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

09/02/2025

Covington Special Care Community LLC
The Cottages of Covington
17012 SE Wax Road
Covington, WA 98042

RE: The Cottages of Covington # 2594

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 64950 (Completion Date 09/02/2025) and 59537 (Completion Date 07/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/02/2025 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;

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

If you have any questions, please contact me at (206)305-3489.

Sincerely,

James Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages of Covington **Provider Type:** Assisted Living Facility

License/Cert.#: 2594
Intake ID: 179052
Compliance Determination #: 59537
Region/Unit #: RCS Region 2 / Unit D
Investigator: Harrison Udoye
Investigation Date(s): 05/13/2025 through 07/01/2025
Complainant Contact Date(s):

Allegation(s):
Alleged Neglect

Investigation Methods:

Sample:	Total residents: 59 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Activities Resident care equipment Resident rooms Resident rooms Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Family members Business office manager Therapy staff Staff development coordinator
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Staff patterns

Investigation Summary:

Report of alleged neglect in the memory care of the Assisted Living Facility (ALF). Interview and record review showed that Named Resident admitted to the facility on [redacted]/2025 from [redacted]. Named Resident was dependent on staff from all activities due to history of cognitive impairment. Facility staff failed to properly assess Named Resident's needs as stated in the negotiated service agreement. The failure to address some of the Named Resident needs led to

open wounds on both buttocks and hospitalization. Unable to substantiate any abuse or neglect allegation. Facility failed practice identified. Citation issued for ongoing assessment under WAC 388-78A-2100.

Conclusion / Action:

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

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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 05/13/2025 of:

The Cottages of Covington
17012 SE Wax Road
Covington, WA 98042

This document references the following complaint number(s): 179052, 178223, 178053, 175759

The following sample was selected for review during the unannounced on-site visit: 2 of 59 current residents and 1 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

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

07/02/2025
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.

Administrator (or Representative)

7/14/25
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 interview and record review, the facility failed to complete an updated assessment for 1 of 1 resident (Resident 1) when there were changes in the resident's overall condition. This failure placed Resident 1 at risk of a decline in their medical condition, severe dehydration, and skin breakdown that was prone to infection.

Findings Included...

Review of facility undated document titled, "Admission Record", showed the facility admitted Resident 1 on [redacted]/2025. Resident 1 admitted with multiple diagnoses which included: [redacted] due to a known physiological condition (a state of normal functioning of the body) without behavioral disturbance; [redacted] and [redacted]

[redacted] not due to substance or known physiological condition.

Review of facility's undated document titled "Service Plan Report" showed that upon admission, Resident 1 required total assistance from staff with all care needs. The care plan showed Resident 1 was unable to make their needs and preferences known and that facility staff needed to anticipate Resident 1's needs. The care plan showed that when Resident 1 was admitted to the facility on [redacted]/2025, Resident 1's skin was intact. The care plan showed that Resident 1 required total assistance from facility staff to maintain skin integrity. The plan showed no documentation or instructions to staff to complete routine daily or weekly skin assessments on Resident 1. The plan showed that facility staff were to notify Staff B, Director of Nursing, when Resident 1 required more assistance with care needs and repositioning.

Review of Resident 1's records showed there was no documentation anywhere that showed staff completed any daily, or weekly, skin assessment checks prior to 05/11/2025. There was no documentation anywhere that showed staff reported Resident 1 needed more assistance with care.

Review of Resident 1's Progress Notes, dated 04/30/2025, showed that Resident 1 was drowsy during lunch time and had a difficult time eating regular food. The notes documented that Staff B contacted Resident 1's Power of Attorney (POA) and requested a change in Resident 1's diet, from a regular diet to a pure-texture diet (a type of modified diet where all foods are blended or processed into a smooth, pudding-like consistency). There was documentation in the progress notes and in the service plan that showed the diet was changed. There was no documentation in the progress notes or the service plan that showed the change in the diet worked to meet Resident 1's nutritional needs.

Review of Resident 1's Progress Notes, dated 5/13/2025, showed that when staff discovered the open wounds on both sides of Resident 1's buttocks, Resident 1 expressed no signs of pain or discomfort. The progress notes showed Resident 1 was sent to the hospital on 05/12/2025 due to generalized weakness, high temperature, and the pressure wounds.

During an interview on 05/13/2025 at 11:33 AM, Staff A, Assistant Executive Director, stated that on 05/11/2025, while in the facility, Resident 1 spent most of the day in their recliner chair while family visited. Staff A stated that when the care staff assisted Resident 1 with peri care, staff noticed the open wounds on both sides of Resident 1's buttocks. Staff A stated that the care staff immediately notified Staff B.

During an interview on 06/09/2025 at 9:37 AM, Staff B stated that on [redacted]/2025, when the facility admitted Resident 1 to the memory care unit, an assessment was completed. Resident 1's skin was intact. Staff B stated that a few days after admission, Resident 1 seemed to be drowsier and sleepier than when they first admitted to the

facility. Staff B notified both Resident 1's representative and the facility physician. The facility physician ordered a reduction in Resident 1's psych medications. Staff B stated that the medication change was only effective for a couple of days. Staff B stated that when the facility staff notified them of open wounds on Resident 1's buttocks, Staff B determined that Resident 1 had developed pressure wounds (an open area characterized by full-thickness skin loss, extending into the fatty tissue without exposing muscle, tendon, or bone). Staff B immediately initiated a treatment plan. Staff B stated that on 5/11/2025, they opened an internal investigation to try and determine how the wounds started. The investigation determined that one of the care staff did not assess and report the wounds to facility management.

During an interview on 06/11/2025 at 10:15 AM, Collateral Contact 1 (CC1, Resident 1 representative) stated that Resident 1 was a patient at [redacted] for four months before Resident 1 admission to the memory care unit. Resident 1 was ambulatory with minimal assistance, unable to make needs known, incontinent (unable to voluntarily control retention of urine or feces in the body) and totally dependent on care staff for all Activity of Daily Livings (ADLs- basic self-care tasks that are essential for maintaining independence and living well for example bathing, dressing, toileting eating and getting in and out of bed). CC1 stated that Resident 1's skin was intact without any redness or open wounds prior to transferring to the memory care unit.

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 Covington is or will be in compliance with this law and / or regulation on (Date) 8-15-2025 .

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

Administrator (or Representative) — 7/14/25 Date