of Resident 2's service plan, dated 02/07/2024, showed Resident 2 received hospice services. Review of provider note, dated 10/08/2024, showed Resident 2 discharged from hospice services due to overall improvement in condition. There was no updated assessment or changes to Resident 2's service plan after the discharge from hospice.

Review of Resident 2's service plan, dated 09/27/2024, showed Resident 2 used a wheelchair. There was no updated information, or any re-assessment associated with Resident 2's change of condition related to diagnosis of [redacted] on 10/25/2024. There was no documentation of the knee fracture, no documentation of pain medication used, and no documentation of the use of the knee immobilizer. There were no instructions for staff about Resident 2's new care needs.

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) 1.31.25 requesting extension

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

FR Maynard BSW
Administrator (or Representative)

1.3.2025
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(2) The assisted living facility must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

(b) The resident dies;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

During an interview on 11/06/2024 at noon, Staff B stated that Resident 2 showed signs and symptoms of leg pain for a few weeks. Staff B stated that Resident 2's primary care provider prescribed Diclofenac cream for pain. Staff B stated that when the pain cream did not work, the facility provider prescribed an opioid based pain medication. Staff B stated that when this pain medication did not work, the pain medication dosage was increased. Staff B stated that the increase of medication no longer worked, and an x-ray was ordered. The x-ray determined Resident 2 had an acute impacted fracture of the lower leg.

Review of Resident 2's service plan, dated 02/07/2024, showed Resident 2 received hospice services. Review of provider note, dated 10/06/2024, showed Resident 2 discharged from hospice services due to overall improvement in condition. There was no updated assessment or changes to Resident 2's service plan after the discharge from hospice.

Review of Resident 2's service plan, dated 08/27/2024, showed Resident 2 used a wheelchair. There was no updated information, or any re-assessment associated with Resident 2's change of condition related to diagnosis of [redacted] on 10/25/2024. There was no documentation of the knee fracture, no documentation of pain medication used, and no documentation of the use of the knee immobilizer. There were no instructions for staff about Resident 2's new care needs.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(2) The assisted living facility must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

(b) The resident dies.

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

(4) In case of a resident's death, the assisted living facility must notify the coroner if required by RCW 68.50.010 .

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the responsible paying agency when 4 of 4 residents (Resident 3, Resident 4, Resident 5, and Resident 6) were hospitalized or passed away. The failure placed Resident 3, Resident 4, Resident 5, and Resident 6 at risk of financial overpayments and potentially being unable to remain at the facility.

Findings included…

During an interview on 11/14/2024 at 3:34 PM, Staff A, Executive Director, stated that the facility used a system for notifying the payor for resident services. Staff A stated that the facility nursing staff completed a report that was forwarded to the business office staff. Staff A stated that the business office staff contacted the payor to notify them of the change to the resident's location or status. Staff A stated that payors were always notified, as soon as possible, of any change to a resident's location or death.

Resident 3
During an interview on 12/04/2024 at 9:27 AM, Collateral Contact 2 (CC2), Home and Community Services (HCS) Case Manager, stated that on [redacted]/2024, they received a telephone call from the intake team to inform CC2 that Resident 3 was in the hospital. CC2 stated that the facility staff did not contact or update them, and they were unaware Resident 3 was in the hospital. CC2 stated that on [redacted]/2024, they called Staff A to verify Resident 3's location. CC2 stated that Staff A confirmed Resident 3 was admitted to the hospital on [redacted]/2024, five days prior, for a fall that resulted in a broken neck. CC2 stated that on 11/14/2024, Resident 3's guardian informed CC2 that Resident 3 passed away in the hospital on [redacted]/2014. CC2 stated that there was no notification from the facility that Resident 3 passed away in the hospital.

Resident 4
During an interview on 12/17/2024 at 9:51 AM, CC2 stated that on [redacted]/2024, they called Resident 4's Durable Power of Attorney (DPOA) to schedule the yearly assessment interview. CC2 stated that the DPOA told them that Resident 4 passed away on [redacted]2024, seven days prior. CC2 stated that they were unaware Resident 4 passed away. CC2 stated that the facility never informed them that Resident 4 passed away. CC2 stated that on [redacted]/2024, they sent an email to Staff A to inquire about the status of Resident 4. CC2 stated that they received a follow-up email from Staff A that stated Resident 4 passed away on [redacted]/2024 while on Hospice Services. CC2 stated that Staff A's email confirmed Resident 4 death, 11 days after Resident 4 passed away. CC2 stated this was the only time the facility acknowledge Resident 4 passed away.

Review of the email, dated [redacted]/2024, showed Staff A verified Resident 4 passed away

11 days prior. The email showed no documentation that Staff A provided notification to the payor, as required.

Resident 5
During an interview on 12/04/2024 at 9:27 AM, CC2 stated that on [redacted]/2024, they spoke with Staff B regarding another resident. CC2 stated that during the conversation of another resident, Staff B informed CC2 that Resident 5 was in the hospital for hip surgery. CC2 stated that Staff B said Resident 5 was transported to the hospital on [redacted]2024, five days earlier due to a fall. CC2 stated that on [redacted]/2024, they received an email from Staff A that reported Resident 5 passed away on [redacted]2024, in the hospital, four days prior. CC2 stated that the facility did not report Resident 5's transfer to the hospital or their death, as soon as possible.

Review of an email, dated [redacted]024, showed Staff A notified CC2 that Resident 5 admitted to the hospital on [redacted]2024. The email showed Staff A reported that Resident 5 underwent hip surgery repair for fracture related to fall that occurred on [redacted]/2024. The email showed Staff A reported to CC2 that Resident 5 passed away in the hospital on [redacted]2024.

Resident 6
During an interview on 12/04/2024 at 9:37 AM, CC2 stated that on [redacted]2024, they received an email from the facility 's Business Office that Resident 6 admitted to the hospital on [redacted]2024. CC2 stated that they were informed Resident 6 returned to the facility on [redacted]2024. CC2 stated that they were never notified by the facility when Resident 6 admitted to the hospital.

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) 1.31.25 requesting extension

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

FIC Maymouth-BSW
Administrator (or Representative)

1.3.2025
Date

11 days prior. The email showed no documentation that Staff A provided notification to the payor, as required.

Resident 5
During an interview on 12/04/2024 at 9:27 AM, CC2 stated that on [redacted]/2024, they spoke with Staff B regarding another resident. CC2 stated that during the conversation of another resident, Staff B informed CC2 that Resident 5 was in the hospital for hip surgery. CC2 stated that Staff B said Resident 5 was transported to the hospital on [redacted]/2024, five days earlier, due to a fall. CC2 stated that on [redacted]/2024, they received an email from Staff A that reported Resident 5 passed away on [redacted]/2024, in the hospital, four days prior. CC2 stated that the facility did not report Resident 5's transfer to the hospital or their death, as soon as possible.

Review of an email, dated [redacted]/2024, showed Staff A notified CC2 that Resident 5 admitted to the hospital on [redacted]/2024. The email showed Staff A reported that Resident 5 underwent hip surgery repair for fracture related to fall that occurred on [redacted]/2024. The email showed Staff A reported to CC2 that Resident 5 passed away in the hospital on [redacted]/2024.

Resident 6
During an interview on 12/04/2024 at 9:37 AM, CC2 stated that on [redacted]/2024, they received an email from the facility 's Business Office that Resident 6 admitted to the hospital on [redacted]/2024. CC2 stated that they were informed Resident 6 returned to the facility on [redacted]/2024. CC2 stated that they were never notified by the facility when Resident 6 admitted to the hospital.

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)_____ .

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

_____ _____
Administrator (or Representative) Date