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

05/09/2025

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) 59399 (Completion Date 05/09/2025) and 55044 (Completion Date 03/12/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/09/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

The Department staff who did the On Site verification:
Harrison Udoye, Community Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer
Jamie Singer, 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: 166149

Compliance Determination #: 55044

Region/Unit #: RCS Region 2 / Unit D

Investigator: Harrison Udoye

Investigation Date(s): 02/19/2025 through 03/12/2025

Complainant Contact Date(s): 02/19/2025

Allegation(s):

Improper facilitation of resuscitation efforts

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified staff Nursing staff Residents Family members Business office manager Human resources Staff development coordinator
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Personnel files Staff training records

Investigation Summary:

Report of alleged neglect in the memory care unit of the Assisted Living Facility (ALF). Interview and record review showed that Named Resident was dependent with all

Activity of Daily Living (ADL's). Facility staff provided care and service to Named Resident. On 02/06/2025 at about 11:45 AM, facility staff found Named Resident weak and unresponsive in their wheelchair. Facility staff immediately called 911 and was instructed by 911 operator to start lifesaving chest compression. Compressions started until staff located Named Resident's life saving orders. Facility staff failed to inform the 911 operator that Named Resident had a "Do Not Resuscitate" (DNR) order in place. Emergency Medical Team (EMT) arrived, noted a weak pulse, and transported Named Resident to the hospital without any chest compression. No abuse or neglect noted. Facility staff failed to follow their policy and procedure on the DNR order. Citation issued.

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: 166343
Compliance Determination #: 55044
Region/Unit #: RCS Region 2 / Unit D
Investigator: Harrison Udoye
Investigation Date(s): 02/19/2025 through 03/12/2025
Complainant Contact Date(s): 02/19/2025

Allegation(s):

1) Alleged neglect
2) Improper medication services.
3) Inappropriate actions by outside provider (Hospice)

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Family members Business office manager Therapy staff Staff development coordinator
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Staff patterns

Investigation Summary:

1) Report of alleged neglect in the memory care unit of the Assisted Living Facility (ALF). Interview and record review showed that Named Resident was dependent with all Activity of Daily Living (ADL's). Facility staff provided care and service to Named Resident. On 02/06/2025 at about 11:45 AM, facility staff found Named Resident

weak and unresponsive in their wheelchair. Facility staff immediately called 911 and was instructed by 911 operator to start lifesaving chest compression. Compressions started until staff located Named Resident's life saving orders. Facility staff failed to inform the 911 operator that Named Resident had a "Do Not Resuscitate" (DNR) order in place. Emergency Medical Team (EMT) arrived, noted a weak pulse, and transported Named Resident to the hospital without any chest compression. No abuse or neglect noted. Facility staff failed to follow their policy and procedure on the DNR order. Citation issued.

2) Allegation of overmedication in the memory care of the Assisted Living Facility.
Interview and record review showed that Named Resident was in the facility locked unit due to severe cognitive impairment. Named Resident was dependent on facility staff for all ADLs and mobility. Facility staff do not prescribe or order medication for residents in their facility. Facility staff do notify Residents' Primary Care Providers (PCP) and their representatives for any change in condition. PCPs then decide if medical intervention were necessary. Facility staff followed medication orders given by PCPs. Facility staff followed their policy and procedures. No failed practice identified. Facility met their regulatory requirements.

3) Alleged unwelcome Hospice practices
After interviews and record reviews, it was shown that the outside provider contracted with residents' representatives to provide care for residents in the facility. Hospice agency practices were out of licensing jurisdiction for the Residential Care Service (RCS) to investigate.

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

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 02/19/2025 of:

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

This document references the following complaint number(s): 166343, 165843, 166149

The following sample was selected for review during the unannounced on-site visit: 3 of 57 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Harrison Udoye, 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

Statement of Deficiencies	License #: 2496	Compliance Determination # 55044
Plan of Correction	The Cottages of Renton	Completion Date
Page 2 of 3	Licensee: Renton Special Care Community LLC	03/12/2025

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

03/18/2025 — 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.

[signature] — Administrator (or Representative)

3/25/2025 — Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow their policies and procedures to follow the care plan for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk of bodily harm and went against their wishes.

Findings included...

Review of the facility's undated policy titled," Advanced Directive" showed that the facility recognized every resident's advanced directive (a legal document that outlines a person's wishes regarding their medical care in the event they become unable to make decisions for themselves due to illness, injury, or other incapacities). The policy showed residents were not discriminated against based upon their advanced directive. The policy stated the facility would make every attempt to honor the resident's wishes, unless to do so would violate state or federal law.

Review of the facility's Resident Characteristics Roster, dated 03/12/2025, showed 57 residents had advanced directives in place.

During an interview on 02/19/2025 at 11:20 AM, Staff B, Director of Nursing, stated that on 02/06/2025, facility staff found Resident 1 extremely weak and unresponsive. Facility staff called 911 and staff were instructed by the 911 operator to start chest compression while medics were enroute. Staff B stated that upon the medics' arrival, medics confirmed Resident 1 had a pulse and the medics did not continue the chest

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

03/18/2025 — 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.

Administrator (or Representative)

Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow their policies and procedures to follow the care plan for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk of bodily harm and went against their wishes.

Findings included...

Review of the facility's undated policy titled," Advanced Directive" showed that the facility recognized every resident's advanced directive (a legal document that outlines a person's wishes regarding their medical care in the event they become unable to make decisions for themselves due to illness, injury, or other incapacities). The policy showed residents were not discriminated against based upon their advanced directive. The policy stated the facility would make every attempt to honor the resident's wishes, unless to do so would violate state or federal law.

Review of the facility's Resident Characteristics Roster, dated 03/12/2025, showed 57 residents had advanced directives in place.

During an interview on 02/19/2025 at 11:20 AM, Staff B, Director of Nursing, stated that on 02/06/2025, facility staff found Resident 1 extremely weak and unresponsive. Facility staff called 911 and staff were instructed by the 911 operator to start chest compression while medics were enroute. Staff B stated that upon the medics' arrival, medics confirmed Resident 1 had a pulse and the medics did not continue the chest

Statement of Deficiencies	License #: 2496	Compliance Determination # 55044
Plan of Correction	The Cottages of Renton	Completion Date
Page 3 of 3	Licensee: Renton Special Care Community LLC	03/12/2025

compressions. Staff B stated that as the medics arrived, the facility staff found Resident 1's advanced directives. The directives showed Resident 1 had a Do Not Resuscitate (DNR) order. Staff B stated that the medics transported Resident 1 to the hospital. Staff A, Executive Director, and Staff B acknowledged that the facility staff did not follow the facility's advanced directives policy.

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) 3/25/2025.

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

JR Nugent- BSW — 3/25/2025

Administrator (or Representative) — Date

compressions. Staff B stated that as the medics arrived, the facility staff found Resident 1's advanced directives. The directives showed Resident 1 had a Do Not Resuscitate (DNR) order. Staff B stated that the medics transported Resident 1 to the hospital. Staff A, Executive Director, and Staff B acknowledged that the facility staff did not follow the facility's advanced directives policy.

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