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

05/08/2025

Snohomish ALC LLC
Cottages of Snohomish
1124 Pine Ave
Snohomish, WA 98290

RE: Cottages of Snohomish # 2740

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 59298 (Completion Date 05/08/2025) and 54780 (Completion Date 03/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/08/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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.

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

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(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

(d) Chapter 246-841 WAC, Nursing assistants; and

The Department staff who did the On Site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (253)281-1245.

Sincerely,

Anthony Devito, Field Services Administrator
Region 2, Unit Z
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Snohomish
Provider Type: Assisted Living Facility

License/Cert.#: 2740
Intake ID: 159016
Compliance Determination #: 54780
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/27/2024 through 03/07/2025
Complainant Contact Date(s): 11/26/2024

Allegation(s):

1. The Assisted Living Facility (ALF) allowed the Named Resident's (NR) medications to run out.
2. The NR ran out of their briefs.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 8 Closed records sample size: 1
Observations:	Identified resident Residents Medication administration
Interviews:	Nursing staff Residents Family members Nurse delegator
Record Reviews:	Facility policies care plans MARS progress notes

Investigation Summary:

1. The NR ran out of three of their medication on 12/10/2024. The ALF staff were able to get a refill of all the medications and resumed the medications as scheduled on 12/11/2024. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2210. Medication services.
2. Interview with the ALF staff indicated they could not recall residents running out of incontinent product supplies. The ALF had a new Licensed Nurse (LN) and put a new system in place to ensure resident's supplies would always be available. Observation showed, the Sampled residents had supplies in their rooms and the ALF had their emergency house supplies.

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Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Snohomish
Provider Type: Assisted Living Facility

License/Cert.#: 2740
Intake ID: 162376
Compliance Determination #: 54780
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/27/2024 through 03/07/2025
Complainant Contact Date(s):

Allegation(s):

1. Residents were not getting their medications.
2. There was an unexpected death. A Med Tech was informed to check on a resident. The resident passed away the next day.
3. There was only one caregiver working at the memory care unit which had 8-9 residents. The ALF was lying about staffing.
4. A resident had a "Do Not Resuscitate" order and staff took their paperwork off the wall.
5. A Named Resident was DNR. The Staff used the NR like a dummy to practice chest compressions after they were dead.
6. Residents were not getting served with food. One day for a meal they were served mozzarella sticks, croutons and a roll.

Investigation Methods:

Sample:
Total residents: 46
Resident sample size: 8
Closed records sample size: 1

Observations:
Identified resident
Residents
Medication administration
Activities
Dining
Resident care equipment
Resident rooms

Interviews:
Nursing staff
Residents
Family members
administrator
Nurse delagator

Record Reviews:
Facility policies
care plans
progress notes
MAR
Schedule

This document was prepared by Residential Care Services for the Locator website.

Investigation Summary:

1. There were three sampled residents who did not receive their medications as ordered. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2210. Medication services.
2. The Assisted Living Facility (ALF) investigated the incident. Records showed the Named resident (NR) was on a "Do not resuscitate" order. The ALF staff monitored and the NR and was on alert charting. The NR passed away and the ALF followed their protocol. The law enforcement was notified and cleared the NR's body to be released.
3. The ALF increased their staffing for the memory care unit (MC) by maintaining two staff for the morning and evening shifts. For the night shifts, the care staff would call help from the assisted living units through their radio as needed. The MC unit was observed with two staff working for the morning and evening shifts. Review of schedule showed the ALF had two care staff scheduled to work each for the day and evening shifts. The Families reported being happy the MC unit was staffed with two care staff.
4. The Named Resident (NR) was found unresponsive by the Assisted Living Facility (ALF) staff. The ALF staff followed their protocol and called 911. The 911 instructed the ALF staff to perform cardio-pulmonary resuscitation. The Paramedics arrived, took over and pronounced the NR dead. The Snohomish County Sheriff was notified, arrived at the ALF and cleared the incident for any foul play. The ALF conducted an in-service and ensured that all Physicians Order for Life sustaining Treatment forms (POLST) for residents were easily accessible for staff. The ALF had the "Do not Resuscitate" or POLST forms in their Emergency binder and Resident charts. The charts were located in each of the cottages laundry cabinet areas. The ALF stated that they would include in their system placing the forms on the back of residents' doors for easy access.
5. The ALF followed their protocol in responding to medical emergencies. The ALF staff Called 911 and 911 instructed them to perform chest compression or cardiopulmonary resuscitation (CPR). The Paramedics arrived and assessed the NR. CPR was stopped. The ALF reviewed with their staff their protocol and devised a new system for their Physician Orders for Life Saving Treatment forms to be posted at the back of residents doors.
6. During the unannounced visit, staff served their lunch. During the unannounced visit on 01/22/2025, the residents were served with chef salad, dinner roll, orange slices, hot beef sandwich with choices of bread, milk, juice, tea or coffee. Review of the menu showed the menu was followed. Interview with the chef showed they prepare the foods in their kitchen and delivered to the cottages.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Snohomish

Provider Type: Assisted Living Facility

License/Cert.#: 2740

Intake ID: 164171

Compliance Determination #: 54780

Region/Unit #: RCS Region 2 / Unit A

Investigator: Wesler Dumecquias

Investigation Date(s): 11/27/2024 through 03/07/2025

Complainant Contact Date(s):

Allegation(s):

1. The ALF allowed unlicensed staff to pass medications. The staff did not have a MedTech Training or credentials.
2. The ALF had an unsafe staffing ratio, and residents would be left unattended.
3. There were 14 residents that can fit in one cottage.
4. A Named Staff made a few medication errors and was working as a Med tech. Staff were working as Med Techs without the training or credentials of a Med Tech.
5. The ALF's heating and cooling system was broken.
6. The ALF's bathrooms and ceilings in the bathroom had mold.
7. A Named Resident complained of not receiving their medication in a timely manner and was feeling dizzy.
8. The ALF's Regional manager told a staff not to return to the ALF premises after they submitted the report to the State.
9. The ALF had no housekeeping staff.

Investigation Methods:

Sample:
Total residents: 46
Resident sample size: 8
Closed records sample size: 1

Observations:
Residents
Activities
Dining
Resident rooms
Medication administration
Resident to resident interactions
Staff to resident interactions
room temperature

Interviews:
Nursing staff
Residents
Family members
administrator
Nurse delegator

Record Reviews:
Personnel files

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Staff training records
Staff patterns
care plans
MARs
Progress notes
Staff schedule
Shower logs

Investigation Summary:

1. The ALF allowed two staff that were not nurse delegated prior to checking blood sugars and administering insulin. Failed practice identified. A citation was issued for noncompliance with WAC 388-78A-2320- Intermittent nursing services.
2. The ALF increased their staffing for the memory care unit (MC) by maintaining two staff for the morning and evening shifts. For the night shifts, the care staff would call help from the assisted living units through their radio as needed. The MC unit was observed to have two staff working for the morning and evening shifts. Review of schedule showed two care staff were scheduled to work each day and evening shifts. Interview with family members confirmed their satisfaction of seeing the MC unit was staffed with two care staff. The Assisted Living had residents that did not need 1:1 supervision. The sampled residents were able to call for help with their call pendant and emergency call buttons.
3. Review of records showed the ALF had Six cottages. Four cottages were occupied by residents. One cottage was occupied by 12 residents. Review of bed capacity showed the ALF had 84 licensed beds. There was no cottage that had 14 residents. The memory care unit was staffed with two care staff each for the day and evening shift, and one for the night shift with a float staff helping coming from the Assisted living cottages.
4. The ALF investigated the medication error and followed their protocol. The ALF determined that the Named Staff (NS) misunderstood reading the order and missed a dose of a Named Residents medication. The NS was not nurse delegated. A citation was issued for noncompliance with WAC 388-78A-2320- Intermittent nursing services.
5. Observation and interview showed the ALF heating system was fixed at the time of the unannounced visit. The ALF's memory care unit where the issue was observed had rooms that were individually equipped with a thermostat. The Room temperatures ranged from 70 to 78 degrees Fahrenheit. Interview indicated that at times there were couple rooms where the temperature would increase to 81 to 84 degrees Fahrenheit. The ALF staff remedy would be opening the doors to maintain an acceptable temperature. The ALF continued to monitor their heating system as it fluctuates.
6. Observation during the unannounced visit showed the common bathrooms and sampled residents bathrooms were clean. There was no observed presence of molds. The ALF staff were required to keep the bathrooms clean and organized.
7. The NR did not received their scheduled insulin injection during the unannounced. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2210. Medication services.
8. Interview with current ALF staff indicated that they had no issues reporting their concerns to the State or talking to their supervisors.
9. The ALF implemented a new system where caregivers would perform housekeeping on their assigned Cottages.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐

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Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Snohomish

Provider Type: Assisted Living Facility

License/Cert.#: 2740

Intake ID: 159008

Compliance Determination #: 54780

Region/Unit #: RCS Region 2 / Unit A

Investigator: Wesler Dumecquias

Investigation Date(s): 11/27/2024 through 03/07/2025

Complainant Contact Date(s): 02/07/2025

Allegation(s):

1. The ALF did not have enough staff and there was only one staff assigned at the Memory care section.
2. The NR had an infection.
3. The ALF staff did not provide the NR the required care and services.
4. The NR run out of their incontinent products on two occasions. The products were not fitting properly.
5. The NR had an infection which was not cared for by the ALF staff.
6. The NR run out of their medication and did not received their prescribed medications.
7. The NRs' room was intermittently cold and warm.
8. The NR left the ALF unsupervised.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 8 Closed records sample size: 1
Observations:	Residents Resident rooms
Interviews:	Nursing staff Residents Family members Adminstrator
Record Reviews:	Incident investigation Facility policies care plans Assessments progress notes MARS

Investigation Summary:

1. The ALF increased their staffing for the memory care unit (MC) by maintaining two staff for the morning and evening shifts. For the night shifts, the care staff

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would call for help from the assisted living units through their radio as needed. Observation showed the MC unit had two staff working for the morning and evening shifts. Review of the work schedule showed two care staff were scheduled to work for the day and evening shifts. Interview with family members confirmed their satisfaction of seeing the MC unit was staffed with two care staff.
2. The NR had a fungal infection. The ALF were following their skin monitoring protocol. Review of progress notes showed the ALF staff were already monitoring and applying powder to address the skin issue. No failed practice was identified.
3. The Named Resident (NR) was cognitively impaired. Records reviewed showed the NR initially would take showers weekly and then increased to two times a week. Interview and records showed the NR had a documented showers in the ALF caregiver's computer logs. The ALF staff would record in the NR's progress notes and in the activities of daily living portion of their electronic documentations. An in-service was conducted for the care staff and was reminded on how to properly document and record showers done. No failed practice was identified.
4. The Named Resident (NR) has cognitive impairment. Records review showed the NR initially would take showers weekly and then increased to two times a week. Interview and records showed the NR had a documented showers 13 times from 11/18/2024 to 12/09/2024. The ALF staff would record in the NR's progress notes and in the activities of daily living portion of their electronic documentations. Prior to 11/18/2024, the ALF transitioned to their new electronic documentations. An in-service was conducted for the care staff and was reminded on how to properly document and record showers done.
5. The ALF staff identified the NR's skin infection, placed the NR on alert charting and monitored. The NR was treated with an antibiotics and followed up by the Licensed nurse. The Doctor was aware.
6. There were three sampled residents who did not receive their medications as ordered. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2210. Medication services.
7. Observation and interview showed the ALF heating system was fixed at the time of the unannounced visit. The Room temperatures ranged from 70 to 78 degrees Fahrenheit. Interview indicated that at times there were rooms where the temperature would increase to 81 to 84 degrees Fahrenheit. The ALF staff remedy would be opening the doors to maintain an acceptable temperature. The ALF continued to monitor their heating system as it fluctuated. No failed practice was identified.
8. The Named Resident (NR) had cognitive impairment. The ALF cottage had a gated and secured perimeter. The ALF went out through the patio door for a walk. The ALF noticed the fence board was broken when they went to check on them. The NR was found by the ALF staff at the Elementary School adjacent to the ALF and returned the NR to the cottage. The ALF staff assessed the NR, placed the NR on alert charting and the Maintenance staff fixed the fence. The ALF followed the care plan at the time of the incident. The ALF staff updated the care plan to meet the the NR's needs. All parties were notified. No failed practice was identified.

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

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 11/27/2024 and 02/05/2025 of:

Cottages of Snohomish
1124 Pine Ave
Snohomish, WA 98290

This document references the following complaint number(s): 155668, 159016, 162492, 162918, 162376, 164171, 159008

The following sample was selected for review during the unannounced on-site visit: 8 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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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.

Residential Care Services _____ 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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement a safe medication system and ensure 3 of 3 residents (Resident 1, 2, and 3) received their medications as prescribed. These failures resulted in Residents 1, 2, and 3 not receiving their medications as ordered. These failures placed Resident 1, 2 , 3 and all residents who were on medication services at risk of medical complications related to not receiving their medications.

Findings included…

Review of an undated “MEDICATION SERVICES” policy showed the ALF would assist and/or administer prescription and over-the-counter medications as allowed by state

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statute/regulations and will maintain records of such assistance/administration.

Resident 1

Review of an undated Face Sheet showed Resident 1 was admitted on [redacted]/2024 with multiple diagnoses including [redacted] ([redacted]).

Review of Care plan dated 11/19/2024 showed Resident 1 need assistance with medication administration. Resident 1 would receive all their medications per the physician's orders.

Review of the Medication administration record (MAR) dated November 2024 and December 2024 showed Resident 1 was prescribed Donepezil 5 milligrams (mg) tablet (tab), one tab by mouth every evening for agitation and behaviors. The MAR showed the medication was marked “NA” on 11/29/2024 and from 12/02/2024 to 12/10/2024. The legend on the MAR showed "NA" meant not available

Review of Progress notes dated 11/27/2024 and 12/02/2024 showed the medication for Resident 1’s agitation and behavior was missed because the supply ran out and Resident 1 needed a new prescription for refill.

On 11/27/2024 at 1:20 PM, Staff C, Medication Technician (Med tech), stated that Resident 1’s medication for their agitation and behavior was not given on 11/29/2024 and from 12/02/2024 to 12/09/2024 because they ran out and was waiting for a new prescription from Resident 1’s Primary care physician.

Resident 2

Review of an undated Face Sheet showed Resident 2 was admitted on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]).

Review of Care plan dated 06/26/2024 showed Resident 1 needed assistance with medications services. The ALF staff would assist Resident 2 in their medication administration as ordered by their physician.

Review of the Medication administration record (MAR) dated February 2025 showed Resident 2 was to receive an insulin pen injection of lispro 100 units/ milliliters (u/ml) four units subcutaneously (under the skin) every day in the afternoon after lunch. The

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MAR showed the insulin injection was scheduled to be given at 1:00 PM. The MAR showed a blank box with no entry or signature on 02/05/2025.

On 02/05/2025 at 2:21 PM, Staff D, Med tech, stated that they were only asked by Staff E, Director of Wellness, to give another residents' insulin but not Resident 2.

On 02/05/2025 at 3:28 PM, Staff E stated that they told Staff D that they would continue to give all succeeding medications for all the four cottages. Staff E confirmed that Resident 2 had not yet received their 1:00 PM insulin. Staff E stated that Staff D should have given it.

On 02/05/2025 at 2:55 PM, Resident 2 stated that they were worried because they did not yet receive their insulin injection for the 1:00 PM.

Resident 3

Review of an undated Face Sheet showed Resident 3 was admitted on [redacted]/2024 with multiple diagnoses including [redacted].
Review of a care plan dated 10/29/2024 showed Resident 1 needed assistance with medications services. The ALF staff would assist Resident 2 in their medication administration as ordered by their physician.

Review of the MAR dated February 2025 showed Resident 3 had the following orders:
1. Insulin Lispro 110 units/Milliliters (u/ml) pen, inject 0-10 units subcutaneously three times daily before meals per sliding scale, No Lispro if pre meals blood glucose less than 100 (Sliding scale scheduled insulin) for diabetes Mellitus Type 2 to be given at 8:00 AM, 12:00 Noon, and at 4:00 PM.
2. Insulin Lispro 100 u/ml pen, inject 5 units subcutaneously three times daily before meals (routine scheduled insulin) for diabetes Mellitus Type 2 to be given at 8:00 AM, 12:00 Noon, and at 4:00 PM
3. Lantus insulin 100 u/ml, 10 ml. Inject 20 units subcutaneously every evening at 8:00 PM for diabetes Mellitus type 2.
The MAR showed the Sliding scale scheduled lispro insulin and routine scheduled lispro insulin were scheduled to be given at 12:00 noon on 02/05/2025. The MAR showed it was administered at 2:17 PM, which was two hours and 17 minutes late. The MAR showed from 01/01/2025 Resident 3's lispro insulin were documented given 86 times for the month of January and 14 times for the month of February 2025 more than two hours from the scheduled time of administration.

On 05/02/2025 at 2:15 PM, Staff D was observed checking Resident 3's blood sugar and gave Resident 3's routine scheduled lispro insulin after the lunch meal and over two hours late.

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On 02/05/2025 at 2:21 PM, Staff D stated that she was called by Staff E to give the insulin injection for Resident 3. Staff D stated that they were aware that it was scheduled at 12:00 noon but they had to give it late because Staff E told them to go and give it.

On 02/05/2025 at 3:28 PM, Staff E stated that they administered the morning medications for Resident 3 and instructed Staff D to administer their injection. Staff E stated that they were not aware it was given that late. Staff B stated they informed Staff D that they would continue to give all the medications for all the four cottages.

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, Cottages of Snohomish 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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

(d) Chapter 246-841 WAC, Nursing assistants; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure nurse delegation (ND) for blood sugar monitoring and administration of insulin was in place for two Staff (Staff F and Staff G) before allowing them to check residents' blood sugar and administer insulin for 2 of 2 resident's (Resident 2 and 3) who had diabetes. These failures resulted in staff F and G conducting nursing tasks without proper nurse delegation and nurse oversight. These failures placed all residents receiving insulin and blood sugar checks at risk of harm and complications.

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Findings included…

Review of Washington Administrative Code 246-840 showed The Nurse Delegation Program, Under Washington State law, allows nursing assistants working in certain settings to perform certain tasks—such as administration of prescription medications or blood glucose testing—normally performed only by licensed nurses. A registered nurse must teach and supervise the nursing assistant, as well as provide nursing assessments of the patient's condition. Documentation must be specific and include all required information.

Note: RCW 18.88A.210 Delegation—Basic and specialized nurse delegation training requirements. (3)(a) Before commencing any specific nursing care tasks authorized under this chapter, the nursing assistant must (i) provide to the delegating nurse a certificate of completion issued by the department of social and health services indicating the completion of basic core nurse delegation training, (ii) be regulated by the department of health pursuant to this chapter, subject to the uniform disciplinary act under chapter 18.130 RCW, and (iii) meet any additional training requirements identified by the Nursing care quality assurance commission. Exceptions to these training requirements must adhere to RCW 18.79.260(3)(e)(vi). (b) In addition to meeting the requirements of (a) of this subsection, before commencing the care of individuals with diabetes that involves administration of insulin by injection, the nursing assistant must provide to the delegating nurse a certificate of completion issued by the department of social and health services indicating completion of specialized diabetes nurse delegation training. The training must include, but is not limited to, instruction regarding diabetes, insulin, sliding scale insulin orders, and proper injection procedures.

Review of the ALF's undated Disclosure of Services showed the facility would provide intermittent nursing services using nursing assistants under the delegation of a registered nurse. The ALF would provide diabetic management.

Resident 2

Review of undated Face Sheet showed Resident 2 was admitted on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]).

Review of Care plan dated 06/26/2024 showed Resident 1 needed assistance with medications services. The ALF staff would assist Resident 2 in their medication administration as ordered by their physician.

Review of the Medication administration record (MAR) dated February 2025 showed Resident 2 was to receive an insulin pen injection of lispro 100 units/ milliliters (u/ml)

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four units subcutaneously (under the skin) every day in the afternoon after lunch.

Review of MAR dated December 2024 and January 2025 showed Staff G, Caregiver/Medication Technician, checked blood sugar and administered Resident 2's insulin on 12/15/2024 and 01/13/2025.

Review of Resident 2's MAR dated January and February 2025 showed Staff F, Caregiver/Medication Technician, administered insulin injection, checked the blood sugar and signed eight times for January and one time for February prior to their being nurse delegated.

Resident 3

Review of undated Face Sheet showed Resident 3 was admitted on [redacted]/2024 with multiple diagnoses including [redacted]

Review of Care plan dated 10/29/2024 showed Resident 1 needed assistance with medications services. The ALF staff would assist Resident 2 in their medication administration as ordered by their physician.

Review of the MAR dated February 2025 showed Resident 3 had the following orders:
(2) Insulin Lispro 110 units/Milliliters (u/ml) pen, inject 0-10 units subcutaneously three times daily before meals per sliding scale, No Lispro if pre meals blood glucose less than 100 (Sliding scale scheduled insulin) for diabetes Mellitus Type 2 to be given at 8:00 AM, 12:00 Noon, and at 4:00 PM.
(3) Insulin Lispro 100 u/ml pen, inject 5 units subcutaneously three times daily before meals (routine scheduled insulin) for diabetes Mellitus Type 2 to be given at 8:00 AM, 12:00 Noon, and at 4:00 PM
(4) Lantus insulin 100 u/ml, 10 ml. Inject 20 units subcutaneously every evening at 8:00 PM for diabetes Mellitus type 2.

Review of MAR dated December 2024 and January 2025 showed Staff G checked blood sugar and administered Resident 3's insulin two times on 12/15/2024 and three times on 01/13/2025.

Review of Resident 3's MAR dated January and February 2025 showed Staff F administered insulin injection, checked the blood sugar and signed five times for January and five times for February prior to their being nurse delegated.

On 02/05/2025 at 3:50 PM, Staff A, Assistant Executive Director, stated that Staff G,

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Med Tech, was a Med Tech from their company's other ALF. Staff A stated that they were not aware that Staff G was not nurse delegated to check blood sugar and administer insulin for their ALF.

On 02/06/2025 at 10:58 AM, Staff A confirmed that Staff G was not nurse delegated to check blood sugar and administer insulin for any of the ALF's residents.

On 02/06/2025 at 10:25 AM, in an email, Collateral Contact 1 (CC1), Nurse Delegator, stated that Staff F was not delegated because CC1 did not received from the ALF any documents or certifications for Staff F to be nurse delegated.

Review of CC1's Delegation Audit 2025 titled "Nurse Delegation Visit for Oral, topical medications, blood sugar checks and insulin administration" for Resident 2 and 3 showed Staff F was delegated only on 02/10/2025 after the Residential Care Services unannounced visit on 02/05/2025. Staff G was not listed as nurse delegated to perform the task of checking blood sugar and administering insulin for the ALF's residents.

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, Cottages of Snohomish 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

This document was prepared by Residential Care Services for the Locator website.